# Everything is possible: personal leadership experiences

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*My Scottish grandfather used to say 'When all is said and done; there is more said than done'.* Making things happen requires leadership.

Leadership is creating extraordinary results through ordinary people. There are lots more complicated or esoteric definitions of leadership, but this simple definition summarizes what I have personally learnt from 20 years in four health systems across three continents.

Leadership involves personal characteristics which include transmitting passion, energy and heat into an organization as well as leading through people.

Leadership in the National Health Service (NHS) faces particular challenges.[1] We can do more medically than most governments can afford, most expensive decisions are made by doctors, yet doctors often see themselves as heroic healers. The explosion in medial knowledge and capability has transformed many life sentence diagnoses into long-term conditions, yet these medical changes have occurred in a system that is still too fragmented and disorganized to absorb them.[2] There is evidence that some of the best hospitals are led by physicians[3] yet doctors are often reluctant to lead and are concerned about deskilling on the 'dark side of management'. You would not run an army with civilians – we do need to run the NHS with much stronger clinical leadership.

Identifying those with the right characteristics to lead is not simple. The Texas Rangers are the second oldest law enforcement agency in the USA. Their history is steeped in stories of the Wild West and maintaining law and order. One of their legendary leaders Captain Bob Crowden said *'A Texas ranger is an officer who is able to handle any situation without instructions from higher authority'.* We ask our clinical leaders to bring order to and handle very difficult situations and we rely on them to do so, all the time and especially when we are not visible or present. It is our clinical leaders who confront a surgeon who really should retire, who tackle a colleague whose infection rates are too high, who discipline a colleague whose demeaning behaviour has caused offence and talk a family through a clinical error.

These challenging situations are made more difficult by the nature of how we develop and select clinical leaders. As doctors in training they focus on a particular medical specialty. Within that specialty they then sub-specialize into a more circumscribed area of medicine. Once they are a consultant, they perfect that specialization. Then after a further few years, we suddenly expect them to demonstrate extraordinary leadership among colleagues they have 'grown up' with for many years. This is of course the opposite approach from usual leadership development. Those with that inherent skill are not always evident – a good analogy is a herd mentality. In herds there is a lead cow; this cow will lead the herd through the gate. They are at the front, initially, however once they get to food it is the dominant cow that takes her food first. So how can we distinguish the dominant forces within our medical herds from the most obvious or noisy practitioners? If we listen and ask enough people we can find the dominant person in any herd over time. Once we have identified those leaders another question for us is who we spend our time with? Is it those who eat energy/the energy sappers, or those that inject energy, who are contagious with their energy and convey that energy positively around them.[4] Our time is the most precious currency we have. Where and with whom we spend our time is one of the most conspicuous acts we undertake. So who we choose to spend our time with is a very powerful


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indicator of worth to the whole organization. It is all too easy to spend our time with the noisy apparent leads rather than with the possibly more reflective self-assured forces that actually have sway and influence.

In Japan there are three alphabets with tens of thousands of Kanji or pictograms to describe things, this alone complicates communication. A truism from Japan is that everything is possible; but everything is difficult. Leading change is complicated and difficult and is possible with forethought. One of the starting points of any change is raising the level of dissatisfaction with the current state. This is a very uncomfortable period. It is all too easy to rush this phase and the very fact that is embarrassing and awkward to confront reality encourages speed to get it over with, at the expense of achieving a deep understanding and achieving a general consensus. A little structure helps create positive long-term momentum.[5]

Vividly describing why change is required and why and how things will be better afterwards is a prerequisite of any change and was unfortunately poorly communicated during the initiation of the recent health reforms. Clarity and purpose that engages the heart and the head, blending passion and altruism with logical analysis is a powerful force.[6] From my own experience, creating a vivid picture of the future state with a memorable dialogue is vastly superior to a bland statement which could be interchangeable with to any other organization. Talk of process re-design or governance will leave most cold. Translation into issues of patient care, safety and clinical professionalism will attract the most cynical, especially when accompanied by comparative data.

Creating time to build the right team or driving force is a sound investment. Often the initially most critical can be the most creative and persuasive. The team needs 'big' people with big titles and 'small' people with small titles. Most implementation problems occur when strategy meets implementation and requires people from all levels to carry out changes. I prefer to create 'consequences' to 'quick wins'. The concept of a quick win could be interpreted as fabricating short-term tricks. An American primary school teacher once taught me and my son that there are positive and negative consequences for everything we do. If he was good he received warmth and encouragement, when bad he sat on the 'cat chair' at in front of the class. So for example, when the Emergency Department changed their rotas to working until midnight seven days a week and reliably reduced assessment and treat times while increasing patient plaudits, we added new consultants to make the changes sustainable. Once the changes are underway, listening posts are vital for keeping abreast of the real impact on change on the ground. I was first taught this by a Ward Sister filling up water jugs on a busy but well staffed ward. When asked why she did such an apparently menial task when so many other less qualified staff were available, she replied that she learnt more on her 'water round' than on any formal Consultant ward round. A key question for us is who do we listen to? How many porters or housekeepers names do we know? The gossip super highway is not the exclusive preserve of the consultant body. The 'big people' and the 'small people' contribute at least equally to the Gossip Super Highway. The thousands of people who work in our organizations look exquisitely at the space between what we say and what we do. They measure it to within a nanometre. The smaller it is, the more they trust us. If time and how and with whom we invest it is our main currency of investment, the consistency of our actions is the interest rate we earn on those investments.

Reward and recognition is so important in creating positive consequences. In the NHS, material reward is a controversial topic; however, gestures of thanks, handwritten notes or conspicuous events to thank staff and teams do create consequences. I have also learnt how important home is. We all talk about work at home to a greater or lesser extent. A word of thanks sent home has a 'signal amplification' effect. There is a danger of over use, but judicious letters or gestures of appreciation sent home for extraordinary efforts help separate the great from the mediocre.

This leads to the culture of change. Culture is what defines people's actions when we are not looking. Setting a culture takes time and endless energy. An ex-Trappist monk once explained that too many people think of communication as throwing pebbles into a pond. The more pebbles they throw, the more they are communicating. In reality it is the impact of the ripples on the reeds

around the pond that determines the effectiveness of our communication. Communicating the vision and culture requires multiple approaches. For example our IT Department reliably tells me that only about 30% of our staff read their emails regularly.

In the words of Martin Luther king 'The true test of a man is not where he stands at comfort and conscience. The real test is where he stands at times of conflict and confusion'.

The true test of clinical leadership is upon us. We can do more than governments can afford, the health service is going through its largest change since its inception and we are in the depths of the deepest and most prolonged recession. Meanwhile the public have unaltered and high demands on their healthcare.

The health service is full of clinical leaders. Some have already been appointed and others are still to be recognized or to yet realize their full potential.

So, we need to become better at identifying our clinical leaders and better at developing their skills. Boards need to dedicate time, energy and resources to succession planning as well as support and encouragement of these extraordinary leaders. We need to create positive consequences for leadership roles and guard against clinical deskilling.

We do stand at a time of conflict and confusion, the true test of clinical leadership is now.

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