

Leadership, as a part of a curriculum of study, is in vogue in medicine and in many other disciplines. In his 2010 James Mackenzie Lecture,¹ Ritchie defines leadership as 'the ability to influence and motivate people' and describes leaders as people who 'cope with change, they set vision and direction, and stimulate team members to follow that vision'.

It may seem ironic that leadership is assuming greater prominence just at the time that the opportunities for self-direction are diminishing,² but this is no time for cynicism. Ritchie makes a connection between professionalism and leadership and we should think of these as being intertwined, with leadership being both part of core professional behaviour and a driver for its continual reform.

GROWING OUR LEADERS

Professionalism is deeply valued, but not so deeply understood: the opposite could become the case with leadership. The Medical Leadership Competency Framework (MLCF) is a reference point for all specialties,³ and provides a 'leadership compass' that Ritchie exhorts us to use in order to 'grow our leaders'.

If we are to do this, how may we proceed? We have conducted a pilot project in the Yorkshire and the Humber Deanery, using a cohort of registrars in the final 6 months of their third year of training.⁴ We wanted to see whether an exercise involving identifying and leading a project in the registrars' host practices, supported by a facilitated action learning set of peers, could develop leadership skills.

The MLCF identifies five core leadership domains in which all doctors should aim to become competent.⁵ The greatest gains in self-reported competence were in the domains of personal qualities, particularly self-awareness, that is itself an important component in the development of insight. Perhaps as a result of this, trainees' self-ratings were lower in some areas toward the end of the programme, showing a greater awareness of personal limitations.

When working with others, trainees took tentative steps to develop teams, and found that the experience of creating the impetus and mechanism for change often placed relationships under stress. A note of realism also crept in, with several commenting that



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teamworking can sometimes delay taking necessary action. Fewer changes were seen in the domains of managing services and setting direction, but realistic opportunities to develop these skills often do not come until later professional life.

One of the greatest reported benefits of the pilot was the opportunity for trainees to make the transition from tightly defined curriculum-based training to greater independence in practice and thought. Space to reflect is vital if trainees are to appreciate the complexity of generalism at deeper levels of learning and in ways that this can translate to practice.

BARRIERS AND BEARTRAPS

Our pilot indicates the need for the educational community to research and debate this relatively new area of training, and not to jump too quickly from frameworks to programmes. In anticipation of this debate on leadership training, some difficulties and potential pitfalls can already be identified.

Currently, leadership is not consistently understood. In particular, the new common framework is relatively unknown to many educators although a grasp of its scope can readily be gained by using the MLCF self-

assessment tool.⁶ Leadership may be equated to managerialism, that is not readily valued. Even though the General Medical Council requires competence in both, doctors may not appreciate the distinction, or understand how the management skills of monitoring, coordinating, and planning are vital to the leadership functions of setting direction and facilitating change.⁷

Doctors may justifiably ask about leadership: 'Do they mean me?'. One common assumption is that leaders are generals, rather than foot soldiers with the potential to be generals when circumstances require. If leadership is distributed, so must followership be, itself a related and necessary behaviour.

General practice is characterised by uncertainty and complexity⁸ and operates through relationships with a wide range of people with whom partnership is a key principle. Although we now have a generic framework for leadership, the context in that it is taught and practised will lead to differences in emphases and possibly to different expressions of competent leadership. With this in mind, the GP curriculum is being modified to bring together and emphasise the leadership competencies and to show how it may be applied by generalists.⁹

PERMISSIONS AND OPPORTUNITIES

General practice has had a head start in teaching the attitudes and behaviours of partnership, but to develop leadership abilities, doctors in training depend on opportunities to propose and carry through changes, that is a challenge to those who control the workplace. However, the challenge is greater than simply providing permission and support. In the flattening hierarchies of medical practice, changes of direction cannot occur in a workplace that does not value and promote leadership, and this in itself will require a change of group culture both within and between specialties and professions.

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Complex attributes are all too often grasped and taught superficially. However leadership, as part of professionalism, needs to be understood and taught at a deep level if it is to achieve its transforming potential and to become truly valued. If this does not happen, leadership will simply be a badge that doctors wear, rather than a way of ‘being’, in which they believe. This is a considerable but important endeavour which is why, for the educational community, leadership training also represents a leadership challenge that is worth rising to.

Amar Rughani,

Associate Postgraduate Dean, Yorkshire & the Humber Deanery, RCGP examiner, and Blueprinting clinical lead & Curriculum development group member, Sheffield.

Andy Godden,

GP Trainer, Sheffield, GP Tutor, Yorkshire & the

Humber Deanery, and Associate Director, NHS Revalidation Support Team, Sheffield.

Dominic Patterson,

Training Programme Directed, Doncaster GP Speciality Training Programme and GP Tutor, Yorkshire & the Humber Deanery, Doncaster.

Henry Smithson,

GP and Acting Head Academic Unit of Primary Medical Care Medical School University of Sheffield, Sheffield.

Provenance

Commissioned; not externally peer reviewed

Acknowledgements

We would like to thank Dr Jo Buchanan, who as Deputy Director of General Practice in Yorkshire & the Humber Deanery, strongly supported the leadership project.

DOI: 10.3399/bjgp12X616229

ADDRESS FOR CORRESPONDENCE

Amar Rughani

Medical Centre, 1, Bevan Way, Chapeltown, Sheffield, S35 1RN, UK.

E-mail: amar.rughani@sheffield.ac.uk

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