Leadership reframed

'Every time you send an email inviting me to participate in a medical "leadership" event, a part of me dies,' tweeted Ben Goldacre, junior doctor and *Bad Science* columnist, recently.

I know how he feels. Leadership events are — often although not always — predicated on the assumption that attendees can be supplied with a dose of leadership fairy-dust via PowerPoint® bullets and naff group exercises, and then sent back to sprinkle it on troubled organisations, recalcitrant staff, and needy patients.

The idea that tools such as SMART ('specific, measurable, achievable, realistic and timescaled') objectives or the Belbin Team Roles Questionnaire will transform the delivery of health care presupposes that leadership in this context is essentially a managerial technique for increasing the efficiency of a process. As Goldacre perceptively mused, if you buy into this mind-set, you unwittingly concede a more professionally-oriented framing of what leadership is.

I recently had the great good fortune to spend a few days with Edvin Schei, Norwegian GP and philosopher whose paper *Doctoring as leadership* deserves to be more widely read.[1] Schei locates 'leadership' in relation to the doctor–patient relationship: we lead, first and foremost, not in committees or teams but in the clinical consultation. He argues, unfashionably but persuasively, that an unequal power relationship between doctor and patient is inevitable, and clinical leadership is about how we handle this inequality for the benefit of the patient.

In Schei's model, two forces militate against effective clinical leadership. The first is the depiction of medicine as nothing more or less than an objective and rational exercise in decision science. The second, somewhat paradoxically, is the fashion in bioethics to depict patient autonomy as an unassailable principle of good practice. We can't have a leader–follower relationship in the clinical consultation, the prevailing argument goes, because we need 'patient empowerment'.

Schei rejects this argument on the grounds that it is illness itself, not medical paternalism, that makes the patient vulnerable and the clinical relationship necessarily unequal. In our society, doctors are invested with symbolic authority: they are the people to whom we expose our imperfect bodies and disclose information that is embarrassing or stigmatising. Serious illness is usually frightening and involves a threat to the existential self (pain, disfigurement, loss of dignity or status, and so on). In such circumstances, we go to the doctor not only to receive scientific advice, but also for a socially-sanctioned witness to our suffering.

It is telling that when doctors get seriously ill, even when their illness is in the area of their own clinical expertise, the first thing they tend to do is seek out another doctor before whom they can become vulnerable. In such circumstances, few of us would be interested in an 'equal' relationship.

Leadership, suggests Schei, is about maximising the power to heal while minimising the risk of abusing this power. To achieve excellence, we need to hone our ability to empathise and our willingness to learn from patients. When they start covering this agenda in 'leadership events' I might just accept an invitation to attend one.

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DOI: 10.3399/bjgp12X653688

REFERENCE

1. Schei E. Doctoring as leadership: the power to heal. *Perspect Biol Med* 2006; **49(3)**: 393–406.

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