Time to get serious about distributed leadership: lessons to learn for promoting leadership development for non-consultant career grade doctors in the UK

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ABSTRACT

COVID-19 has exposed the National Health Service (NHS) to the greatest challenge in its existence, highlighting the need for nimble, reactive and inclusive leadership. It is set against a backdrop of a workforce recruitment and retention crisis predicted to worsen in coming years. There is a need to do things differently in healthcare, including better diversity and distribution of leadership. We make the case for senior non-consultant doctors, in the UK more usually referred to as specialty and associate specialist or locally employed doctors. These skilled, experienced medics have much to offer yet are frequently overlooked, with little guidance or support from central organisations and medical colleges or within NHS Trusts themselves. In this commentary, we suggest ways this workforce might be better tapped into, to the benefit of patients and healthcare systems, as well as the doctors themselves.

INTRODUCTION: THE OPPORTUNITY OF COVID-19 AS A SYSTEM DISRUPTOR

The COVID-19 pandemic increased healthcare demand, including rapidly changing novel clinical needs, at a time when organisations were already struggling with limited resources, and a workforce recruitment and retention crisis.1 Because of this, leadership had to adapt quickly and innovate as routine services were cancelled or altered;2 while the increase in sickness rates, staff quarantining and social distancing meant that there were far fewer social supports for everyone, including for those at the frontline.3 The pandemic emphasised the importance of staff well-being4 and of flexible, emotionally intelligent and better distributed diversity of leadership.5

Here we discuss the case for more leadership from non-consultant career grade doctors (known in the UK as specialty and associate specialist (SAS) doctors, ‘middle-grade’ or ‘locally employed’ (LE) doctors). In a hierarchical profession within hierarchical organisations, this large part of the medical workforce, accounting for one in five doctors, has traditionally been excluded from such leadership positions yet has much to offer. Here we also describe the barriers these doctors typically face, as well as the potential benefits overcoming these might produce for patients and organisations, as well as the individual staff. We argue that this fits in wider contemporary healthcare leadership conversations on better diversity and representativeness, and, we believe, resonates with parallel calls for more healthcare leaders from nursing and other allied health professionals.

COVID-19 may represent a disruptive opportunity in terms of more distributed leadership and management. Contemporary developments such as integrated care systems and matrix management might prove vehicles to help embed this after the pandemic.

WHAT IS DISTRIBUTED LEADERSHIP AND WHY DOES IT MATTER?

Leadership roles are many and varied, from facilitation, collaboration and influence, as well as carrying other aspects such as power and prestige. Distributed leadership (DL) has been defined as a type of leadership in which generic leadership tasks, such as power and facilitation, are shared to influence resource availability, decision making and goal setting within an organisational perspective.6 In other words, DL recognises the collective actions of everyone who contributes to leadership practices, regardless of them being designated as formal leaders.6 DL has been considered a positive type of leadership for health and social care organisations7;8;9 because the healthcare context involves multiple stakeholders, with different interests, sharing change agency roles,10 and because it has been associated with adaptation to changing conditions, service improvement and with practitioners’ role satisfaction.9;10 It should be noted that DL can be considered more narrowly as a specific theoretical approach, or in the broader sense of the meaning, overlapping with related concepts such as ‘shared’ or ‘collaborative’ approaches11; this manuscript adopts the latter approach with a view to providing more practical perspectives on how to enhance the roles of SAS/LE doctors.

In the contemporary National Health Service (NHS), management and leadership roles vary widely, from profession-specific leaders to matrix management covering other professional groups and services. This occurs at many levels from teams, through departments, to sites and organisations. Good, effective, collaborative leadership and management exists already, but professional hierarchies, traditional power relationships and centralised performance regimens may nevertheless still act at times as barriers to its effective implementation.9 The current healthcare demands and strains, which have been exacerbated by the COVID-19 pandemic, have been described as representing a ‘wicked problem’ that requires
better collaborative engagement; this is equally an opportunity to consider novel leadership opportunities.12

