Chapter 2
Clinical Leadership and Engagement: No Longer an Optional Extra

John Clark

> *...the quality of clinical leadership always underpins the difference between exceptional and adequate or pedestrian clinical services which in aggregate determine overall effectiveness, safety and reputation*
>
> —(Sir Bruce Keogh, NHS, UK) [1]

Abstract Effective clinical leadership and engagement are increasingly being recognised as important contributors to the delivery of high standards of clinical care and organisational performance. This chapter argues that it is no longer acceptable for a doctor just to be a clinical expert. Other competences, including appropriate management and leadership skills, should be integral elements of practice and thus need to be included as part of selection of medical students and doctors at all levels as well as incorporated within education and training.

This chapter outlines some of the key management and leadership competences all doctors at every level should attain. It also provides some advice on how best these might be realised during postgraduate training.

Whilst all doctors as practitioners require a basic tool-kit of management and leadership competences others, who decide to move into positional leadership roles, will potentially need some more advanced ones.

However, engaging doctors in the running, planning and improvement of services, in conjunction with other clinical and non-clinical managers and leaders, is critical to the delivery of high quality care. This chapter will discuss what good clinical engagement can look like and offers advice on how doctors can help create service and organisational cultures where patient-care is genuinely the number one priority.

J. Clark (✉)
Department of Health, Institute of Health Leadership, Level 2B, 189 Royal Street, East Perth, WA 6004, Australia
e-mail: john.m.clark@health.wa.gov.au

The King's Fund, London, UK

University of Warwick Medical School, Coventry, UK

S. Patole (ed.), *Management and Leadership – A Guide for Clinical Professionals,*
DOI 10.1007/978-3-319-11526-9_2

Key Points

- With increasing emphasis on clinical leadership and engagement, doctors are expected to not only be clinical experts but also have management and leadership skills
- Working collaboratively not only in the clinical domain but also in management and leadership leads to more effective outcomes
- The terms leadership and management are often used interchangeably but there are important differences. Leaders ask themselves "where are we going" whereas managers tend to ask "how do we get there?"
- The five domains of the medical leadership competency framework include demonstrating personal qualities, working with others, managing and improving services, and setting direction. However delivering highest quality services to patients, service users, carers and the public is at its heart.
- Engagement of clinicians as a 'shareholder' in the running, development and improvement of their specialty or service should not be an optional extra. It should be central to their role as a good doctor.

Keywords Medical leadership · Clinical leadership · Physician leadership · Medical engagement · Staff engagement · Medical leadership competences · Leadership development

Health organisations are putting increasing emphasis on clinical leadership and engagement for the delivery of the highest quality of care. This chapter seeks to demonstrate that to be a good doctor in the twenty first century requires good management and leadership ability as well as clinical expertise. Once a doctor is appointed to a consultant or GP position they ipso facto become leaders in their specialty, service or hospital not necessarily in a formal leadership role but as professionals who are expected to give a lead. Some doctors once appointed as consultants take on positional roles (part or full-time) e.g. Head of Department, Director of Education, Clinical Director or Director of Clinical Services at some stage but all doctors at every level in their practitioner roles need to practice good management and leadership. It should not be an optional extra.

The desire for greater medical leadership and engagement within healthcare organisations needs to be understood within what organisational theorists call professional bureaucracies [1]. In such organisations, front line staff have considerable control over the content of the work they do by virtue of their training and specialist knowledge. Executives, and particularly non-clinical executives, will often have considerable difficulty directing those that they feel should be under their control often leading to minimal impact or indeed downright resistance. In essence, this means that clinical staff and particularly doctors can have greater influence than the hierarchy might initially suggest. This can, of course, be both positive and negative and highlights the importance of effective leadership and engagement at all levels and recognition that clinicians and managers working closely together to enhance clinical services should be the goal.

Doctors have been involved in the running of health services, locally, nationally and internationally since the pioneers who initiated and organised health services many centuries ago. What is new is the emerging evidence of the relationship between the extent to which doctors are engaged in the planning, prioritization, shaping and improvement of services and the wider performance of that service and organisation, including clinical outcomes and quality of care [1].

