

**PWG Policy on Management and Leadership
Training
October 2008**

From
PWG Secretariat

To
All delegations

Note

Permanent Working Group of European Junior Doctors

Leadership and Management Training for all Doctors

PWG Policy Statements:

PWG Believes that:

Medical Management and Leadership should begin at medical school, and continue through to and beyond gaining a certificate of completion of training.

Training in Medical Management and Leadership should be a compulsory core competency of any post-graduate training scheme, and appropriate to the level that would be needed on the completion of a training scheme.

Training in the compulsory part of Medical Management and Leadership for the purposes of gaining a certificate of completion of training should be free to the doctor.

The competence framework in Medical Management and Leadership, should be adopted as a minimum standard for training in this field within specialities.

Training programs should be reviewed by 1/5/2013 to ensure that Medical Management and Leadership training should be a core component of gaining a certificate of completion of training.

Not every doctor makes a good manager or leader, but efforts should be taken to identify those that have the potential to be good managers and leaders, and those identified as such should be provided the opportunity for further training in this field.

Contents

1. Preamble
2. Why is training in Leadership and Management necessary?
3. What sort of leadership training is currently available?
4. What aspects could training involve?
5. How is medical leadership training being delivered?
6. Who should deliver medical leadership training?
7. Two types of leadership
8. Ways of learning leadership
9. Modelling
10. Who pays for training?
11. When should you train leaders and managers?
12. Competence Framework for discussion.

1. Preamble

Historically, doctors have carried large amounts of responsibility, and yet there has been no formal structure, or standard in the way that this responsibility is used, shared and inherited. This document seeks to give all member states a framework, with which they can base a small amount of core and further training for their current and future medical staff, which can give clarity and subsequent portability of doctors within Europe.

All doctors have a different style of working, and there is no 'correct' way of managing day-to-day responsibilities, however, there are many less productive ways to manage. Healthcare is a rapidly dynamic industry, with many differences across member states, this document seeks to incorporate the local differences, as well as providing a basis for large, recognised, and repeatable training programs to help the modern doctor.

It is sometimes said that leadership and management skills are something you either have or you do not; however, formal teaching could help those who do not possess these skills become more productive, practice more safely, and ultimately be happier and more satisfied doctors.

2. Why is Leadership and Management Training necessary?

All doctors have been confronted with situations where they feel things could have gone better, this may be with a patient, a colleague, a boss, or it may be with themselves. The problems inherent in most healthcare systems are fundamental,

and are built on the foundations at medical school – so it becomes necessary to learn, and develop these skills from an early stage.

Some elements of leadership and management are already taught in some member states, however that which already exists varies widely from hospital to hospital; and country to country. This document does not aim to be perfect in the strategy that it suggests, but designs to be the minimum standard to which member states' medical schools and postgraduate training organisations can benchmark themselves. This could form part of the PWG European Visitations program, to provide information to employers, as well as future medical graduates on what level of responsibility they will be providing training to.

Having a clear standard and manageable system for training is vital to protecting individuals from litigation (in 'lawsuit' hungry societies), enabling development and implementing change throughout healthcare in Europe.

For over twenty years there has been :

'recognition of the imperative for doctors to play a bigger part in management of budgets and services than has traditionally been the case' (Ham, 1980, p2138).

This is culminating in the current changes and movement back towards doctors' roles in management activities. The number of doctors working in senior managerial positions varies widely, in some countries this can be very low, whereas in others this may reach over 50% in hospitals, and 40% in general practice.

Not all doctors will become future leaders, however, it is important to have medically trained leaders within the healthcare system.

All doctors have to fulfil some management duties from early on in their careers:

'If we are to realise the benefits of the reform strategies all doctors MUST accept that they are managers as well as clinical experts' (Clarke, 2006, p15)

Firth-Cozens (2003) also sees teamwork and leadership training as key factors in helping stress prevention and stress reduction for doctors.

Some studies advocate the use of personality models such as Myers-Briggs to examine the skills, knowledge and abilities of leaders, and analyse what 'type' produces the better leaders (Hogan, Curphy and Hogan, 1994; Firth-Cozens, & Mowbray, 2001). However, leaders' skills will vary, and it is important therefore to deliver a set of skills to all doctors that are compatible with a modern dynamic healthcare system. It is important to help and recognise individual doctors that may become the future leaders within any healthcare system, recognise and train them to the best of their abilities

The level of managerial involvement of doctors varies across Europe, and is changing:

'some countries have a history of much greater medical engagement and leadership. Indeed, in many countries, all senior health leaders are clinicians by background [...] other countries, with similar managerial and leadership arrangements to the UK, e.g. Italy, France, Denmark, Sweden and Australia, are embarking on similar strategies to engage clinicians more effectively.'

