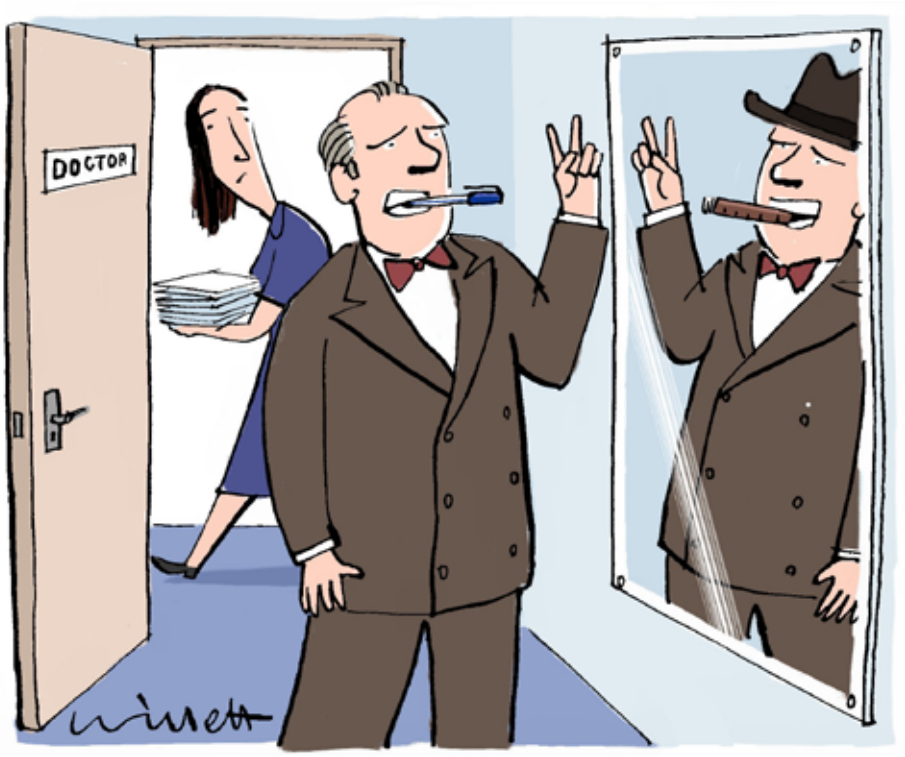
DOCTORS AS LEADERS

Next week, the *BMJ* and the King's Fund will hold a debate asking if doctors have neglected their duty to lead the NHS. **Candace Imison** and **Richard W Giordano** describe the importance of doctors as leaders



An extensive consultation exercise led by the King's Fund and the Royal College of Physicians with hundreds of doctors across England last year identified a lack of medical leadership.[1]

"There's no easy way to sugar the pill—according to the doctors who took part in this consultation exercise, medical leadership (with a few notable exceptions) was conspicuous by its absence," it said.

These findings seem to be supported by Professor Aidan Halligan's (former Director of Clinical Governance for the NHS) reflections on clinical leadership last year. Talking about his work across seven different trusts—which were all dealing with the consequences of a lack of clinical leadership—he said: "In every service, I noticed underlying themes of poor leadership, professional isolation, ineffective systems and processes, disempowerment and poor communication. The underlying team issues included an "everyone knows" culture, active covering up, indecision, a disconnect between management and clinicians, and a culture of fear."[2]

More recently, in their review of Mid Staffordshire NHS Foundation Trust, the Healthcare Commission highlighted deficits in clinical leadership and governance:

"Worryingly, many consultants considered that governance at the trust was something that was done to them, rather than being a key part of clinical activity in which they had a major part to play," the investigation said.[3]

The findings of the Healthcare Commission make salutary reading. They speak about managerial and clinical failures, but also raise important questions about a more generic leadership failure in the medical profession. How could professionals stand by and allow patients to receive substandard and in some cases life threatening care?

And yet there are also signs that clinicians are taking on the leadership challenge. At the highest levels, in the United Kingdom, clinical leadership appears strong. The appointment of Lord Darzi and the national clinical directors to lead on the development and implementation of the National Service Frameworks has brought doctors to the top table of health service policy. Some outstanding clinicians are also leading change locally, including those pioneering service line management in NHS Foundation Trusts, the most forward thinking practice based commissioners, and even a few NHS chief executives. But do they reflect the mainstream or are they leadership outliers?