What is Clinical Management and Leadership?

Later in this chapter the range of management and leadership competences that all doctors and indeed all clinical professionals should practice will be explored and how they might be acquired and when? But what do we mean by management and leadership?

A quick review of any airport bookstall will confirm that there are probably more books and texts on management and leadership than any other subject. There are thousands of definitions and descriptions and numerous serious and less-serious authors offering their particular nuance. One of the most quoted definitions is perhaps from John Kotter [2] who differentiates between management processes that are concerned with planning, budgeting, organising, staffing, controlling and problem-solving and leadership processes that involve establishing direction, aligning people, motivating and inspiring.

The King's Fund, an independent charity ('Think Tank') that works to improve health and health care in England, has undertaken considerable research and published widely on health management and leadership, particularly clinical. Their website (www.kingsfund.org.uk) offers some rich material that should be of interest to readers of this book. In their Commission [3], The Fund defines leadership as the art of motivating a group of people to achieve a common goal. This demands a mix of analytical and personal skills in order to set out a clear vision of the future and defining a strategy to get there. This requires good communication skills and ensuring the appropriate skills are assembled to achieve it.

As the Commission also highlighted, leadership requires considerable management skills to get any job or change implemented and confirms that leadership in healthcare is needed from the executive team or board to the ward and should involve clinicians as well as managers.

There is perhaps some perceived sense of differential status between being called a medical administrator, manager or leader. Some may argue that a medical administrator or manager is more about maintaining the status quo whereas a medical leader conjures up a vision of a heroic leader driving change. It is perhaps no coincidence that more doctors appear to be willing to get involved in leadership if it is about leading service improvements and with the title of physician or medical leader.

Over the past decade, there has been a steady growth of designated medical leadership roles. Initially, many of these were seen as roles to represent medical colleagues in the senior executive governance arrangements. This often meant a sense of doctors taking it in turns to assume the role, generally reluctantly. Over time, as

Table 2.1 Characteristics of management and leadership. (Bolman and Deal [6])

Aspect	Management	Leadership
Style	Transactional	Transformational
Power base	Authoritarian	Charismatic
Perspective	Short-term	Long-term
Response	Reactive	Proactive
Environment	Stability	Change
Objectives	Managing workload	Leading people
Requirements	Subordinates	Followers
Motivates through	Offering incentives	Inspiration
Needs	Objectives	Vision
Administration	Plans details	Sets direction
Decision-making	Makes decisions	Facilitates change
Desires	Results	Achievement
Risk management	Risk avoidance	Risk taking
Controls	Makes rules	Breaks rules
Conflict management	Avoidance	Uses
Opportunism	Same direction	New direction
Outcomes	Takes credit	Gives credit
Blame management	Attributes blame	Takes blame
Concerned with	Being right	What is right
Motivation	Financial	Desire excellence
Achievement	Meets targets	Finds new targets

demands for greater improvements in quality, efficiency and resolving inappropriate variations have increased, so doctors have increasingly been extorted to move from representational to executive roles.

As Griffiths et al [4] comment, the terms *leadership and management* are often used interchangeably but note there are important differences i.e. managers work within a system to maintain or meet goals and direction through effective use of resources. They contrast this with leaders who set the vision and direction and motivate others to achieve the goals. Put simply, leaders ask themselves "where are we going" whereas managers tend to ask "how do we get there?"

Long [5] refers to the work of Bolman and Deal [6] which reaffirms that leading and managing are distinct but both are important. They provide a really useful taxonomy of the characteristics of management and leadership as outlined in Table 2.1.

Exercise

You might want to consider the characteristics of management and leadership in the table above and use it to self-assess and also perhaps to assess a manager and a leader you know well in your organisation.

Understanding that there is no single universal and evidence-based set of characteristics that define an effective leader is often hard for doctors with scientific leanings to understand. It means that individuals with different qualities can contribute very effectively as leaders but in different ways, depending on their own personal sets of strengths and weaknesses.

