How doctors in senior leadership roles establish and maintain a positive patient-centred culture

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The GMC commissioned this research to understand how doctors in senior leadership roles approach the goal of sustaining and building positive workplace cultures in which patients experience safe, high quality care. Published research evidence, informed commentary and practice wisdom all suggest there is an association between constructive working cultures, and the achievement of measurably better outcomes for patients. Consequently, current frameworks for health care leadership in the UK[1] and elsewhere urge attentiveness to the need to promote patient centred, cohesive, supportive, collaborative and inclusive cultures.

However, there is only a limited evidence base describing the day to day challenges experienced by senior medical leaders in working to achieve positive patient centred cultures. This study therefore sought to capture senior medical leaders' perspectives on the components of positive cultures, and convey to readers their 'lived experience' of attempting to nurture positive cultures in a wide range of health care structures and organisations.

Research themes

This study was framed around four overarching research themes.

- How do senior medical leaders themselves conceptualise a positive culture, and their role in promoting it?
- How do senior medical leaders identify the presence or absence of a positive culture?
- How have senior medical leaders approached the task of building or sustaining a positive culture, and what resources and methods have proved helpful to them?
- How far do senior medical leaders' approaches to thinking about culture, and building supportive cultures, appear to cohere with behaviours being promoted by commentators and system leaders?

While there has been extensive research into health care cultures and leadership, the questions set out above remained unanswered. However, evidence on the association between health care cultures and patient outcomes, findings from research into medical leadership, and studies of high performing health organisations, all provide an important backdrop to this study. That literature is summarised in the full report.

How the research was done

In depth interviews were used to explore the perspectives and experiences of senior medical leaders. Twenty-seven interviews were carried out during 2018 specifically for this project. About one third of participants were women and about one fifth were from BAME groups. The project has also drawn on material from an earlier study of medical directors' perceptions of moral dimensions of leadership completed by the same researcher in 2011. That study consisted of twenty four participants. One fifth were women but none were from BAME groups, reflecting the low proportion of BAME doctors in medical director roles a decade ago.

Senior medical leaders were recruited from a wide range of roles and organisations:

[1] https://improvement.nhs.uk/resources/developing-people-improving-care/

- NHS England mental health trusts, teaching hospitals, district general hospitals.
- NHS England, Health Education England, NHS Improvement
- NHS Scotland
- Independent hospital groups

The range of participants' roles included:

- Medical Director, Assistant or Associate Medical Director, Divisional leader.
- Consultants with additional significant leadership responsibilities, such as leading and creating specialist care networks.
- GPs who also hold commissioning and educational roles.
- Recent past Presidents of medical Royal Colleges.
- Chief Executive, Non Executive Director (medically qualified).

Key findings

How do senior medical leaders themselves conceptualise a 'positive culture'?

The notion of 'positive culture' in health care settings invokes complex and varied understandings and ideals among senior doctors. Eliciting medical leaders' views on culture demonstrated very clearly that health care is not a single culture. Rather, it is a shifting constellation of intersecting influences and subcultures that challenge, influence, and inform leaders' choices.

Leaders drew on a wide range of reference points to express their conceptions of culture, which were often implicit and embedded within other concepts and ideals. Some conceptions are apparent as 'background conceptions' (ideas which may not always be at the forefront of leaders' day to day thinking but shape their expectations and values); and others as 'role derived conceptions' (which come more to the fore in leaders' day to day thinking because they are elicited by leadership activity).

'Background conceptions' include:

a) Philosophies of care. There are deeply held views on what constitutes good medicine, and therefore what constitutes a good care culture. These perspectives are a cherished element of leaders' professional and personal identities. For example some doctors prize relational care principles highly, prioritising therapeutic relationships with patients and families; others foreground technical clinical excellence and prioritise knowledge, technique and research. Leaders' priorities affect their choices and choices of those around them.
b) Specialty cultures and other specialist knowledges. These cultures inculcate powerful normative expectations. Assessments of culture are coloured by the professional cultures of specialties, for example the extent to which they promote and advance inter-professional working. As medical leaders advance in their specialty or within medical management roles they frequently also acquire additional subject knowledges, such as medical educational knowledge, which in turn elicits attentiveness to aspects of culture such as approaches to training.
c) A sense that generational changes in medical culture, including a more diverse workforce, contributes to shaping new norms. Leaders recognised that different groups have varying needs of work cultures, such as working arrangements that accommodate family obligations, and respect ethnic and cultural differences.
d) Experience in other sectors. Some have experienced approaches to leadership in other sectors, notably the armed services, which prioritise particular aspects of culture such as teamwork.

