

The Review

Clinical leadership:

individual advancement, political authority, and a lack of direction?

'No amount of competencies, skills, authority, or inspiration will make leadership good if it leads us off a cliff. A moral compass is essential ...'

'Doctors and leadership: oil and water?' asked Richard Smith, before he became editor of the *BMJ*. 'Doctors have problems with leadership, both leading and being led,' he pointed out, quoting Leadership Professor Warren Bennis: 'leading doctors is like herding cats.'¹ Only a few years ago, the question of whether doctors should be doing more to lead the NHS was still open to debate.²

Questions are no longer asked about whether doctors can or should do leadership. Since Ara Darzi's 2008 NHS Review emphasised the importance of 'leading change in the NHS' and 'fostering leadership for quality'³ leadership has appeared with increasing prominence in medicine's clinical and political rhetoric. Competency frameworks and an industry of medical education have been constructed to support a standardised model of leadership. The Health and Social Care Act and discussions surrounding it have further influenced the concept and promotion of clinical leadership. However, questions persist about what leadership actually means in medicine.^{4,5} This essay suggests that the morality of leadership and the direction of progress have been overlooked.

OLD-FASHIONED LEADERSHIP IN PATIENT CARE

Clinical leadership once described the role of clinicians implementing hands-on change and improvement in clinical practice (for instance, implementation of hospital information projects,⁶ management of stroke,⁷ and interventions for specific patients⁸). A 2005 *BMJ* editorial on the theme of patient safety, for example, asserted that 'basic errors in clinical care' arise from the insufficient contribution of experienced staff, insubstantial support of junior doctors, and 'inadequate time devoted to team-building': clinical leadership was advocated as the solution to these problems.⁹ The theme was elaborated by correspondents who emphasised the value of teaching leadership and helping doctors 'understand the impact of their behaviour and actions on the team'.¹⁰ Another letter-writer advised:

*'What is required, however, is not the leadership beloved of politicians, where bullish confidence and decisiveness, often in the face of considerable opposition, are the order of the day. Rather, an atmosphere of trust in the clinical team is needed ...'*¹¹

This discourse and its implied definition of clinical leadership (trust-engendering, team-building leadership-within-the-clinic) no longer pertains: the 'leadership beloved of politicians' prevails. An individualistic, hierarchical, and highly-politicised notion of clinical leadership has been created alongside proposals for reconstruction of the NHS.

TODAY'S MEDICAL LEADERSHIP

Ara (now Lord) Darzi has returned to his operating theatre, but continues to advocate 'excellent leadership'.¹² For Bruce (now Sir) Keogh, surgeon and NHS Medical Director, the importance of leadership is self-evident:

*'We all know that where you have good clinical services they're underpinned by good clinical leadership and that where you have poor clinical services they're underpinned by poor clinical leadership.'*¹³

Perhaps it is self-evident too that these clinicians in senior NHS positions should affirm the importance of clinical leadership. Their endorsement has tacitly associated leadership with seniority while overtly confirming clinical leadership as a technical venture. 'Aspiring clinical leaders' says Darzi, 'will need to learn about the funding, governance, and management that are integral to the system ...'¹² Some knowledge of these concepts may be useful, but the sort of technical, expertise-driven, competency-based leadership implied here by Darzi has been criticised as too individualistic, restrictive, and embedded in hierarchy.¹⁴ Bolden and Gosling articulate how 'competency-based approaches tend to neglect the more subtle moral, emotional, and relational aspects of leadership'.¹⁵ Yet, a competency-based model has been widely adopted within the NHS; Clinical Leadership Competency Frameworks have been drawn up,¹⁶ and GP trainees have been encouraged to subscribe to these.¹⁷

Individualism and hierarchy are meanwhile upheld by competitive clinical

leadership fellowships, leadership awards, and a growing industry of clinical leadership-themed training courses, qualifications, and online learning tools. The targeting and uptake of these initiatives among individual clinicians (often aspirant juniors), rather than clinical teams, inherently undermines leadership as a collaborative venture. The *BMJ* Clinical Leadership Programme has regularly e-mailed promotional materials to potential applicants under headings such as: 'Future proof your career'; 'Improve the care you deliver and your career prospects'; 'Make your CV stand out from the crowd'; 'Invest in your future'. Here, leadership for the advancement of individuals and individualism is clearly apparent.

POLITICAL USE OF CLINICAL LEADERSHIP

'Clinically-led health services'; 'a service led from the front'; 'handing power to the clinicians': these or similar phrases appeared in many of Health Secretary Andrew Lansley's speeches and statements on the subject of the NHS reforms. A notion of clinical leadership has been deeply embedded in the proposals for NHS reform contained in Lansley's Health and Social Care Bill. The Bill's proposals were not mentioned in the 2010 general election campaign, nor in the Coalition Agreement of May 2010 which vowed to 'stop the top-down reorganisations of the NHS'.¹⁸ Nonetheless, the replacement of 'NHS management' by something like 'clinically-led health services' had already become a political inevitability. During the UK's first ever televised election debate last year, NHS managers were portrayed as ruthlessly compromising patient care. Nick Clegg claimed:

*'Under this [Labour] government, they've employed 5000 more managers in the NHS, yet the maternity ward in the NHS hospital where my third son was born just over a year ago is threatened with closure ...'*¹⁹

David Cameron displayed equivalent outrage: 'the number of managers is going up five times faster than the number of nurses in our NHS'.¹⁹ Subsequent removal or re-packaging of NHS management was inevitable: 'clinical leadership' offered an alternative that was not only politically

acceptable, but potentially appealing.