Shared leadership is becoming more and more prevalent in health organisations. The days of the heroic leader are perhaps becoming history. As healthcare becomes ever more dependent on multi-disciplinary working so it is becoming increasingly recognised that working collaboratively not only in the clinical domain but also in management and leadership leads to more effective outcomes. Evidence shows that shared leadership often involving at specialty level the Clinical Head of Department, Nurse Unit Manager and Business Manager can create the climate for innovation and improvement. In some of the top performing hospitals in the USA, the Board hold the duality of the medical leader and business manager at specialty or directorate level jointly accountable for performance; joint rewards for good performance and joint penalties for poor performance.

Alimo-Metcalfe and Franks [7] argue that the new focus for leadership is on how to increase employee engagement with the aim to increase not only the performance of the organisation but also the satisfaction of its employees. This notion of greater engagement will be explored later in this chapter.

What Management and Leadership Competences Do ALL Doctors Need?

You will be very familiar with competency frameworks throughout your medical education, training and practice. Until fairly recently, few frameworks explicitly included management and leadership competences although historically some have been incorporated within, for example, professionalism, personal or professional development, communication skills and teamwork. More recently, some student-selected modules have offered management and leadership outside the core curriculum.

The UK, Denmark and Canada have perhaps led the way in seeking to develop a common and recognised management and leadership framework for all doctors. Other countries, including Australia, through the Royal Australasian College of Medical Administrators (RACMA), have developed excellent management and leadership frameworks for doctors moving into positional leadership roles but it is my contention that doctors at all levels should attain a core set of management and leadership competences to be a good doctor.

The Royal College of Physicians and Surgeons of Canada developed the CanMEDS Roles Framework and associated competences. CanMEDS is not a medical management and leadership group of competences. It offers a high level of description and implies a range of underlying sub-sets of competences in terms of how these would actually be achieved in practice through the application of specific

skills and knowledge to particular situations. It, in effect, describes what is expected of a good doctor i.e. in addition to being a medical expert, a doctor should be a:

- Professional
- Communicator
- Collaborator
- Manager
- Health Advocate
- Scholar

This CanMEDS network is now informing many other frameworks around the world. The original framework (2005) and later iterations can be accessed at www.royalcollege.ca.

In response to various scandals of poor care being delivered in NHS hospitals (UK), the medical profession was put under pressure during the first decade of this century to take a more active role in the management, leadership and improvement of health services. This led to the development of a Medical Leadership Competency Framework (MLCF) jointly by the Academy of Medical Royal Colleges (AoMRC) and the NHS Institute for Innovation and Improvement (NHS Institute) [8] in 2008. It has subsequently been refined but the MLCF describes the leadership competences doctors need to become more actively in the planning, delivery and transformation of health services as a normal part of their role as doctors.

The purpose of the MLCF is to provide the medical professional, regulatory, educational and service bodies and individual doctors with a description of the core management and leadership competences expected of all doctors as they graduate from medical school, progress though postgraduate education and training and become consultants or GPs. Although some of the competences might have previously been implicit in medical education and training, the MLCF provides a consistent and explicit framework that should apply to all medical school curricula, postgraduate education and college standards. The whole concept of the MLCF is based on the concept of shared or distributed leadership where leadership is not just the province of those in positional roles but where there is a shared responsibility for the success of the service or hospital.

The General Medical Council (GMC) in the UK has provided some very powerful messages about the importance of medical leadership. *Tomorrow's Doctors* [9] specifies expected outcomes and standards of undergraduate medical education including the need for doctors to have a commitment to improving healthcare and providing leadership. This view has been reinforced in the GMC paper *Leadership and Management for all doctors* [10] which stresses the importance of all doctors at all levels providing leadership and vision as well as contributing to improvements in the quality of service. The GMC's *Good Medical Practice* [11] is even more specific offering some key ethical guidelines with reference to professional and personal responsibilities of doctors as leaders. These include working with colleagues, communication, teamwork and service improvement along with many other competences.

There are five domains of the MLCF (Fig. 2.1) but delivering services to patients, service users, carers and the public is at the heart. The premise is that EVERY

Fig. 2.1 Medical leadership competency framework image. (The Medical Leadership Competency Framework and associated graphics are © NHS Leadership Academy and Academy of Medical Royal Colleges, 2010. All rights reserved)

doctor should be competent in each domain to deliver appropriate, safe and effective services.