(Clarke, 2006, p14)

The level of training provided at present is highly variable. In the UK, for example, the NHS Institute has found that the development opportunities for management training at medical schools, postgraduate deaneries and health organisations, are very varied, and need to be brought in line with each other (Clarke, 2006), across Europe, these differences are found between all member states.

Doctors' responsibilities are growing and changing, and they are central to delivery and policy change for healthcare system reform. Doctors effectively have two sides to their role: as medical practitioners and also in managerial and leadership roles (Clarke, 2007). We have to recognise that modern healthcare requires medically trained managers to the highest level.

Cross and Akram (2007) state that doctors are in a position of influence and responsibility, but may lack *'adequate business experience'* (p33).

Clarke (2007, p15) explains that the Board of the National Union of Consultants in the Danish Medical Association developed *'a set of eight roles of the future Specialist'*, which included the following:

- Medical expert
- Professional
- Manager/Leader
- Academic
- Collaborator
- Communicator
- Promoter of Health
- Adviser

There are also the contemporaneous pressures on doctors that include the following responsibilities:

- greater demand for accountability for the safety, quality and efficacy of healthcare
- greater demand for public access to medical information

(Clarke, 2007).

Firth-Cozens and Mowbray (2001) emphasise that different types of leaders affect the wellbeing and stress levels of their staff differently, and that this in turn affects quality of patient care, including safety.

'there is often a distinction made between leadership and management—management being seen as the seeking of order and stability while leadership is about seeking adaptive and constructive change. (Firth-Cozens and Mowbray, 2001, pii3)

Good leadership promotes better patient outcomes, indeed *'Good leadership produces good teams with low stress and better patient care'*. (Firth-Cozens & Mowbray, 2001, pii5)

3. What sort of leadership training is currently available?

Post graduate leadership courses available for GPs, career trainees, and consultants are becoming more widespread, but they represent only a minority of doctors, and only a small number of doctors are attending them.

Cross & Akram (2007) give an overview of a GP leadership training course that is provided by the RCGP (UK Royal College of General Practitioners). The RCGP's course provides training on Policy, Management, Strategy and Planning. The RCGP's course addresses three aspects of management, as follows:

- *'managing me, my team, and my practice*
- *managing my locality and my community*
- *management at a strategic or national level'* (p34)

At undergraduate level, there are no formalised inclusive structures to provide leadership training except for that mentioned later. There are some attempts by medical schools to begin to address this problem.

There are some formalised leadership training programs orientated towards healthcare, but these vary in cost, length, and qualification from approximately €500 to €10,000, and at the moment costs are almost always borne by the training doctor. Some pilots are being undertaken at present where management is a new branch of specialist training, in Sweden this year this is being undertaken in Management and Economic skills.

4. What aspects should the training involve?

Part of leadership may involve changing one's mindset to be inquisitive about policy, both local and national, and develop the ability to articulate this to others (Cross and Akram, 2007).

Financial policy and leadership: an understanding of costs and how balance sheets work are needed for today's leaders (Cross and Akram, 2007). The balance needs to be struck between appropriate financial involvement and appropriate delegation, having a formalised structure for training may pave the way for this.

Negotiation: *'What qualities are needed for effective leadership? One persuasive argument is for managers to negotiate rather than impose new policies'* (Olsen & Neale, 2005)

Communication skills: The Faculty of Medicine at Sweden's Lund University (2007) describes the following as the key aspects of communication studies for the undergraduate student to be able to:

- Listen and talk to people from different groups, of different ages
- Lead and supervise
- Cooperate in projects across boundaries between disciplines and professions
- Summarize and document results from investigations, projects and research
- Teach, inform and instruct
- Argue, disagree and convince
- Engage and inspire other people
- Make decisions and priorities in consultation with other people

The following were covered on a leadership course for post-graduate paediatricians, as researched by Leslie et al (2005):

- self-management skills (self-awareness, personal leadership style development, career plan, role management, and time management),
- systems management skills (assessment of system needs and development of strategic plans), and
- leadership competencies within the context of a team (development of a shared vision, communication of purpose, fostered collaboration, empowerment of others, and establishment of trust).

Leaders need to be able to understand and pre-empt their team members' needs. It has been shown that there can be discrepancies between leaders' perceptions of junior doctors' stress levels and the reality of these. One study examined house officers' attitudes to work and stress levels, and also their consultants' views of the

same. There was a gap in these perceptions, and the higher the gap, the higher the stress level.

Firth-Cozens And Mowbray's (2001) interpretation of this was that *'the team leader's skill in accurately recognising the views of his or her staff members was an important factor in their wellbeing and in the general working of the team'*.