For medical doctors, consultants are at the top of the hierarchy ladder in secondary care, clinically leading multidisciplinary teams. Their training and experience mean that, among doctors, they most commonly lead teaching and training of junior doctors, contribute to research and have informal or formal leadership positions of service development and change.13 14 The deeply rooted historical aspects of this mean that consultants may struggle sharing their leadership and managerial roles with other doctors. There are likely many factors underpinning this: such aspects may be part of their job description; they might require the consultant’s specific skill set and knowledge; and there might be relevant issues of corporate governance and responsibility necessitating a consultant. Indeed, this evolution has been formalised through NHS and other healthcare contracts and professional accountability, for example, in the UK through the General Medical Council (GMC). Although less evidenced, there might also be ‘softer’ cultural issues at play, such as consultants feeling they ‘must’ or ‘should’ hold on to certain roles: this could involve a complex interplay of factors such as a sense of professional obligation, or putatively more negative issues such as prestige and power. However, the multiple and highly demanding roles consultants are expected to perform have been linked with high rates of burnout and early retirement.15 Having other medics who can undertake some of the leadership and management roles traditionally ascribed to them offers the possibility of both supporting the consultant body, as well as diversifying those in such positions, and adding new experiences and perspectives to organisations, as well as sharing the recognition and respect frequently associated with consultant roles.

SAS DOCTORS: AN UNTAPPED WORKFORCE FOR MANAGEMENT AND LEADERSHIP

SAS doctors: what are they?

SAS doctors, by definition, are not on a formal training programme or working in a consultant or GP principal post.16 They represent a significant, important and diverse part of the UK medical workforce—accounting for about 20% of doctors17—and have a wide range of skills, experience and subspecialities.18 Many SAS doctors, though not all, will have completed postgraduate training and could apply for consultant posts, but are SAS doctors by choice, as they prefer to focus on clinical activities, which is the mainstay of this grade. This may present a paradox for SAS doctors in terms of the central argument of our paper: namely, it is undoubtedly true that many will have chosen SAS work explicitly to avoid some of the aforementioned challenges of consultant work, including leadership and management responsibilities. Furthermore, their job descriptions and pay scales reflect the lack of these roles. However, we believe that this risks, and indeed has resulted in, an organisational and professional dichotomisation and mindset that doctors either have no such responsibilities or they take on the full gamut of those of a consultant. The very term ‘middle grade’ is perhaps inevitably confusing and inferring a lack of seniority, potentially reducing leadership engagement from the doctors themselves, as well as their Trusts and the health organisations employing them. Indeed, many SAS and LE doctors find the terms ‘middle grade’ and ‘non-consultant career grade’ to be derogatory, essentially defining them by ‘what they are not’, which, speculatively, exacerbates the problem.

Existing guidance on leadership for SAS doctors

NHS Employers, along with the British Medical Association, has created specific job plan templates, charters and guides for SAS doctors’ development.18 19 These documents state that SAS doctors with the appropriate skills and experiences should be encouraged to apply for formal management and leader roles, such as teaching, research or governance leads, as well as take on other less formal types of ‘project work’ and roles within organisations. The SAS Doctor Development guide suggests SAS doctors should have extended roles, such as educational and clinical supervisors, management, appraisal and induction roles and even guardians of safe working hours.18 Health Education England and NHS Improvement also published a report aiming to maximise the potential of SAS doctors.20 This report recognised the importance of supporting SAS doctors’ development and encourage organisations to implement the Charter and stated that to make these changes happen, SAS doctors need to have a clear role in workforce planning.

Challenges in the current system: putting the problem ‘in’ the SAS doctor?

Despite these valuable efforts to support the development of SAS doctors, a recent survey conducted by the GMC reported that only 32% of SAS doctors agreed that their employer have made efforts to implement these charters and almost 30% had not even heard about the charter in the first place.21 Currently, ensuring SAS doctors’ appropriate professional development is still largely placed on the SAS doctors themselves, rather than on their managers or employers; in practice, very few are involved in non-clinical activities.21 The apparent lack of, or at least highly inconsistent, leadership development for SAS doctors has been highlighted and ‘addressed’ by different organisations.22 However, there is still a lack of good understanding of those factors limiting the implementation of the SAS Charter, and until the benefits of involving SAS doctors in leadership and management for the organisations are recognised, effective changes might still not happen. What is missing from these reports is information on how many SAS doctors might wish to take up such roles (and what types of management and leadership roles) and the supports (or lack thereof) of those who have sought such roles. Likewise, these guides do not provide suggestions about how engagement on these roles will be remunerated. Although many SAS doctors might engage in more leadership and managerial roles for their own professional development and job satisfaction, the lack of financial remuneration might hinder SAS doctors from going beyond their clinical activities.