Each of the five high level domains is divided into four elements and each of these is further divided into four competency outcomes (Table 2.2).

Whatever stage you are in your career as a doctor, the MLCF should apply to you. As Spurgeon and Klaber [12] confirm, the MLCF was designed to be relevant to doctors at all levels; undergraduate, postgraduate and the first revalidation following award of Certificate of Specialist Training. It provides a progressive statement of the relevant management and leadership competences that need to be acquired over time. For example, it would not be appropriate for a medical student to be required to demonstrate ability in *Setting Direction* upon graduation but *working within teams* would clearly be important.

The figure below (Fig. 2.2) offers a general sense of which particular competences should be acquired at different stages of career.

Exercise

Undertake a self-assessment of your management and leadership competences by accessing the following MLCF website: www.leadershipacademy.nhs.uk/discover/leadership-framework/

List those where you have identified development needs and consider how you might best meet them.

Table 2.2 The medical leadership competency framework domains

Domain	Elements
Demonstrating personal qualities	Developing self-awareness
	Managing yourself
	Continuing personal development
	Acting with integrity
Working with others	Developing networks
	Building and maintaining relationships
	Encouraging contribution
	Working within teams
Managing services	Planning
	Managing resources
	Managing people
	Managing performance
Improving services	Ensuring patient safety
	Critically evaluating
	Encouraging improvement and innovation
	Facilitating transformation
Setting direction	Identifying the contexts for change
	Applying knowledge and evidence
	Making decisions
	Evaluating impact

More recently Health Workforce Australia (HWA) has developed Health LEADS Australia: the Australian health leadership framework. It focuses on the capabilities required to deal with contemporary Australian health issues and builds on validated international work. It has five areas for focus:

- (L)eads self
- (E)ngages others
- (A)chieves outcomes
- (D)rives innovation
- (S)hapes systems

The framework is being developed and has the potential to inform future curricula for medical and indeed all clinical professionals. It can be accessed at www.hwa.gov.au

Management and Leadership Training and Development

An increasing number of health organisations and medical colleges are now offering management and leadership training and development. Some Departments of Health and Health Services in Australia, particularly Western Australia and Vic-

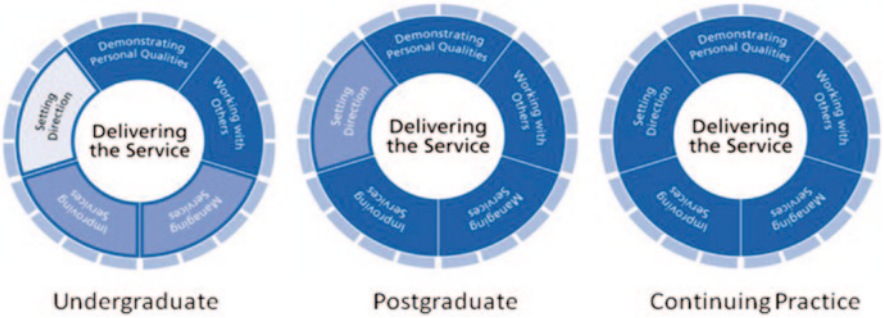

Fig. 2.2 The Medical Leadership Competency Framework and associated graphics are © NHS Leadership Academy and Academy of Medical Royal Colleges, 2010. All rights reserved

toria, have schemes where junior doctors are encouraged to take time out of their specialty training to undertake a service improvement project and to learn more about management and leadership that is relevant to their stage of career. Some very impressive initiatives have been implemented and a new cadre of doctors keen to be engaged in shaping the future modus operandi for delivering care is being created.

Other enlightened health systems, hospitals and health services are recognising that management and leadership training and development should be offered to all new consultants and well before some may take on positional leadership roles. The days of remedial management and leadership development for Clinical Heads of Departments etc should be past but there is still some way to go.

Historically, a few doctors have opted to study for a Masters in Business Administration or Management but there is now some increasing interest in studying for a postgraduate program in medical or clinical leadership focused on specific local issues i.e. theory applied to the context of the participant's workplace. Such programs can be just for medical leaders e.g. Clinical Heads of Department or perhaps the clinical department leadership team studying and working together to solve local issues.