A good debate about whether or not our doctors are letting the side down on leadership also needs to consider whether doctors are able to lead and, ultimately, if it really matters whether or not they do.

Many clinicians would argue that their capacity to lead has been undermined by managers and that the system, not the profession, is driving the failure in clinical leadership; delivery of targets is rewarded with little insight into the quality and outcome of patient care. And they would point to the different systems used in places with excellent reputations for medical leadership, such as the United States health management organisation Kaiser Permanente.

It is also important to recognise the challenge that leadership poses to clinicians. The clinical leader must understand the big picture along with its component elements as well as their own position in it and how they influence it. Without thinking of health care as a system, the potential leader risks influencing only one part of it, which means their efforts will simply dissipate. In 2003 Richard Smith argued in the *BMJ* that "Doctors are losing out in modern healthcare systems because of their discomfort with leadership, strategy, systems thinking, negotiation, gen-

uine team working, organisational development, economics and finance."[4] As to where responsibility lies for ensuring effective clinical leadership, key qualities—such as a systems based approach, subtle powers of persuasion, and self awareness—are not those normally associated with medical training. Nor are they an integral part of the institutional reward and incentive structure for practising clinicians. In fact, professional training and development from the undergraduate years onwards is largely focused on excellent medical competence and judgment, assessed through exams and interviews.

This situation, however, is beginning to change, as can be seen in the Medical Schools Council consensus statement on the role of the doctor, which emphasises leadership. In the United States, progress has been faster and there are now examples at Duke and Harvard universities of integrated leadership and clinical training in their MSc and MD programmes.

But does it matter whether we have good clinical leaders or not? All the evidence points to an emphatic yes. Not only has poor medical leadership been shown to be a key factor in failures of health services such as those described earlier, it is also critical to the success of health improvement programmes. If the current health reforms such as Practice Based Commissioning are to succeed, they too will require strong clinical leadership.

Much more difficult to answer is the question of whether or not we have enough effective clinical leaders in England—and, if not, why not? Over to the debate.

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This debate will take place on 28 April at The King's Fund, Cavendish Square, London. To reserve a free place email events@kingsfund.org.uk. Or listen to a podcast after the event on bmj.com.

Competing interests: None declared.

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This house believes doctors are neglecting their duty to lead health service change

ANTHONY DEVLIN/PA ARCHIVE/PA PHOTOS

PROPOSER

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OPPOSER

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At worst the doctor should do the patient no harm. At best they should practice EBM—in this case, economics based medicine—by focusing on the comparative cost effectiveness of competing interventions.[1] EBM requires doctors to recognise the universal issue of opportunity cost, where a decision to treat one patient involves the denial of treatment to another patient. It also obliges the doctor to focus on value: the value of what they give up when they treat a patient (cost) and the value of what is gained as a result of treatment—hopefully improved length and quality of life for the patient. Clinical practice should be driven by the pursuit of EBM, conditioned by humane consideration of the patient's needs, particularly at the end of life.

From Barbara Castle in 1976[2] to Ara Darzi in 2008,[3] there has been political and policy focus on variations in clinical practice and a failure by the profession to acknowledge these problems and practise safe, conservative evidence based medicine. Consequently patients with similar characteristics and needs receive very different packages of care. This is a ubiquitous international problem, with evidence from the United States that improved practice could produce better care and save 20-30% of the budget.[4]

When clinicians and hospitals "fail" clinical leadership has proved to be inadequate

Healthcare systems are not underfunded. They are profligate. The failure to translate evidence and policy advocacy into improved care has wasted resources and deprived patients of care from which they could benefit. Such inefficiency is unethical and prima facie evidence for deregistration of medical practitioners.

So why have doctors failed to translate evidence into practice? Clinicians practise in isolation rather than corporately. They hide behind media induced blame of "management" for clinical failures, as epitomised by the problems in Mid Staffordshire Trust. The quality of patient care is largely determined by doctors and their clinical colleagues. Any "failure" to deliver good quality care to patients is a product of management, both clinical and non-clinical. When clinicians and hospital "fail" clinical leadership, as exemplified in Bristol and elsewhere, has proved to be sadly inadequate.

The failure of clinicians to demand and use comparative data facilitates the maintenance of poor practice. Their often fierce herd protection of colleagues ensures that non-clinical managers proceed too meekly in collaboratively exploring and mitigating practice variations to protect the frequently defenceless consumer.

