Exploring UK health-care providers' engagement of trainee doctors in leadership

ABSTRACT

The need for doctors at all levels to undergo some form of leadership development is well evidenced, but provision remains patchy and models underpinning such development are often inconsistent. This article sets out the findings of a literature review into leadership development opportunities for doctors in training in the UK.

Health-care provision is constantly evolving and the ability to develop and fund services capable of keeping pace with groundbreaking medical research is further challenged by rapidly advancing technological innovation, including artificial intelligence and mobile technologies. It is imperative that the next generation of medical leaders develops the knowledge, skills, mind sets and approaches to manage such pressures in the context of increasing public expectations and a reduced tolerance for mistakes.

Many reports note that leadership skills are essential for all doctors and, when health-care providers fail to engage their medical workforce, things can go wrong (e.g. Armit and Roberts, 2009; Francis, 2013). Leadership is necessary not just to maintain high standards of care, but also to transform services and achieve even higher levels of excellence (Department of Health, 2007; Keogh, 2013). It is most helpful if doctors begin developing their leadership skills at the earliest stages of their careers, and if those responsible for their training programmes integrate leadership training as a core domain of their undergraduate and postgraduate education (Winthrop et al, 2013). Organizations can gain huge benefit by recognizing the valuable contribution that doctors in training can make as agents for change and the 'invaluable eyes and ears' (Francis, 2013) that they provide on the frontline. While anecdotally doctors in training are increasingly being valued by the organizations they work for, they are still perceived to be under-represented when planning and implementing change within health care (Winthrop et al, 2013). Medical engagement should not be an optional extra but an integral element of any health-care organization (Clark and Nath, 2014), and with doctors in training providing 25% of the total medical workforce within the NHS they should be fully used (General Medical Council, 2015).

Doctors in training should 'not just be the clinical leaders of tomorrow, but the clinical leaders of today' (Keogh, 2013) and this review explores the relationship between doctors in training and their organizations. Nearly 10 years on from the Tooke report, which recommended that greater attention should be paid to developing the leadership skills of doctors in training (Tooke, 2008) and 5 years on from the Keogh review which commented that 'too many (doctors in training are) not being valued or listened to' (Keogh, 2013), this article explores whether, and if so how, leadership development opportunities are provided that value doctors in training, develop them for leadership in an uncertain and more complex future, and treat them well. The review focuses on methods and approaches currently being used in the UK to encourage the engagement of doctors in training in opportunities aimed at specifically developing their leadership skills.

Dr Christopher J Miller, ST7 Registrar, Department of Geriatric Medicine, University Hospitals of Leicester NHS Trust, Leicester LE1 5WW

Dr Alex Till, Psychiatric Core Trainee, School of Psychiatry, Health Education North West, Liverpool

Professor Judy McKimm, Professor of Medical Education and Director of Strategic Educational Development, Swansea University Medical School, Swansea

Correspondence to Dr CJ Miller (c.j.miller@doctors.org.uk)

Developing medical leadership

In keeping with the 'great man' theory (Bolden et al, 2003) of 'heroic leadership' (The King's Fund, 2011) that has historically dominated health-care leadership theory, leadership qualities are often argued to be innate. Some have argued that leadership training should only be offered to those who show an interest or aptitude (Mintz and Stoller, 2014) or who reach certain senior positions. However, these views are now seen as outdated and there is general acknowledgement that leadership can and should be learned (Gentry et al, 2012).

One-off leadership development programmes (e.g. short courses, workshops) are widespread but can only go so far. Petrie (2014) describes leadership development that provides an underpinning knowledge and skills base as 'horizontal leadership development programmes'. He suggests that a reliance on purely horizontal leadership is incomplete, and fails to fully develop effective leaders for four reasons:

1. Wrong focus: one-off programmes primarily deliver theory and information rather than allowing leaders to develop themselves
2. Lack of connectivity: the theory and knowledge gained is frequently disconnected from the 'real world' of clinical work. This can lead to an inability to convert

theory learned into actions to address real problems
3. Leader in isolation: lack of engagement of key stakeholders during a leader's development can result in leaders missing out on support, advice and accountability from colleagues, and experience resistance from stakeholders that are surprised by a change in the leader's behaviours
4. Too short: traditional programmes are typically delivered in 'short bursts' rather than as a process over time which limits meaningful reflection and hinders the consolidation of further learning (Petrie, 2014).