Some of the best performing hospitals and services internationally are typified by sustained investment in management and leadership. Some of the development programs are uni-disciplinary, particularly for postgraduate trainee doctors and new consultants. Others reflect the multi-disciplinary nature of healthcare delivery and are included within a suite of development programmes for all senior managers and leaders. Learning about management and leadership with others particularly around real local issues helps create the culture of mutual respect and partnership working.

Most hospitals and health services have someone with responsibility for management and leadership development and this person should be delighted to discuss your interest and development needs. Securing greater engagement of doctors, as 'shareholders', in the running and shaping of services and hospitals is increasingly being seen as critical to the enhancement of quality, safety and effectiveness and the reduction of inappropriate clinical variation.

The past few decades have seen the growth of a general management culture generally supported by some limited medical leadership with perhaps too many doctors seeing themselves as 'stakeholders'. High performing hospitals internation-

ally tend to be typified by cultures where doctors and managers work closely together to achieve the common goals of high quality care and value and where all doctors feel highly engaged.

Medical Engagement: No Longer an Optional Extra

As Spurgeon et al. [13] suggest, engagement has become a popular, much used term supplanting more traditional concepts such as job satisfaction and motivation. Feeney and Tiernan [14] provide a very useful overview of the literature on the emergence and development of the concept of engagement.

MacLeod and Clarke [15] offer an excellent review of staff engagement across a range of sectors and identify more than fifty definitions of employee engagement. They conclude that there is no universal definition but that there is strong relationship between the extent of engagement and performance.

Guthrie [16] argues that medical engagement should be one of the top priorities for chief executives. He argues that at a structural level (creating appropriate facilitative arrangements) and a personal level (one-to-one communication) it is possible for executives and managers to build up levels of physician engagement. Toto [17] using Gallup survey data, demonstrates that engaged physicians can have a direct impact on the financial performance of hospitals in the USA.

West and Dawson [18], in a paper commissioned by The King's Fund, reported that engagement is linked to a range of individual and organisational outcome measures including staff absenteeism and turnover, patient satisfaction and mortality and safety measures including infection rates. They concluded that the more engaged staff members are, the better the outcomes for patients and the organisation generally.

Involving doctors in leadership roles in the UK has been an explicit aim since the Griffiths Report into the NHS management was published in 1983. Dickinson et al. [19] refer to the consequences of doctors not being involved in leadership by citing the highly publicised The Francis Inquiry Report [20] into the failings of care at The Mid-Staffordshire Hospitals (UK) highlighting that most doctors felt disengaged and undervalued. This report concludes that much more needs to be done to support.

The Institute for Healthcare Improvement (IHI) in the United States has developed a framework for how organisations can improve medical engagement. Given the evidence supporting the importance of engagement and working with some of the highest performing hospitals in the USA, the IHL have developed a framework for engaging physicians in quality and safety. This framework includes:

- discovering common purpose, such as improving outcomes and efficiency
- reframing values to make doctors partners in, not customers of, the organisation, and promoting individual responsibility for quality
- fine-tuning engagement to reach different types of staff—identifying and encouraging champions, education leaders, developing project management skills and working with laggards

- using improvement methods such as performance data in a way which encourages buy-in rather than resistance
- making it easy for doctors to do the right thing for patients
- supporting clinical leaders all the way to the board
- involving doctors from the beginning—working with leaders and early adopters, choosing messages and messengers carefully, making doctor involvement visible, communicating candidly and often, and valuing doctors' input by giving management time to them

Full details of the IHI Paper *Engaging physicians in quality and safety* can be found at www.IHI.org

In the UK, a medical engagement scale was developed as part of the joint Enhancing Engagement in Medical Leadership project between the Academy of Medical Royal Colleges and the NHS Institute of Innovation and Improvement that also developed the Medical Leadership Competency Framework (MLCF) already referred to earlier in this chapter.

