FOR WHAT IT IS WORTH: OBSERVATIONS ON MANAGEMENT AND LEADERSHIP IN THE NHS, AND THE ROLE OF DOCTORS IN THE FUTURE

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Declaration
The views in this paper are personal and not of any of the organisations I am associated with.

SUMMARY

In this personal account, Rajan Madhok, a PCT Medical Director, shares his observations from a long career in medical management and suggests that doctors need to become more involved to ensure a sustainable NHS. The findings hopefully will provoke a debate about the nature and organisation of management in the NHS including what role doctors could/should play.

INTRODUCTION

The obvious question has to be why? Apart from the fact that everyone feels the need to tell their story, why do I want to inflict on others this report about leadership and management in the NHS –assuming anyone will read it. After all I am not a big name, rather I have been a jobbing doctor in medical management at local levels; certainly I am no expert in leadership or a policy pundit. Never the less, I do get asked by fellow, and especially junior, colleagues, both clinical and managerial, who are keen to learn about management and leadership in the NHS. This is for them.

Another part of the why is Why Now? The answer to that is simply this – I am going through yet another reorganisation of the NHS, and am trying to make sense of my time in the NHS. Writing helps me in this regard. I also genuinely believe doctors must play a more active role in the NHS. Doctors may be reluctant enablers but they can be powerful disablers.

Finally, I also feel that I have reached the stage (age) where I can be more open (*sic*), and not be embarrassed if I get it wrong. I am under no illusion that what I am writing is necessarily new or complete, and that at times I may be mistaken. However, personal stories can be quite useful for learning.

This report is in three parts. Part One is my assessment of what has happened in the NHS during the last 20 years. Part Two outlines what I have learnt about management and leadership for health in the NHS. In Part Three I summarise the key lessons and why I believe that doctors should become more involved. One limitation of the paper may be the absence of examples to illustrate key points, and that is partly due to my desire to keep it short, and partly I have aimed the paper at an (somewhat) 'informed' audience. This is neither a text book on management nor a recent history of the NHS – it is a reflective personal analysis.

Some caution, however, is in order before you proceed. What follows is highly personal and subjective; I am an eclectic and voracious reader, and have drawn on not just my direct observations and discussions with colleagues but also on my readings. The other reason I have to say this here is that I may be seen to be plagiarising by quoting work of others – I do not mean to, and would be happy to acknowledge them if advised. I am also very mindful of Codman's saying about publications being advertisements, and I do not wish this paper to be an advertisement for me. This is not my life story so I will gloss over quite a lot of personal detail but I do give some information mainly as context for the substance of the paper.

PART ONE: MAJOR DEVELOPMENTS IN THE NHS

After qualifying in India, I came to the UK in 1980 and started training in surgery. In 1988, I left the pursuit of my dream to become a consultant orthopaedic surgeon and retrained in public health; and since 1994 have been a Board level director in many NHS organisations, on the purchasing/commissioning side. Over the years I have covered service/academia; NHS/ International; and public/private/voluntary sectors to varying levels.

My management career, post clinical years, spans three political eras:

1. Conservative (Thatcher/Major)
2. Labour (Blair/Brown)
3. Coalition (Cameron/Clegg)

I have worked through the 'Working for Patients' (produced by the Thatcher Government which introduced the internal market concept and which was the starting point for the subsequent changes in the NHS) to the present day 'Equity and Excellence' which is the Coalition Government's proposal for the reform of the NHS. Below I outline what I believe have been the fundamental underlying developments/changes that have shaped policy and delivery of health services and that have a bearing on the management and leadership issue.