In short, the primary function of most 'horizontal development' is to transfer information to the leader to improve his/her knowledge, skills and competencies. 'Vertical leadership' is where the leader puts his/her understanding and experience into practice in real life situations. Vertical development recognizes that the leader already has the knowledge, and aims to transform the leader by developing more complex and sophisticated ways of thinking (Petrie, 2015). The process of 'vertical leadership development' relies on testing, refining and solidifying a leader's habitual routines and thinking styles. A longitudinal and balanced process blends 'heat experiences' (challenging situations), 'colliding perspectives' (different views of a situation) and 'elevated sense making' (deep thinking and reflection using theories or models) to allow leaders at any stage to achieve the next developmental level and fulfil their potential (Petrie, 2015).

One example of colliding perspectives is emphasized by Reinertsen at al (2007) who describe the complexities in the relationship between clinicians and managers. The competing logics of doctors, who typically have an individualized focus on patients, and managers, who generally take a wider systems' view, often creates conflict. These colliding perspectives can lead to strained relationships between managers and more junior clinicians and staff who may not have the knowledge, experience or interest in the complexities of budgets, service provision and rationalisation. Similar to inclusive leadership which celebrates and welcomes diversity, leaders should be encouraged to listen to others' views and opinions, to be challenged, to consider ideas that may differ from their own, and to be willing to adapt and change (Till et al, 2016a). Self-insight and self-regulation are vital to such an approach (Goleman, 1995), as well as an understanding of unconscious and cognitive biases.

How are doctors in training being encouraged to engage with clinical leadership?

Medical Leadership Competencies Framework

The development of leadership skills has been traditionally omitted from both undergraduate and postgraduate medical curricula. To tackle this shortfall in training, the Enhancing Engagement in Medical Leadership project was jointly undertaken between the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement (Ham and Dickinson, 2008). This project aimed to 'nurture a culture of engagement, whereby doctors were able to take more of an active role in the planning, delivery and transformation of NHS services'. The creation of the Medical Leadership Competencies Framework (NHS Institute for Innovation and Improvement and Academy of Royal Colleges, 2010) meant that, for the first time, guidance was available to help educationalists design undergraduate and postgraduate medical curricula to meet defined competencies in medical leadership and management.

Many universities and medical Royal colleges altered their postgraduate curricula to place increased emphasis upon leadership, including the development of academic foundation competencies on medical leadership and management (UK Foundation Programme, 2017). However, the translation of this into developmental opportunities and specified training requirements was often lacking, resulting in a significant discrepancy between undergraduate medical degrees and postgraduate medical specialties as to what is required (Jefferies et al, 2016; Till et al, 2016b). Since the publication of the Medical Leadership Competencies Framework, new generic NHS leadership frameworks have been published. While these provide a 'one stop shop' for all health-care professionals interested in leadership development, they may also be confusing for staff less familiar with such frameworks.

Undergraduate medical education

Development of leadership skills and competencies need not wait until a doctor in training reaches postgraduate level. As already discussed, horizontal development (whereby the leader gains knowledge, skills and competencies) can begin at any stage of training and from which vertical development can then be cultivated. Medical school provides an ideal opportunity to develop as a leader and allows students to test, redefine and solidify their own understanding of leadership and individual leadership behaviours. A clear focus is required at undergraduate level on leadership development and should begin at the earliest stages, with the provision of formal learning opportunities combined with support and recognition by the school of informal leadership activities and development.

Till et al (2017) describe twelve tips for integrating leadership development into undergraduate medical education, set out in *Table 1*.

Medical schools can tailor their leadership development offer in line with their philosophy and structure and incorporate leadership development as a part of their core curriculum. Till et al (2017) 'suggest the following core knowledge and competencies should be embedded throughout the programme:

- Core concepts and models of leadership, management and followership
- Health management, systems, services and structures
- Law, ethics, morals and values
- Quality improvement, patient safety and audit
- The roles and responsibilities of different health workers

Table 1. Tips to integrate leadership development into undergraduate medical education

Understand the evidence, rationale and outcomes required for leadership development in the undergraduate curriculum
Reframe leadership as a core part of a medical professional's identity
Enable an exploration of self
Facilitate leadership development through team working
Cultivate an understanding of the organizations and systems that deliver health and care
Adopt the characteristics of successful programme design
Define and map a 'core curriculum' in leadership development and provide additional opportunities for those who are more interested
Assess the development of leadership competencies, knowledge, skills and behaviours
Embrace the hidden curriculum through near-peer learning
Support specialist faculty to lead the development and integration
Connect and harness the power of networks
Contribute to building the evidence base for integration of leadership development into undergraduate medical programmes
From Till et al (2017)

- Change and project management principles
- Communication skills: written, verbal, non-verbal
- Group and team dynamics, effective interprofessional teamworking
- Developing self-insight, cultural and emotional intelligence through reflection, feedback and conversation
- Being and becoming a professional.'

Medical students, like all health-care professionals, can 'learn to lead' and they should be supported to do so, despite an already crowded undergraduate medical curricula.