Spurgeon et al. [13] advise that the Medical Engagement Scale (MES) was developed on the conceptual premise that medical engagement is critical to implementing the radical changes and improvements sought by the NHS (UK) and that medical engagement cannot be understood from consideration of the individual employee alone. They contend that it is not sufficient for an individual doctor to express a desire to be engaged but that the organisation must create the conditions, opportunities and processes whereby such individuals are encouraged and supported. They define engagement as 'the active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high quality care'.

The Index of Medical Engagement has three meta-scales: working in an open culture; having purpose and direction; and feeling valued and empowered. Data from over 70 hospitals has now been collected from hospitals in the UK which shows a strong association between medical engagement and performance as measured by the independent health care regulator. Data is also now being collected from a number of Australian and New Zealand hospitals and the MES is being extended to use in a number of other countries.

Another King's Fund Report [21] confirms further evidence of the benefits of medical engagement in referring to a study undertaken by McKinsey and the Centre for Economic Performance at the London School of Economics [22]. Their work examined the performance of around 1300 hospitals across Europe and the USA. Overall they found that hospitals that are well managed produce higher quality patient care and improved productivity, including significantly lower mortality rates and better financial performance.

A really good example of the application of the IHI model for medical engagement can be found at the McLeod Regional Medical Center in South Carolina. Here, doctors engage with each other to drive learning, quality and professional satisfaction. The study by Gosfield and Reinertsen [23] of how McLeod Regional Medical Center used medical engagement to secure major quality advances highlights how visitors 'marvel at the enthusiastic, effective leadership of McLeod's doctors in

quality, safety and value initiatives—without any significant financial incentives'. McLeod's techniques for engaging doctors include:

- asking doctors to lead improvement—the mantra is 'physician-led, data-driven and evidence-based'
- asking doctors what they want to work on—McLeod initiates about 12 major improvement efforts each year, based on doctors' recommendations
- making it easy for doctors to lead and participate—McLeod provides good support staff for improvement and does not waste doctors' time
- recognising doctors who lead, including the opportunity to present to the board
- supporting medical leaders when obstructed by difficult colleagues
- providing development opportunities—McLeod helps doctors learn about quality, safety and human factors

The evidence from different studies only serves to reinforce the importance of both clinical leadership and engagement. To some extent taking on positional leadership roles could be seen as optional. Some clinicians just do not possess the inclination or have the ability to undertake such roles but engagement as a 'shareholder' in the running, development and improvement of your specialty or service should not be an optional extra. It should be central to your role as a good doctor.

Exercise

In what ways might you contribute more effectively to the management, leadership and improvement of your service? List ways in which you could become more of a 'shareholder'?

As mentioned previously, good engagement is achieved where there is a desire by both clinicians and the organisation to work together and to maximise the contribution the former can make to enhancing quality, outcomes and overall performance. So, what typifies highly performing and medically engaged hospitals? The evidence from the studies above suggests that some of the following are features and should provide some ideas as to how you can make an even bigger difference to the patients and communities you care about.

Structure

- are doctors seen as key contributors to decision-making and encouraged to assume leadership roles?
- are sufficient doctors (both full-time and part-time) involved in the top executive teams and boards as well as at the specialty or service level?
- are doctors encouraged to take the lead on important initiatives within the hospital e.g. ICT, Quality and Safety, Governance, Service Improvement etc?

Process

- are management, leadership and service improvement interests and competencies assessed when making appointments?
- are they also genuinely discussed and incorporated within appraisals?
- is positive encouragement given to new specialists (and indeed others) to acquire management and leadership competencies through either uni- or multi-disciplinary training and development programs?
- do non-clinical managers and leaders work in partnership at all levels with clinicians?
- do clinicians with potential for management and leadership roles get identified and supported?
- do clinicians help create cultures where quality and safety are paramount and where they take the lead in identifying new standards and ensure that unacceptable variations are challenged?
- are junior doctors given every encouragement to acquire management and leadership competencies, particularly around service improvement?

Outputs

- does your specialty and hospital compare very favourably against similar services in terms of clinical outcomes, patient experience, quality, safety and value?
- is your service the one of choice by patients and other stakeholders?

Summary

Reviews of hospitals or services where poor clinical performance has been made public all highlight failings in clinical leadership and engagement. More needless harm is done to patients through poor management and leadership than by clinical incompetence. Clinicians are in the best position to know when systems and processes are dangerous or just sub-optimal.