There are fora and tools to redress this. Job planning and appraisal are mandatory for all doctors and, at least in theory, offer up formal, fixed opportunities to discuss leadership and management ambitions and aims. Job planning in particular can build in the necessary time, resources and training needed, as well as including targeting objectives over a period of time. As well as motivation from the appraised doctor, this also requires encouragement and support from the appraiser. Coaching is becoming more common for healthcare leaders, and this opportunity could be offered more broadly (this is now occurring for SAS/LE doctors in the NHS Trust of three of the authors).

It is not clear how effective job planning and appraisal are in practice, and there is a dearth of ‘success stories’ that might provide inspiration or guidance to others. What has been shown, unfortunately, is survey data indicating that SAS doctors experience disproportionate rates of bullying and harassment at work, often feel isolated, have less supervision and more cursory appraisals and are more likely to be referred to the GMC.21 The
current system does not appear to be working in bringing out the best of SAS doctors, and certainly not in encouraging their adopting leadership and management roles.

**Challenges in the system: lack of organisational support for SAS doctors**

Consultants and doctors in training posts increasingly receive specific management and leadership teaching and experiences and will typically have been encouraged to lead projects to prepare them for these roles. This is not the case for SAS doctors, who are left to their own initiative to look for opportunities to develop these skills and find opportunities to put them into practice. Developing leadership capability requires leadership developmental programmes and sharing of leadership tasks from senior management, formal and informal leadership development, mentoring and focus on helping those with less experience develop their leadership potential.

Structural problems continue outside of NHS Trusts. Notably, there is a long-standing issue regarding representation with Royal Colleges, as within some colleges SAS doctors do not have the same rights—as such voting rights—as fully registered members, despite paying fees to comply with GMC requirements. The Faculty of Medical Leadership and Management (FMLM), which is a UK medical organisation aimed to improve medical leadership, currently offers memberships to SAS doctors, and in their past events, they have organised workshops focused on leadership for these doctors. However, they offer the same type of membership, and benefits, offered to consultants, which suggests a lack of acknowledgement regarding the different challenges and needs faced by SAS doctors. Additionally, the last FMLM event specifically organised for SAS doctors took place in 2013, while the last post regarding SAS issues in the FMLM website, which coincidently called for a ‘Time for action’ to involve SAS doctors, the decision making of the new NHS, was posted in which coincidently called for a ‘Time for action’ to involve SAS doctors while the last post regarding SAS issues in the FMLM website, and needs faced by SAS doctors. Additionally, the last FMLM event specifically organised for SAS doctors took place in 2013, while the last post regarding SAS issues in the FMLM website, which coincidently called for a ‘Time for action’ to involve SAS doctors, the decision making of the new NHS, was posted in 2014. Of note, in this journal, *BMJ Leader*, we could not find any paper focused on SAS doctors, though we recognise that it is a relatively new journal, and its content is dependent on the submissions of others.

**OTHER INTERSECTIONAL ISSUES IMPACTING SAS REPRESENTATION**

These experiences fit within broader contemporary discussions on diversity and representation in healthcare. This includes various levels of intersectionality that have been shown to impact healthcare progression—many of which disproportionately impact SAS doctors—such as ethnicity, gender and sexual orientation. We note that this is more widely felt through different professional groups including nursing and allied health professionals. Infamously, the NHS continues to have ‘snowy white peaks’ of management and leadership.