Postgraduate medical education

When doctors in training undertake formal leadership development they are significantly more likely to feel valued by their organization, are more likely to engage (Micallef and Shaw, 2014), and are more likely to have their ideas implemented (Gilbert et al, 2012). The provision of leadership education during postgraduate medical training is well underway with many opportunities on offer for doctors, and it is well recognized that leadership and followership needs to be incorporated into a doctor's training to support the development of professionalism (Royal College of Physicians, 2005). While formal efforts

Table 2. Leadership opportunities for UK doctors in training

Level and type of training	Description and examples
National leadership opportunities	Available in all four nations, the National Medical Director's Clinical Fellow Scheme, ADEPT clinical leadership fellows' programme, Scottish Clinical Leadership Fellows' Scheme, and Welsh Clinical Leadership Training Fellows provide a limited number of doctors in training with the opportunity to work on national projects alongside senior NHS leaders. The aim of these fellowships is to 'fast-track' skills in leadership, management, strategy, project management, and health policy for the benefit of UK health systems. The Faculty of Medical Leadership and Management provides a repository of resources, professional recognition, training events and an annual conference aimed at doctors and students at all stages of their career who are interested in leadership and management
Regional leadership opportunities	Available within certain areas, schemes such as the Darzi fellowships (Health Education England Kent, Surrey, Sussex) or the Future Leaders Programme (Health Education England Yorkshire and Humber) exist to provide health-care professionals (not exclusively doctors in training) the opportunity to work on a defined service innovation or transformation project and often combine this with formal medical leadership and management education. Darzi fellows report a 'mind shift in their self-understanding, confidence and knowledge of leadership' (Stoll and Foster-Turner, 2010)
Local leadership opportunities	Alongside bespoke local opportunities, many NHS trusts and health boards provide their own development programmes for doctors. One example is that some trusts in England have subscribed to the Royal College of Physicians (London) Chief Registrar Scheme. This supports aspiring clinical leaders to develop the skills required for their future consultant roles, while developing their confidence and profile to pursue local and national senior leadership roles in the future. The scheme provides formal leadership and management training by the Royal College of Physicians (London) and the Faculty of Medical Leadership and Management
Leadership foundation programmes	Some foundation programmes have established academic training in leadership and management. These roles take many forms and usually balance clinical work with some non-clinical quality improvement work and formal leadership and management education and training
Postgraduate qualifications	Numerous UK universities offer postgraduate qualifications in medical and clinical leadership and management. Some universities collaborate with other organizations such as the Royal College of Physicians (London) and the Faculty of Medical Leadership and Management; other bodies (e.g. Health Education England, NHS Scotland and the Wales Deanery commission formal education from universities for doctors in training and qualified doctors
Leadership courses	Many bodies (e.g. the Kings Fund, NHS England Leadership Academy, Academi Wales, Northern Ireland Medical and Dental Training Agency) offer various 'stand-alone' leadership development courses ranging from 'introduction' level courses (e.g. the Edward Jenner programme, NHS Leadership Academy) through to those aimed at individuals pursuing senior leadership roles (e.g. the Top Manager programme, The King's Fund)

such as those listed within *Table 2* are much needed, too often they occur in isolation with a lack of integration between like-minded individuals. On returning from many of these schemes, doctors in training report a lack of understanding and appreciation from colleagues and seniors of their new skill set which hinders their continued development and stifles the impetus that these opportunities have provided (Armit and Roberts, 2009).

Time out of programme is one method of development (e.g. through 1- or 2-year fellowships) but not all doctors in training will be able to take part as a result of locality, personal commitments or financial reasons. Access to leadership opportunities should therefore be broadened and developed with more being available within training. The awareness of everyday, so-called little 'l' leadership (Bohmer, 2010) should be encouraged and, following radical changes to the way doctors are trained, e.g. through European Working Time Directive legislation and Modernising Medical Careers (Grant and Goddard, 2012; Whallett and Coleman, 2016), multiple developmental opportunities still exist within everyday practice and should be taken advantage of. For example, while little 'l' leadership roles have been disrupted by increasingly consultant-led care and hospital at night teams making it harder for registrars to take charge and assume leadership roles within this setting (Blakey et al, 2012), doctors in training now have greater opportunities to engage with patient safety initiatives, quality improvement and service redesign (Till et al, 2014, 2015).