'Role-derived' conceptions of culture are based in:

e) Specific settings and activities. Different types of care call forth different care cultures and different needs for leadership. For instance, network models of specialist care have to develop working cultures that transcend geographical and organisational boundaries, standardise treatment, and bind together a large and disparate group of clinicians who may rarely meet face to face. A GP partnership faces different challenges, stemming from being a small group of relatively independent decision makers.
f) Specific responsibilities. Leaders responsible for managing performance, revalidation, job planning etc. will be dealing directly with specific aspects of culture. Other special roles, like providing interventions for teams in difficulty, foreground specific types of culture work such as enabling other leaders to manage negative behaviour.
g) Continuing professional development and experience. Medical leaders alter their thinking about culture as they gain leadership experience. They may come to focus more on the need to attend to culture in order to achieve clinical goals.

Senior medical leaders possess rich and diverse views on what medical cultures look like, how medical cultures work in practice, and the structural pressures that may require them to change. Although they may only rarely articulate these views, they contribute to shaping their immediate actions and their plans for the future. Engaging medical leaders in considering their role in building a positive culture invokes complex and diverse ideas in response.

How do senior medical leaders identify the presence or absence of a positive culture?

> ***"When you spend some more time, you will know it...It's not just the smiling staff who greet you when you walk in. It takes a bit longer to get to know the team. A dysfunctional team, when they're faced with challenges, it brings out all the issues within the team…A team with a better culture…put aside some of the differences, or they might even use some of the differences in a positive way to focus on what is the task, the patient care...You would still have the conflict, you would still have the problem but the team will trust in each other that actually they are working for a greater cause."***

Leaders have access to a great deal of hard and soft data that can give an indication of the quality of cultures in organisations. There is no shortage of information. Rather, the challenges they face are to make sense out of all of the disparate sources, to manage their own and their colleagues' cognitive and emotional responses to unwelcome information, and to find ways of changing undesirable situations once they have been identified.

Participants referred to a wide range of organisational indicators - such as serious incident rates, staff grievance data, appraisal compliance, staff surveys and safety climate questionnaires – to provide either proxy or direct measures of their organisation's culture and subcultures. They also described using 'soft' signals. These served as rough and ready assessments, an alert to problems, or provided a narrative around quantitative data to aid interpretation.

These soft signals are summarised in the table that appears below (next page). The table is a summary of soft signals that came to the fore in interviews, and should not be viewed as a comprehensive overview of the characteristics of negative and positive cultures. Fuller descriptions are provided in the research report.

Signal type	Positive signs	Negative signs
Appearances	• Environment welcoming, clean & well kempt, tidy • Visible signs (e.g. notice boards) of feedback being acted on and of ongoing improvement activity • Patients engaged, positive, active where possible • Observable staff attitudes, including responsiveness, 'can do' attitude, attention to detail	• Environment unwelcoming, tatty, unkempt, untidy • No visible sign of interest in getting and acting on feedback or of improvement work • Patients not engaged, passive, discouraged • Cynicism, 'don't care' attitude, staff have let things go
Patient experience and needs	• Genuine attentiveness to patient voice and experience as part of clinical excellence • Low level of patient dissatisfaction • Focusing on patient needs helps discourage or resolve professional conflicts	• Lack of interest in patient experience, focus on purely technical clinical outcomes • High level of patient dissatisfaction • Professional conflicts are taking priority and displacing focus on patient needs
Attitude to organisational routines	• Examples include good handovers, willingness to standardise, flexibility • Cooperation	• Lax implementation of protocols such as surgical checklists, resist standardisation, inflexibility • Resistance
Attitudes towards information	• Performance data are welcomed, discussed and viewed as an opportunity for learning	• Performance data are viewed defensively, resisted, dismissed, or selectively analysed
Emotional tone	• Doctors are appropriately managing their own emotions resulting in calm atmosphere and thoughtful decisions • Professionals have sufficient capacity to show compassion towards one another, and take opportunities to interact informally • High morale supports discretionary effort • Appropriate humour supports team functioning	• Doctors' own fear, anxieties or other negative emotions are eliciting these in others and inhibiting team working and decision making • Professionals feel unable to care for each other (possibly owing to stress or burnout) and tend to avoid informal interpersonal contact • Low morale and staff feeling they can't be bothered • Loss of sense of ease & humour in team
Interpersonal interactions	• Supportive approach to trainees and training which results in feelings of security and belonging • Mutually respectful and supportive interprofessional relationships • Willingness to bridge the gap between clinical and managerial language and goals • Civil working relationships even when under pressure, commitment to collective problem solving	• Department not supporting and coaching trainees commensurate with trainee level and experience • Lack of respect for expertise of other health professionals besides doctors • Mutual disdain between doctors and managers and unwillingness to see the others point of view • Uncivil working relationships, belief in blaming and shaming to manage care delivery problems