The challenge for clinicians today is to take responsibility for identifying such failings and to assist with improvements. This requires all clinicians to accept that they have leadership roles as practitioners and to actively engage in driving changes that enhance clinical outcomes and value. Health systems and organisations equally need to create cultures where more doctors are motivated and rewarded to assume leadership roles. However, as Braithwaite et al. [24] warn, medical leadership is not something that can be quickly brought about through a change in structure or by just exhorting clinical and managerial colleagues to change.

The evidence of the relationship between good clinical leadership and engagement means that it is no longer an optional extra. It is, as Sir Bruce Keogh indicates in the quote at the start of this chapter, central to the delivery of the very highest quality of care.

References

1. Spurgeon P, Clark J, Ham C (2011) Medical leadership: from the dark side to centre stage. Radcliffe Publishing, London
2. Kotter J (1996) Leading change. Harvard Business School, Boston
3. The King's Fund (2011) The future of leadership and management in the NHS: no more heroes. The King's Fund, London (Also available www.kingsfund.org.uk)
4. Griffiths D (2010) Clinical leadership—the what, why and how in clinical leadership: bridging the divide. In Stanton E, Lemer C, Mountford J (eds). Quay Books, London
5. Long A (2011) Leadership and management in ABC of clinical leadership. In Swanwick T, McKimm J. Blackwell Publishing, Oxford
6. Bolman L, Deal T (1997) Reframing organization: artistry, choice and leadership. Jossey-Bass, San Francisco
7. Alimo-Metcalfe B, Franks M (2011) Gender and leadership in ABC of clinical leadership. In Swanwick T, McKimm J. Blackwell Publishing, Oxford
8. NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges (2010) Medical leadership competency framework, 3rd edn. NHS Institute for Innovation and Improvement, Coventry
9. General Medical Council (2009) Tomorrow's doctors. General Medical Council, London
10. General Medical Council (2012) Leadership and management for all doctors. General Medical Council, London
11. General Medical Council (2013) Good medical practice. General Medical Practice, London
12. Spurgeon P, Klaber B (2011) Medical leadership: a practical guide for tutors and trainees. BPP Learning Media, London
13. Spurgeon P, Mazelan P, Barwell F (2011) Medical engagement: a crucial underpinning to organizational performance. Health Serv Manage Res 24:114–120
14. Feeney Y, Tierman J (2006) Employment engagement: an overview of the literature on the proposed antithesis to burnout. Ir J Psychol 27:130–141
15. MacLeod D, Clarke N (2009) Engaging for success: enhancing performance through employee engagement. Department for Business Innovation and Skills, London
16. Guthrie M (2005) Engaging physicians in performance improvement. Am J Med Qual 10:235–238
17. Toto D (2005) What the doctor ordered: the best hospitals create emotional bonds with their physicians. http://gmi/gallup.com/content/18361/what-the-Doctor-Ordered.aspx. Accessed 27 May 2011
18. West M, Dawson J Employee engagement and NHS performance. http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf. Accessed on 27 March 2014
19. Dickinson H, Ham C, Snelling I, Spurgeon P Medical leadership arrangements in English healthcare organisations: Findings from a national survey and case studies of NHS trusts. http://hsm.sagepub/content/early/2014/03/10/0951484814525598. Accessed 12 March 2014
20. Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. London. The Stationery Office
21. The King's Fund (2012) Leadership and engagement for improvement in the NHS: Together we can. The King's Fund, London (Also available at www.kingsfund.org.uk)
22. Dorgan S, Layton D, Bloom N, Homkes R, Sadun R, Van Reenen J (2010) Management in healthcare; Why good practice really matters. McKinsey and Co and Centre for Economic Performance, London
23. Gosfield A, Reinertsen J Achieving Clinical Integration with Highly Engaged Physicians. www.providence.org/holycross/MedicalStaffServices/Documents/. Accessed 17 Apr 2012
24. Braithwaite WM (2005) Rethinking clinical organisational structures: an attitude survey of doctors, nurses and allied health staff in clinical directorates. J Health Serv Res Policy 10:10–17