A large proportion of SAS doctors are international medical graduates (IMG), a group of doctors who have been recognised as facing many social and professional challenges, including loss of status, bullying and discrimination. Additionally, doctors from black, Asian and minority ethnic (BAME) backgrounds, which are also over-represented in SAS doctors, have been found to be less likely to apply, be shortlisted or offered a consultant post. BAME doctors report more difficulties and more problematical relationships with senior doctors, compared with white trainees. This suggests many SAS doctors might struggle with additional barriers to engage in leadership roles if they are IMGs or from BAME backgrounds. It is important to highlight the under-representation of BAME staff in leadership positions has not been limited to doctors, as board members and staff at senior levels within the NHS have been identified to be disproportionately white and UK graduates in relation to the make-up of the staff more generally. Overall, top boards and committees need to improve BAME representation because staff need to see themselves at all levels of leadership and because teams that are inclusive and diverse perform better and meet expectations.

**THE WIDER RELEVANCE: TAKING THE ARGUMENTS OUTSIDE OF DOCTORS AND BEYOND THE UK**

Within the NHS, doctors and nurses are often at the centre of the leadership ‘conversation’, with allied health professionals (AHPs)’ roles being often less visible or recognised, despite calls for more such roles to improve healthcare systems. Perhaps akin to ‘non-consultant’, the very term ‘allied professional’ infers a lesser importance. Furthermore, unlike doctors, many have to stop all, or at least most, clinical practice when they move into more senior leadership roles, which likely deters many clinicians.

Outside of the UK, other healthcare professionals have also struggled to engaged in leadership roles or even have their expertise recognised. In the USA, the numbers of nurse practitioners (NPs) and physician assistants (PAs) have increased over the last few years, in part to help cover medical workforce shortages. However, data suggest that PAs are being excluded from leadership positions, as despite sharing similar training and hierarchies with NPs, US directorial and managerial roles are commonly advertised only for doctors and NPs, excluding others from board, managerial or other leadership roles.

The scope of practice clearly can vary widely between countries, and a full description is beyond the scope of this piece. However, we note in particular how the ratio of physicians to the general population can be notably lower in some low-income and middle-income countries, and these might prove particularly apposite examples where invaluable, high-calibre leadership can be provided by others beyond the most senior of doctors.

**CONCLUSION**

Staff inclusion positively influences performance and quality of care: on treating staff in a fair and equitable way and encouraging contribution to the effectiveness of that group. SAS doctors are skilled professionals who carry an enormous breadth of experience and skills, yet they are under-represented and not adequately included in leadership positions.

We recognise that many, but not all, SAS doctors are ‘SAS by choice’, and for some, this means not wishing to take on senior management or leadership positions. However, a perhaps unintended outcome has been a current near inability for SAS doctors who might wish to develop themselves in this way to do so. Guidelines talk of support, but we do not see evidence for this in action. There might well be individual SAS doctors trailblazing such roles, but if so, they lack visibility right now, and the resources are not in place for appropriate guidance and training in most instances. It is currently difficult, therefore, to provide good evidence that SAS doctors taking on leadership and management roles improves care except to note that in almost all instances, greater diversity of people and ideas is good for patients, good for organisations and good for the individuals themselves. There is certainly an ethical argument, fitting with the ethos of the NHS to value its staff, to have values of inclusion, but we are confident that good practice will ultimately...
demonstrate that this also makes healthcare systems more effective.

There is a wide range of potential leadership and management roles: some might be more formalised, such as a Trust governance lead on patient safety, for example, and some might be more informal, such as joining and contributing to a research committee. Individuals will have varying motivations for these, including professional interest and curiosity, and personal development. Most NHS staff do not get remuneration for undertaking any but the more senior and formal leadership positions, and we also recognise the converse dangers of already busy doctors becoming overloaded with new responsibilities that they might not wish to carry. At a moment when there is a shortage of consultants, and the ones currently working are struggling with an increased workload and risking burnout, we might need a more flexible grading system, which allows SAS doctors to be eligible for consultant roles (with appropriate additional training), or for roles that allow them to take on more leadership roles and better support their colleagues but that are also adequately remunerated.

We think that initial positive steps would include networking opportunities for SAS doctors to better hear the experiences and opinions of those in such roles who wish to extend their management and leadership opportunities. The FMLM is, we argue, well placed to support this. We need to start disseminating, highlighting and celebrating best practice and learning and the supports and mentoring that have facilitated this. We would like to see future articles in BMJ Leader by SAS doctors describing their leadership achievements and developments.

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