When a King's Fund report drew attention to the unhelpful disparagement of NHS managers by politicians and the essential role of managers within the health service,²⁰ Lansley revised the target of denigration and necessary 'disempowerment' from managers to 'tiers of management', while clinging to the rhetoric of clinically-led services:

*'If we want the NHS to be truly run from the front line ... If we want to empower patients and clinicians ... It isn't management that we disempower, actually it's the bureaucracy that we disempower, it's those tiers of management that have got in the way of enabling the people who manage the care of patients to take responsibility for the service design that goes with best delivering that care and that is what the Health and Social Care Bill is all about.'*²¹

Lansley consciously embedded clinical leadership deep within his NHS reform plans; so much so that support for the former seems to endorse the latter. Thus re-reading the above passage: 'if we want the NHS to be truly run from the front line ... that is what the Health and Social Care Bill is all about'. What does clinical leadership mean to Andrew Lansley? The above statement reveals that he thinks it has something to do with service design and a lot to do with power.

The promise of power might sway politicians, but 'empowerment' was not sufficient to convince patients and clinicians of the NHS reform proposals. The controversial passage of the Health and Social Care Act hardly needs recounting; reference to the previously-quoted 'leadership beloved of politicians, where bullish confidence and decisiveness, often in the face of considerable opposition' may serve as sufficient reminder. We should be concerned by the clinical leadership Lansley describes and by the leadership he has demonstrated. Nurses voted 99% to 1% for a vote of no confidence in his policies²² and the BMA's GP Committee chairman labelled elements of the proposed NHS reforms 'disgracefully unethical'²³ before Lansley and his reformers conceded that they would have to listen to the opinions of patients and health professionals.²⁴ Leadership cannot always be by consensus and the reactions of prominent figureheads cannot always be prevented. However, the promulgation of leadership based on power, in the absence of consultation, and in the light of contested morality, constitutes an unsettling model.

MORAL LEADERSHIP AND MOBILISING GROUPS

A moral dimension and a discussion of values has been largely absent from discourse relating to both the NHS reforms and the issue of clinical leadership. Yet ethics and values should be central to determining the direction in which we are led and the directions in which we lead others. As clinicians we have been encouraged to lead and given competency frameworks for this purpose; but do we know where we are going?

Influentially-advanced definitions of leadership ignore the issue of direction-finding or imply that direction will be intuitively apparent to the leader: that the challenge of leadership lies elsewhere; in imparting or encouraging the direction among followers. For example, 'setting a vision for people, and inspiring and setting organisational values and strategic direction' is the definition of leadership adopted in the *BMJ*'s newly-published *ABC of Clinical Leadership*.

It is not enough to judge a leader on the basis of their ability to set or inspire values and direction: those values and direction should be subject to judgement too. Good leadership — leadership worthy of the name — must be defined at least in part by its direction. No amount of competencies, skills, authority, or inspiration will make leadership good if it leads us off a cliff. A moral compass is essential. Without morality to orientate our leadership we will find ourselves on treacherous terrain (Hitler was a good leader if we ignore morality).

Questions of how we discern what is 'right' or 'good' have long troubled moral philosophers; the answers may be unknowable to an individual acting alone, but consideration of a shared morality can help. Mapping the values of group-members will be important to direction-finding: uncovering and perhaps challenging well-established assumptions, behaviours, values, and beliefs is difficult and dangerous work, but this is the work of good leadership.²⁵ Clinical experience of patient management in primary care should tell us that relying on authority and technical competencies without negotiating and confronting values is a flawed strategy and one liable to failure.

CLINICAL LEADERSHIP AND FUTURE CHANGE

When Lord Darzi advised on change to the NHS in 2008 he asserted that 'leadership will make this change happen'. Today, change is making leadership happen: not

ADDRESS FOR CORRESPONDENCE

Andrew Moscrop

Oxford University, Department of Primary Health Care, 2nd Floor, 23-38 Hythe Bridge Street, Oxford, OX1 2ET, UK.

E-mail: andrewmoscrop@post.harvard.edu

only is clinical leadership embedded in the NHS reform plans, but it may be more generally true that at times of actual or perceived change or 'crisis' we look for leaders to lead us through.

Prevailing competency- and authority-based models of leadership are inadequate to address the complex, multi-party, value-laden, adaptive challenges of health care. But these models are not yet irrevocably enshrined. Clinicians may have stopped asking whether doctors need to do leadership, but they are still asking what leadership means, and alternative models are being proposed. Recent work has included: an in-depth consideration of morality in medical leadership;²⁶ an account of purposeful, reflective approaches to clinical leadership in primary care;²⁷ and an exploration of the potential of clinical leadership to improve patient care (drawing attention to the tendency of leadership to focus on less patient-focused ideals such as 'a better NHS' and the demonstration of leadership competencies for their own sake).²⁸

Leadership has so far been defined by those who claim to lead; but good clinical leadership is still ours to create. With the passage of the Health and Social Care Act, we might acknowledge the advice of the RCGP Chair that 'we must now look forward and do the best we can by our patients',²⁹ while also recognising the truth of the King's Fund observer who said of the NHS reforms that 'the real impact depends not on their design but on implementation'.³⁰ Instead of looking for leaders to lead us out of our future challenges, we may need to hold true to our values and be prepared to put our own leadership capabilities on the line. For GPs in England, this may have never been more true than now.

Andrew Moscrop,

GP, Department of Primary Health Care, University of Oxford, Oxford.

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