Participant insights also suggested a typology of notable subcultures with features that many recognised, and that may in their different ways present problems to senior leaders. The five notable subcultures are:

- *Diva subcultures*: these arise when powerful and successful professionals are not called to account for inappropriate behaviour, and colleagues modify their working practices to accommodate them.

- *Factional subcultures*: which arise when disagreement within a team becomes endemic and the group starts to organise itself around continuing conflict.
- *Patronage subcultures*: these emerge when colleagues perceive strong bonds of loyalty, dependence and/or respect towards a benevolent leader possessed of social capital. The clinical group becomes reluctant to question or challenge the patron.
- *Embattled subcultures*: these may arise when resource has long been inadequate and is perennially unequal to demand. The group feels besieged by the unmet need they see in patients, and may exhibit burnout, learned helplessness, and resentment. Clinical decision-making may tend to minimise patient need in preference to recognising that needs cannot be met.
- *Insular subcultures*: groups that have become geographically or psychologically isolated from the cultural mainstream of the larger organisation, with the result that behaviours, professional practice, or standards of care deviate from accepted norms.

In addition, leaders also recognised that their own leadership teams, generally comprising both clinical and managerial staff, possessed their own distinctive subculture. Leadership subcultures could themselves exhibit positive and negative features, and these were often readily apparent to staff in organisations. The way leaders conducted their business signalled to staff what was valued, how to behave, what could be said to authority and what could be expected if staff brought problems to the leadership team.

Senior medical leaders also noted the influence of negative behaviours exhibited by non-executive directors and strategic NHS bodies. Close to one quarter of the sample reported having experienced behaviour directed towards them from these quarters that they perceived as either workplace bullying or grave incivility.

How have senior medical leaders approached the task of building or sustaining a positive culture, and what methods have proved helpful to them?

> ***"You just don't know what people will take from the way you behave. I'm really conscious of [role modelling as a leader during] my clinical practice. …It doesn't matter how many times we say to people what we want them to do, it's what people actually observe and experience that counts".***
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> ***"I instigated a governance programme of reviews for the divisions and I made clear that our governance in this organisation would cover quality and safety first, culture and people, operational delivery and finance…The first divisional reviews people were…terrified. They were still scarred by the nature of the reviews held by the turnaround director. Over time, they have grown pleased and accustomed…to the fact that those review meetings are thorough, I do investigate and follow things through, but they are respectful, even-tempered, collaborative, constructive, open..."***

Organisational culture can be viewed in two broadly differing ways. One is to treat organisational culture as a 'thing', something that exists in organisations as a discrete component of organisational life. On this view culture is a singular characteristic of an organisation that, if it goes awry, should be fixed with some sort of cultural engineering activity. The alternative approach is to view organisational culture as something that organisations 'are', so that culture is synonymous with the notion of organisation itself. Those who view culture as synonymous with organisation argue that, *since organisational leadership is inevitably leadership of cultures*, leaders are doing something to culture in *all* of their core activity and whether they intend to or not. Approaching leadership of organisations in this way, the task is not to think (and lead) *about* culture but to think (and lead) *culturally* (Bate, 2010).

Senior medical leaders described ways of thinking about and acting upon culture that are generally more consistent with the second perspective above, treating leadership of the organisation and leadership of culture as in many respects synonymous. For the most part senior medical leaders do not set out to engineer organisational culture as a discrete activity. Rather, they recognise that their routine and unexceptional leadership activity does (or should) impact on culture.

The leadership activities that participants chose to talk about as particularly pertinent to culture were day-to-day cultural housekeeping, with attentiveness to their own behaviour in routine interactions; change management and quality improvement activity; and dealing with performance and behavioural issues.

'Cultural housekeeping' is the frequent, consistent reinforcement of features of culture that are more or less desirable. Virtually all the participants named the time they invested in building relationships to be one of the most important resources at their disposal. They identified as important their everyday conversations, promoting collaborative problem solving, assigning responsibility for outcomes, providing supportive coaching, and consistently role modelling expectations in both their clinical and their managerial practice.