Leadership is directly related to teamwork, and it is vital that a leader enable their team to set common goals and work co-operatively.

'Leadership only occurs when others willingly adopt, for a period of time, the goals of a group as their own' (Hogan, Curphy and Hogan, 1994, p3)

'I suspect the key requirement is to manage their clinical colleagues because no other process has managed to do so with any consistent success. Role of influence, strategic direction and clinical leadership' (Spurgeon, 2001)

5. How is medical leadership training being provided?

There are currently different styles of teaching at undergraduate medical school. These vary from Problem-Based-Learning, (PBL) to integrated or systems based learning and traditional or subject based learning (WAMS, 2007). It may be argued that the PBL style of learning addresses more of the leadership skills of self-management as this type of learning requires a high level of personal study and self-motivation.

Integrated or systems based learning is a cross between PBL and the traditional style, but is based on body systems. There is also emphasis on teaching communication skills, and there is a high level of self-directed learning. Traditional or subject-based teaching involves little or no patient contact until the clinical year (WAMS, 2007).

The Faculty of Health Sciences in Linköping (FHS), Sweden uses PBL and Dahle et al (2002) discuss how this learning style emphasises communication skills and enables lifelong learning. The Faculty of Medicine at Sweden's Lund University (2007) outlines that study of medicine at the undergraduate level should be task-based and outcome-based, i.e. aiming at the type of tasks students must be able to handle on completion of their studies. Lund's undergraduate leadership training focuses on students' future needs and includes aspects on administration and health economics.

Training could consist of a focussed course at a particular stage in training, or form part of the criteria for a CCT, thus, all doctors who wish to become consultants / GPs

/ or senior specialists would all have at least a basic grounding in the skills necessary to manage and lead those within their field.

We recognise that not all doctors make good leaders, but that all doctors need to understand the benefits of good team working.

6. Who should provide leadership and management training?

Leadership and management training should be provided by all doctors, however where specific expertise exists, this should be provided, or commissioned from third parties. Universities should be able to equip junior doctors with basic levels of competence in management. Post-graduate educators and educational directors of training schemes should be responsible for providing, or arranging training to enable the individual doctor to progress to the next stage of their career.

Junior doctors should be able to choose an accredited provider if they seek to undertake private training, but this should only be to attain specialist management training which is otherwise unavailable through the above.

7. Two types of leadership

There are two styles of leadership: transactional and transformational (Firth-Cozens and Mowbray, 2001). Transactional leadership comes from the viewpoint that the leader has power and authority over followers, and this power is used to achieve goals and objectives. There is a focus on errors and problems, and rewarding performance. This is the traditional model of health service leadership in many cases.

Transformational leadership is focused on motivating followers and involving them in the process, and is more able to cope with changes and new processes than is transactional leadership. Whilst transactional leadership holds things stable, transformational leadership leads change. A combination of the two is ideal for a modern health service (Firth-Cozens and Mowbray, 2001).

According to Firth-Cozens and Mowbray (2001), leadership is affected by the following factors:

- Personality and behaviour of the leader
- The context in which the leadership takes place
- The people who are led

This makes leadership a complicated matter.

8. Ways of learning leadership

'A recent study by Palmer, Spurgeon & Clark (2001) examined the views of over 300 clinicians and over 100 managers as to the appropriateness of training content and its timing. Over the 10 areas of management examined there was remarkable agreement between doctors and managers (correlation ranging between 0.88 and 0.93) as to what material should be offered and when it should be offered. If such a model were to be adopted, it would have the great merit of providing a sense of cumulative development such that medical students and Senior House Officers, etc, would acquire the awareness and understanding of management practices at an early stage and more strategic skills would be developed at a later stage, with clinical staff equipped with an appropriate platform to acquire these leadership capabilities'.

(Spurgeon, 2001)

9. Modelling

Modelling is one way of learning good leadership skills. An example is the UK RCGP's course, part of which is spent looking at people in positions of leadership who are succeeding or failing. The aim is to examine what makes people successful by looking at what the leaders do well and what they do poorly (Cross and Akram, 2007).

10. Who pays for this training?

Leadership training can be funded in a number of different ways, ultimately, leadership skills are essential for all doctors, but their provision, and the level to which they can be provided will vary between member states. There should however be a recognised minimum level of training provided to all doctors, and this should form part of recognised medical degrees, or speciality training.

More advanced levels of training should be made available to those doctors who wish to pursue it, or to those doctors entering positions of responsibility where it should form part of induction to these roles.

There are calls for leadership training to be supplied to doctors at all levels.

