Are we leading, or being led?
COMMENTARY ON… HOW TO DEVELOP AND ASSESS THE LEADERSHIP SKILLS OF PSYCHIATRISTS†

Michael J. Smith

Michael J. Smith is a consultant psychiatrist and Lead Associate Medical Director for Mental Health in NHS Greater Glasgow and Clyde. The views expressed in this article are those of the author and do not necessarily represent those of NHS GG & C.
Correspondence Dr Michael J. Smith, William Street Clinic, 130 William Street, Glasgow G3 8UR, UK. Email: michael.smith2@ggc.scot.nhs.uk

†See pp. 30–37, this issue.

SUMMARY

The case for better medical 'leadership' should be grounded in professional values and the need to deliver quality services for patients. But emerging 'leadership language' suggests that new 'talent' in management are in fact influenced by commercial imperatives. The profession needs to monitor such trends with care.

DECLARATION OF INTEREST

None.

Psychiatrists generally agree that management and leadership are important, and that such skills can be taught. We are open to the idea that management responsibilities should be shared by all National Health Service (NHS) staff, and would hope to be able to recognise an effective leader when we saw one. Some might even agree that NHS managers are unfairly denigrated by politicians and the media as 'pen pushers' and 'bureaucrats' (King's Fund 2011). So the article by Brown & Brittlebank (2013, this issue) should serve as a reminder of the importance of medical leadership and of the need for doctors to ensure that they are adequately equipped for this role. With respect to these overt aims, the authors do a useful job.

But might there be more to leadership than meets the eye? The NHS in England is undergoing fundamental, controversial change in the name of 'Liberating the NHS' (Department of Health 2010). It might therefore be prudent to keep a concept such as 'leadership' safely enclosed between inverted commas, while we try to define its meaning in this new context.

Leadership: the new cool?

'Leadership' seems to be an idea whose time has come. The new NHS National Leadership Council (NLC) is so keen on its mission that it proclaims: 'Leadership is the "new cool" – and if it isn't, then it should be' (National Leadership Council 2009a).

Brown & Brittlebank avoid such egregious proselytisation, yet others risk overstating the case for 'leadership'. For example, the Medical Leadership Competency Framework that they quote states that the General Medical Council (GMC) stipulates that leadership is 'already a requirement of all doctors'. But this is not so.

The GMC recognised in *Management for Doctors* (General Medical Council 2006) that leadership was one aspect of effective management; and in *Leadership and Management for All Doctors* (General Medical Council 2012) it correctly stated that 'being a good doctor means more than simply being a good clinician'.

The 2012 document draws a sensible distinction between the responsibilities of all doctors and the specific requirement for doctors with extra management responsibilities. 'Leadership' for all doctors, for example, means that, while the formal leader of the team is accountable for the team's performance, 'the responsibility for identifying problems, solving them and taking the appropriate action is shared by the team as a whole'. Doctors with formal management roles have additional responsibilities, such as 'advancing equality and diversity', maintaining clinical information systems, ensuring clarity about team roles and objectives, and so on.

In *Tomorrow's Doctors* (General Medical Council 2009a), leadership is cited as one of 27 professional characteristics that medical graduates should be able to demonstrate, but it does not appear at all in *Good Medical Practice* (General Medical Council 2009b). It might be stretching a point to describe leadership as a 'requirement' for all doctors. Would it really be desirable to have 120 000 'doctors as leaders' in the NHS?

Professionalism is distinct from leadership

Although ostensibly about 'leadership', Brown & Brittlebank's article describes what are, in fact, timeless qualities of medical professionalism: the ability to be self-aware, to consider others, to practise ethically, to value scientific enquiry and to contribute not only to the health system, but also to the wider community. Yet their article, and other initiatives intended to promote 'leadership', create the sense that 'leadership' is not only

urgent and new, but might also supersede these traditional values.

The GMC document *Management for Doctors* avoids this sense of urgency, describing instead a calmer process of 'getting things done well through and with people, creating an environment in which people can perform as individuals and yet co-operate towards achieving group goals, and removing obstacles to such performance' (p. 4).

This quiet confidence is in marked contrast to the 'behaviours' we are exhorted to expect of leaders, who are described variously by Brown & Brittlebank as busily working to 'recognise', 'identify', 'obtain', 'analyse', 'act', 'feedback', 'demonstrate' and become 'accountable'.

These are not superficial differences. In *Management for Doctors*, the GMC endorsed seven principles for the conduct of holders of public office, expecting good managers to show 'selflessness, integrity, objectivity, accountability, openness, honesty and [finally] leadership' – the 'Nolan principles' (Committee on Standards in Public Life 1995). By contrast, a survey sponsored by the Department of Health of 1132 NHS 'emerging leaders' found being 'inspirational' and having 'integrity' tied for top position, with the bottom four attributes being 'empathetic', 'good temperament', 'experienced', and – finally – 'modest' (National Leadership Council 2009b: p. 14).

Modesty is perhaps in short supply for what *The Emerging Leaders News* repeatedly refers to as 'talent', as in phrases such as 'Generation Y talent', 'mapping talent' and 'talent management schemes' (National Leadership Council 2009a). The NLC had now been merged into the NHS Leadership Academy, for which 'talent management', top talent' and the 'talent pipeline' continue to be key concepts (www.leadershipacademy.nhs. uk). The 'talent' work disproportionately (27%) for NHS foundation trusts, and are mainly (56%) from a business, administration, organisational development, human resources or MBA background. Only 3% are medics (National Leadership Council 2009b).

Professionalism is distinct from 'talent'

Dragon's Den-style corporate boosterism may not always be consistent with deeply held NHS and professional values. If 'professional integrity' has become 'leadership', and 'leadership' is in turn becoming 'talent', then the outline of a significant cultural change begins to come into focus. Writing about the commercialisation of universities, Collini

(2011) describes how social shifts are reflected in language:

'One of the most fascinating yet elusive aspects of cultural change is the way certain ideals and arguments acquire an almost self-evident power at particular times, just as others come to seem irrelevant or antiquated and largely disappear from public debate. In the middle of the 18th century, to describe a measure as "displaying the respect that is due to rank" was a commonplace commendation; in the middle of the 19th, affirming that a proposal contributed to "the building of character" would have been part of the mood music of public discourse; in the middle of the 20th, "a decent standard of life" was the goal of all parties and almost all policies. As with changes in the use of language generally, readers and listeners become inured to what were once jarring neologisms or solecisms, while phrases that were once so common as to escape notice become in time unusable.'

Is this new 'leadership language' part of a similar trend? If so, the displacement of professional language by market jargon may reflect a wider change: from clinical care as a system of values, learning and relationships to a 'healthcare product' that can be bought and sold.

If the leaders of the future are to be doctors with talent, rather than 'talent' with a few doctors, we need to heed the political context in which our assumptions and our organisations are shaped. Are we leading, or are we being led?

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