The chief feature of many participants' accounts of enabling change was how unprepared they had been for this in their early leadership career. Many reflected that they had learned through trial and error that success rested as much on their ability to engage and motivate colleagues as it did on the technical or clinical expertise that they had acquired in their decades of training. They also noted the tendency in health care to invest too little time understanding the problem (particularly from a front line perspective) and to impose quick fixes.

Managing performance, responding to serious incidents, or supporting doctors in difficulty had been a pivotal responsibility for most participants. They viewed this a critical influence on culture for two reasons: first, because it was essential to satisfactorily address performance and safety concerns (including inadvertent error); and second, because it was important to be *seen* to fairly and consistently respond to poor behaviour. Examples were given of the impact on professionals and organisations of handling these matters well, with a strong emphasis on the importance of fair processes and the need to challenge poor behaviour exhibited by high profile doctors.

Leaders also discussed interventions to change the perceived negative culture of a team or subgroup. They recounted dealing with entrenched negative cultures with varying degrees of success. Leaders had generally had recourse to specialist providers, and it was notable that intervening in subgroup cultures was challenging, time-consuming and required continuing attention after the intervention was finished. There is a widespread view that it is extremely difficult to change a 'diva' subculture if the chief actor remains in situ.

How far do senior medical leaders' approaches to thinking about culture, and building supportive cultures, appear to cohere with aspirations being promoted by commentators and system leaders?

> ***"In leadership within the NHS it's about truly listening and trying to engage but it's also about not being held to ransom, knowing when to hold your nerve, and where to compromise."***
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> ***"[A senior colleague] told me to lead with my whole heart, not with my head…What we don't need is people who are trying to be kind of un-emotional people who are just sort of corporate apparatchiks…My job is to create the conditions for other people to give the best care they can. And to do that they have to feel safe, and they have to know that I engage and see them as people."***

One of the aims of the research was to understand the differences and similarities between leaders' accounts of their leadership, and a model of compassionate and inclusive health care leadership being

advocated by NHS Improvement and influential commentators such as The Kings Fund (West et al., 2017). The report compares participants' accounts of their activity with ten principles described in the NHS Improvement *Culture and Leadership Programme*. This Programme reflects the leadership model set out in NHS Improvement's *Developing People – Improving Care* which is in turn based on a model of compassionate leadership delineated by Atkins and further developed by West (Atkins and Parker, 2012, West and Chowla, 2017).

Multiple examples from participants show aspects of leadership activity that reflect principles of compassionate and inclusive leadership. The evidence is not that everything leaders currently do is compassionate and inclusive. Rather, for each of the ten principles of behaviour there are illustrative cases of ordinary leadership activity consistent with these aspirations.

In addition, however, it is notable that leaders are seeking to reconcile competing goals, resist perverse incentives, and navigate conflicting values. For nine out of ten of the behavioural principles, a counterpoint is offered. The counterpoints suggest that in some cases the principle requires balancing by other considerations, while in other cases the principle is important but very difficult to realise in the current structures or constraints that some parts of the NHS experience.

Although the participants provided many instances of leadership action consistent with behaviours associated with compassionate and inclusive leadership, they used different terms, concepts and reference points to describe their actions. One reason for this difference is that leaders use concepts they have acquired via the influencing cultures that are described at the beginning of this summary. Another reason is that the leadership activity in which medical leaders are engaged has its own vernacular. For instance, medical leaders will refer to "supporting doctors in difficulty", an activity that in the *Culture and Leadership Programme* would seem to be categorised under the goal "improving the quality of their work". As one participant noted, clinicians and general managers tend to use a ***"different lexicon…for talking about the same thing sometimes"*** and successful partnership rests on each understanding the other.

Concepts and descriptors in documents such as *Developing People – Improving Care* and the *Culture and Leadership Programme* and their supporting materials[2] tend to reflect the influencing cultures of those contributing to their development just as the concepts and descriptors that senior medical leaders use tend to reflect their influencing cultures. In so far as there are differences in language and perspective between system leaders, regulators, academic researchers and senior medical leaders these may need to be negotiated as part of the collective effort to support doctors and others who lead in healthcare. This study is a contribution to the continuing conversation about medical leadership and health care culture, which has as its goal securing the patient outcomes that all desire.

[2] https://improvement.nhs.uk/resources/developing-people-improving-care-short-guides/ - h2-condition-two-compassionate-inclusive-and-effective-leaders-at-all-levels