The UK Royal College of Physicians (2005) argues that leadership and 'followership' should be incorporated in doctors' training and that managerial competence for doctors is key. It had the following recommendations to make as a result of its 2005 Working Party report:

'On leadership, the Working Party recommends that:

- *leadership and managerial skills are key competencies of professional practice.*
- *Royal Colleges and Faculties identify the standards required of their Membership and Fellowship to satisfy the qualities of professionalism in a modern team-based environment.*
- *Royal Colleges and Faculties, medical schools, the British Medical Association, and other healthcare organisations, take on the responsibility to develop a cadre of clinical leaders. These bodies need to define the skills of leadership that they seek, and implement education and training programmes to develop doctors with those skills.*
- *Royal Colleges and Faculties, together with others, seek ways to strengthen and unify medicine's national leadership and voice.*
- *The Royal College of Physicians, working with others, creates an implementation group to define the requirements for a common forum, the purpose of which would be to speak on behalf of medicine with a unified voice.'*

Reference: Royal College of Physicians, (2005, p46)

One study used both qualitative and quantitative methods to survey medical students from a medical school in the UK and one in Portugal (n=268). Students' opinions were sought on the value and structure of a management and leadership course in medical school. Opinions were compared to those of hospital managers and clinical professors (Martins, Detmer & Rubery, 2005).

The study found that Portuguese students were more convinced of the relevance of leadership and management education than were UK students. Students believed such training should be given in the clinical years, last term or semester and be optional. They believed the core topics should be

- Managing people/team management
- National Health Service
- Doctors & Leadership
- Costs/prices and resource management

(Martins, Detmer & Rubery, 2005)

The Organisational culture of many health services is not historically that of medical leadership.

The UK's National Health Service (NHS) has a different organisational culture than that of many other countries, as the NHS does not have a medical leadership culture. Therefore, the recent advent of Modernising Medical Careers (MMC) in the UK is a major change in postgraduate training in the UK, intended to improve doctors' education and training.

Clarke (2007) contends that MMC is indicative of the contemporaneous shift of expectations of doctors, whereby the emphasis has shifted from just being a competent physician, to that of being able to also manage themselves, their time, team-work and manage others. More doctors are also moving into leadership roles like commissioning, governance and directorates, making leadership skills key to their role.

Globally, in countries where doctors have not been involved in planning and transformation of services, there is increasing recognition that healthcare improvements require doctors' active participation, and thus requires doctors' leadership skills (Clarke, 2007).

11. When should you train leaders and managers?

There are many opportunities to train in management and leadership. Training should begin at an undergraduate level, and continue through to and beyond gaining a CCT. Foundations in leadership should begin at university, with focussed courses and modules. The ability to intercalate in medical management should be an option for those in undergraduate training.

Recognition of medical leadership and management as a medical speciality would enable junior doctors to complete a formal training rotation including management as part of the rotation, thus enabling appropriate progression through to senior grades. This would also provide the basis of medically trained managers who could go on to train other doctors in the same.

Training should be compulsory and practical for all doctors, and should be to a level that is appropriate to the stage of their career.

There should be an internationally recognised medical leadership and management qualification that can be gained through appropriate training and experience.

Produced following the PWG meetings:
3rd to 5th November 2007, Ljubljana, Slovenia
30th to 31st May 2008, Bergen, Norway
7th to 8th November 2008, Tallinn, Estonia

12. Competence Framework

This table is designed to be a guide, and each entry is given a grading, which, can be used as a basis for provision of the competencies. They are broken down into the following:

Essential (E)	Undergraduate (U)
Desirable (D)	Postgraduate (P)
Optional (O)	Specialist (S)

Personal Management (E)

- Time and Resource management skills (EU)
- Goal setting (DU/EP)
- Recognising personal limitations (EU)

Team Working & Managing People (E+D)

- Communication Skills (EU)
- Delegation (DU/EP)
- Recognising limitations (DU/EP)
- Safety Netting (DU/EP)
- Discipline, Enforcing Standards (DP/O)
- Performance Appraisal & Management (DP/O)

Development & Mentoring (DP/ES)

- Teaching Skills (ES/DU/OU)
- Mentoring (EP)
- Inspiring Individuals and Motivation (ES/DP)

Probity & Professional Regulation (EU/EP)

- Professional Integrity (EP)
- Appraisal (EP)
- Appraising (DP/O)
- Personal Development (EP/DU)

Goal Setting (DP)

- Target Management (OS/OP)
- Performance Targets (OS/OP)
- Audit (EU)
- Identifying the need for change (DP/ES)
- Prioritising (DU/EP)

Tackling Underperformance (O)

- Raising concerns (EU)
- Recognising difficulties (DU/DP/ES)

Managing Change (DP)

- Implementation (OS/OP)
- Working with outside agencies (OP/DS)
- Seeking expertise (OP/DS)

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