Enhancing organizational medical engagement

The benefits of medical engagement extend beyond individuals to the organizations they work within, providing higher job satisfaction, fewer serious incidents and better patient experience (Wathes and Spurgeon, 2016). However, many doctors in training feel that their working environments are not receptive to their suggestions. In one study, despite 91.2% of respondents considering themselves as having ideas for improvement, only 10.7% had had these implemented (Gilbert et al, 2012). In addition, most respondents do not feel valued by managers (83.3%), their chief executive (77.7%), their organization (77.3%), the NHS (79.3%) or even their consultants (58.2%) (Gilbert et al, 2012). This is a significant problem. It risks disillusioning the very talent that should be nurtured and can drive those in pursuit of excellence out of the NHS medical workforce.

As knowledge workers (Drucker, 1959), doctors in training are driven by a high sense of purpose and an intrinsic motivation for autonomy, mastery and purpose (Pink, 2011). Health-care organizations must recognize this drive and nurture the latent energy that is currently untapped amongst the junior doctor workforce to meet this need. They must also overcome existing constraints which result in doctors in training being overlooked when leading change (McFadden et al, 2009). The rotational nature of postgraduate medical education has many benefits, but inadequate induction, poor ongoing support systems and the lack of integration within organizational networks can stifle the involvement of doctors in training. While numerous efforts can be used to overcome this, junior doctor forums, committees and groups are mechanisms that can harness doctors in training as agents for change, engage them sustainably with the wider organizational agenda and extend their reach beyond traditional clinical silos. *Figures 1* and *2* illustrate two of many examples from across the UK that have been implemented with varying degrees of success.

The Junior Doctor Leadership Group was created with the aims of:

- 'Providing junior doctors who had demonstrated an interest in NHS management with appropriate training and mentorship in clinical leadership through formal training, peer learning and experiential learning
- Engaging junior doctors in 30-day quality and safety improvement projects as a means of providing experiential learning opportunities and to directly benefit the project with grass-root junior doctor involvement
- Facilitating an increased self-awareness of members to enable them to reflect on their impact and their leadership of teams
- Providing junior doctor representation at all levels of management within the Trust.' (Wathes and Spurgeon, 2016)

The authors describe some initial challenges (integration with managers, empowering members to facilitate real change) overcome primarily by gaining engagement and approval from the Trust Board. Members are allowed 'study leave' to attend meetings, with dates set 6 months in advance to allow members opportunity to change other commitments if necessary. A 2-day induction is provided each academic year with workshops covering resilience, compassionate leadership, professionalism and quality improvement. Each member is supported to lead a 'rapid cycle improvement' project which, once complete, he/she presents to the group.

Figure 1. Junior Doctor Leadership Group, Guy's and St Thomas' Foundation Trust.

The Doctors in Training Committee (Minhas et al, 2017) was established by the University Hospitals of Leicester Department of Clinical Education in 2013. The aim of this committee is to seek involvement from doctors in training in decision-making processes, ensuring that their views and experiences are used to improve patient care. The Doctors in Training Committee offers support by way of representation at most clinical committees within the Trust including the Executive Quality Board and the Clinical Senate. All committees without junior doctor representation can request this from the Doctors in Training Committee if they feel this would be of benefit, or necessary. There is member representation from all specialities and grades, including that of trust grade doctors and medical students. The Doctors in Training Committee offers the chance for junior doctors to develop skills in leadership, advocacy, management and quality improvement. These skills have resulted in several successful projects including improving maternity processes and supporting the development of a new clinical library.

Figure 2. Doctors in training committee, University Hospitals of Leicester NHS Trust.

Conclusions

Engaging and developing doctors in training in medical leadership is vital for health-care delivery, now and in the future. Strong medical leadership that is engaged with the organization has significantly positive effects on individuals, teams, organizations and, most importantly, patients. Where this is lacking, failures in care are frequently seen. Horizontal leadership development programmes delivered

KEY POINTS

- The evidence that leadership skills are needed for all doctors is clear and widely reported.
- Leadership development opportunities for doctors in training at national and regional levels are becoming more widespread.
- Many health-care providers do not engage doctors in training in health management activities and quality and service improvement.
- This failure to use and tap into their energy and talent leads to disillusionment among doctors in training and missed opportunities for organizations.

in isolation are not enough. Developmental opportunities should be vertical, available in-programme and broadened to all doctors in training. This will have the greatest impact on improving patient care and develop the collective capability of the medical workforce to lead change in increasingly turbulent times. While some organizations are proving to be successful at developing leadership opportunities for leadership and enhancing medical engagement within the junior doctor workforce, this is not widespread, and some pockets of very poor support exist.

Greater emphasis and evidence on how to enhance medical leadership therefore needs to be developed and shared among all organizations involved in the training of doctors. Leadership skills and competencies should be integrated within every postgraduate curriculum as a basic requirement to achieve progression through training and, crucially, we must find a way of providing and valuing high quality, universally available opportunities for doctors in training to lead to sustainable health-care improvements.

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