As we stumble from recession into depression, the public finances cannot afford large increases in NHS funding. The demand for care is increasing due to demography and marginal improvements in the cost effectiveness of some medical technologies. Without a quantum shift in collaborative clinical leadership, the NHS will fail to provide adequate patient care. Consequently, care will become even more fragmented than it is now as the affluent exit the NHS and leave the poor and elderly to their lot.

Physicians, heal thyselves, and take the NHS into the EBM Promised Land advocated by Archie Cochrane[5] and other significant leaders of your profession.

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Competing interests: AM is Chairman of York Hospitals NHS Foundation Trust and a member of the Department Of Health's External Advisory Committee on Payment by Results (PbR).

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Doctors have never neglected their duty and have, throughout history, led health service change. It is fanciful to suggest otherwise. Our major teaching hospitals and the specialty of general practice owe their existence to doctors of a different age leading transformational change in service delivery. More recently doctors have shown this ability to lead at the highest levels, championing the calls for bans on smoking, landmines, and torture among other issues.

Successive organisational changes within the NHS in the 1970s and 1980s—particularly the 1983 Griffiths report, which essentially introduced the idea of general management into the NHS—have, however, marginalised doctors from their role in management and have adversely affected their ability to lead healthcare change.

The NHS has only recently recognised that it is essential that doctors are involved in leadership. Lord Ara Darzi's next stage review[1] last year demonstrated the enthusiasm of clinicians from all backgrounds to be involved in leading healthcare change if empowered and invited to do so.

Despite this current disenfranchisement, doctors have remained at the forefront of health service change. Fundholding, for example, has shown the enthusiasm and drive local general practitioners could bring to organisational change.

Without any national policy, GPs have also led change in other fields, quietly and effectively. The area of nursing that has undergone more change and expansion than any other over the past 20 years, often in the face of opposition from the Royal College of Nurses, has been practice nursing. This change has involved the gentle but complete transfer of the management of several long term conditions, such as hypertension, asthma, and diabetes, from hospital outpatients to general practice. It has occurred without targets, diktat, or management intervention.

When Alan Maynard challenged doctors to demonstrate leadership by a wholesale switch to cheaper statins a year or so ago his message was unnecessary. The switch happened. Where clinicians are empowered and able to lead health change they do so without drama.

International organisations involved in healthcare change are totally engaged with clinicians without the prejudice shown by our National Health Service. Leaders from Canada, Cuba, USA, and Germany at the 2007 International Clinical Summit in London talked of "valuing the dissent of clinicians" and clearly understood that clinical leadership was the most underleveraged area of the healthcare system. It is to the detriment of the NHS that our best clinical leaders find career structure, respect, and remuneration in consultancy organisations such as Ernst & Young and Price Waterhouse Cooper, which then ironically sell this back to the NHS.

Where clinicians are able to lead health change they do so without drama

The critical issue for the NHS is that their clinicians are currently disempowered and disenfranchised, poorly supported, and often required to make considerable sacrifices if they are to take on further leadership. It seems to me that if managers are in government then clinicians are her Majesty's opposition and as such their duty is currently to oppose and reveal weaknesses in healthcare change. There is no other action they can take.

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Competing interests: JC has recently been sponsored by South Central Strategic Health Authority on a Higher Potential Leadership Course, run in conjunction with The King's Fund, and is a practising clinician in the NHS and a member of the professional executive committee for Berkshire West NHS (PCT).

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SECOND PROPOSER

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Healthcare used to be cheap and ineffective, now it is expensive and can be highly effective. As the potential to both spend and to heal grows, so does the need to spend wisely to heal most effectively.

Evidence is emerging that clinically led healthcare organisations provide better quality and efficiency.[1] No surprise. Other industries, from energy to information technology to the military, have technical experts leading because they are capable and credible: technical experts often have the best grasp of issues, and people often respond best to peers. The more complex the industry and the tighter its socialisation, the greater the importance of having experts on leadership teams.

Leadership involves deciding what to do on the basis of the best information available, but you must understand that information. Today, clinical IT systems highlight wide variations in quality and in productivity. Doctors' clinical expertise often makes us best equipped to understand and to act on this information. A central leadership challenge is deciding what variation is acceptable and what is not.[2] Well informed doctor-leaders must be part of making that decision.

But what is the evidence that doctors are neglecting their duty to lead in today's NHS? Tolerance of inappropriate variation in itself constitutes a failure of doctors to lead. Examples of variation leading to under-treatment, over-treatment, and ineffective treatment are rife. The 2008 MINAP audit of acute myocardial infarction treatment across England and Wales showed that in parts of London patients have near 100% chance of receiving primary angioplasty. Yet in other major cities, including teaching hospitals with high patient volumes, a patient's chance of receiving this standard of care (even where it is offered) can be as low as 30-40%.[3] Similarly, the likelihood of a woman being offered immediate reconstruction after mastectomy varies by hospital from below 5% to over 40%.[4]

We tolerate failures in safety and reliability that shock people with backgrounds in other industries. The Institute of Medicine estimated up to 100 000 people die unnecessarily each year from shortcomings in care in American hospitals.[5] UK studies suggest about 10% of inpatients suffer an adverse event. A third of these lead to significant disability or death; half are probably preventable.[6] Most doctors are unaware of these data, or believe they highlight "a system problem"—anyone's job but theirs to fix. This is evidence of a leadership failure.

Out of hundreds of Primary Care Trust and Hospital Trust chief executive officers, only a handful are doctors, and nearly 25% of PCTs do not have a medical director. En masse, doctors recoil from management: while over two-thirds of Britain's doctors are BMA members, only 1% are members of the British Association of Medical Managers (BAMM).[7] Yet leadership and management go hand in hand; leaders decide what to do, good managers do it well. The small number of doctors on leadership teams in PCTs and trusts is further evidence of a leadership failure. The NHS has some fine medical leaders, at all levels from CEO to front line. Their achievements highlight the potential currently left untapped since leadership is not a natural part of being a doctor.

First, doctors must lead themselves. Every doctor should commit to understanding their own performance and that of their unit, and to knowing what drives these. And every doctor must set about systematically improving performance.

Second, doctors must take on roles to lead and manage departments and whole organisations—not as reluctant figureheads, but as committed, competent, and creative professionals whose goal is ever higher quality and efficiency, not only for individual patients, but also for populations.

Achieving this requires changes in training, career structures, and financial incentives, greater transparency on performance quality and efficiency, and greater pressure on organisations and individuals to perform. Overall, the test is whether we can make leadership core to doctors' professional identity. We need doctors who are motivated to lead by both an inner sense of purpose and an external sense of peer pressure and pride.

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Competing interests: JM works for McKinsey & Company, a consulting company working with organisations in healthcare and other industries.

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SECOND OPPOSER

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Medicine has been evolving for thousands of years. The NHS is 60 years young. It is an instrument of delivery of health services led by politicians and directed by civil servants to promote the health of the nation. At its core the relative priorities of health care and the way they are received by patients and communities in the UK are shaped by policy. Between the policy at the centre and the individual patient in the distant community are structures which are in a constant state of flux. The NHS is one of many systems in use worldwide and, by most measurements, not necessarily the best.

Few practising doctors today who qualified and trained in the UK will have any experience of any other health system. The NHS has become synonymous in the minds of the public and the profession with health in the UK. In practice the NHS is a choice. For now it is the choice of the British people and has been tested against popular opinion many times since 1948. Most doctors approve of the principle that health care should be available to all regardless of ability to pay. They are less certain of how to deliver those services.

Health care advances through new and better understandings of the causes and the treatment of diseases. It is led collectively by doctors, scientists, and others who are woven loosely into a global community. There is no formal structure that directs the enthusiasms or agenda of those involved. By and large it is an intellectual curiosity inspired by a long tradition of commitment to knowledge and to better patient care that drives the academic community. It is a never ending journey.

There is no shortage of new knowledge whether it is in basic science, therapeutics, or technology. Medical advances are acquired, filtered by the global medical community and then pass into the NHS. Laparascopic surgery and interventional radiology are obvious recent examples Doctors have established and reshaped entire services such as diabetes, terminal care, or management of obesity. Often doctors could achieve more if the structures into which the service changes were being implemented could change at the same speed. The pace of change brought by interventional cardiology is a fine example of doctors staying ahead of a politically driven agenda with technical and pharmacological change being implemented by doctors at a pace which outran service and workforce planning, financial flows and performance targets.

Regardless of the political predilection of the moment it is doctors who must select the most potent opportunities on offer by the academic community and translate these into improvements to patient care. The survive sepsis campaign, now a national programme, was the brainchild of doctors with no special responsibilities to make service change; it was created to solve a problem. Doctors do this well, constantly. Excellent clinical services are built by clinicians and by medical leaders who exist within the system at every level. They lead service change by virtue of their opportunity, their traditions, and their enthusiasm.

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