1. Highly politicised nature of the NHS– no government can ignore the NHS, and political parties in turn 'use' (when in opposition, the parties point to the shortcomings and how these will be addressed) and 'abuse' (when in power, the 'reality' catches up and politically expedient solutions are sought) it.
2. Constant structural change - self-evident and it has affected the commissioning/policy making side rather more than the hospital provider side. I am going through my third major reorganisation in the last decade: in 2001-2002 when the 'old' SHAs were formed, in 2005-6 when PCTs merged, and the current one. I estimate that we lost about 3 years worth of work during this decade because of system paralysis. As soon as the reorganisation is announced, developmental work stops. Add another 2 years to allow the new organisations to settle down and start performing and we are talking about almost half the decade worth of productivity loss.
3. Increased investment – we have gone from austerity of the Thatcher era to the prosperity of Blair era and although the finances are stagnant currently, we are well ahead in terms of where we started from, or compared with other public sectors. However, the burden of PFI and IT projects means less money is available for clinical services. There is a cycle of austerity to prosperity and back, in the NHS, since health care is a constantly expanding field and it is not possible to keep up financially.
4. Increasing desire to manage the NHS – since the Griffiths report of the 1980s, more and more management/performance management has been introduced; and there has been increasing centralisation of power. Certainly the last government fell into the 'dropped bedpan resounding in Whitehall' trap, by wanting to monitor every aspect. The

resultant bureaucracy is an industry in itself, with a huge amount of effort going into paperwork.

5. More open scrutiny – as with many other aspects of public life, there have been attempts to open up the NHS to scrutiny, from Appointments Commission to more recently through the Freedom of Information.
6. Limited emphasis on public health and 'Cinderella' services (mental health, care of the elderly, child health etc) – the Labour Government's initial start with setting up Health Action Zones was soon forgotten and energies shifted to acute services, and the current debate in the NHS is about hospital services.
7. Rising clinical standards – from clinical- audit to - governance to - excellence now, and with the range of agencies including the National Patient Safety Agency, the NHS has made serious inroads into quality and safety. The recent failures including Mid Staffs and the nursing home sector, to me means that more work and a different model of (clinical) governance is needed, and not necessarily that progress has not been made or that professionals are not pushing standards up across the system.
8. Better access to services – with waiting times slashed in many areas: A&E departments, for cancer patients and some aspects of elective interventions.
9. Policy coherence and standardisation – since the introduction of NICE and National Service Frameworks, attempts have been made to develop comprehensive policies, reduce inconsistencies and ensure more equitable standards.
10. Commissioning rather than cooperation as the main lever- certainly during my time in the NHS management since 1991 substantially, we have been locked into the commissioning paradigm.
11. Increasing patient voice – from the Patients Charter to the current Choice initiative.
12. Clinicians have not engaged fully with the management but increasingly this has started to happen – however, although there are some nurses and other clinicians in senior full time management positions, and a few doctors; mostly it is professional managers who run the show.
13. Increasing pace of technological and scientific advances including developments in IT.
14. Increasing specialisation – with each clinical profession moving up the chain with nurses doing more of what doctors did, GPs taking on specialist roles and specialists getting sub-specialised, for example.
15. High public satisfaction - despite 'negative' media portrayal and a possible slight dip due to current public sector changes.

To my mind it is not about judging whether things are good or bad, the above are underlying trends and we have now seen three different political makeups all pursuing similar changes.

My personal opinion is that the NHS is in a better place than it was 20 years ago. I am viewing things from a long term perspective and am also trying to find good.

Even that 'fiasco' the NHS IT project has delivered some successes! Of course this is a generalisation and things could have been a lot better but when viewed dispassionately and from distance (especially at the time of writing this, when there is intense debate about the Coalition's proposed reforms), the statement stands. Despite concerns about the proposed Lansley reforms, and I share some of them, I support his desire to 'depoliticise' NHS, pass the power and responsibility down and to empower doctors.

If I was to name my main disappointments, then the biggest stumbling block has been the primary-secondary care (and some would argue health and social care) divide, and rather than find ways of bridging it, the consistent policy direction with emphasis on purchasing/commissioning has reinforced it. The second is the denial by politicians that the NHS is not affordable and has to set some limits; it can not provide world class state of the art health care to everyone. Rationing has become a taboo word despite evidence, and lately increasing evidence, that some sort of rationing is already happening. Thirdly, I have been really pleased with some of the major developments such as the work of the NICE, NPSA, National Institute for Innovation and Improvement and National Service Frameworks, which have generated unprecedented, and unparalleled elsewhere, intellectual capital, but disappointed to see that we have failed to fully capitalise on this. Amongst other reasons, the failure of execution is partly to do with constant restructuring and resultant instability and partly to do with overall leadership. Finally, and the subject of this paper later, is the limited leadership by the doctors, for various reasons including the lack of career progression in medical management and the associated stresses of the roles with limited incentives.

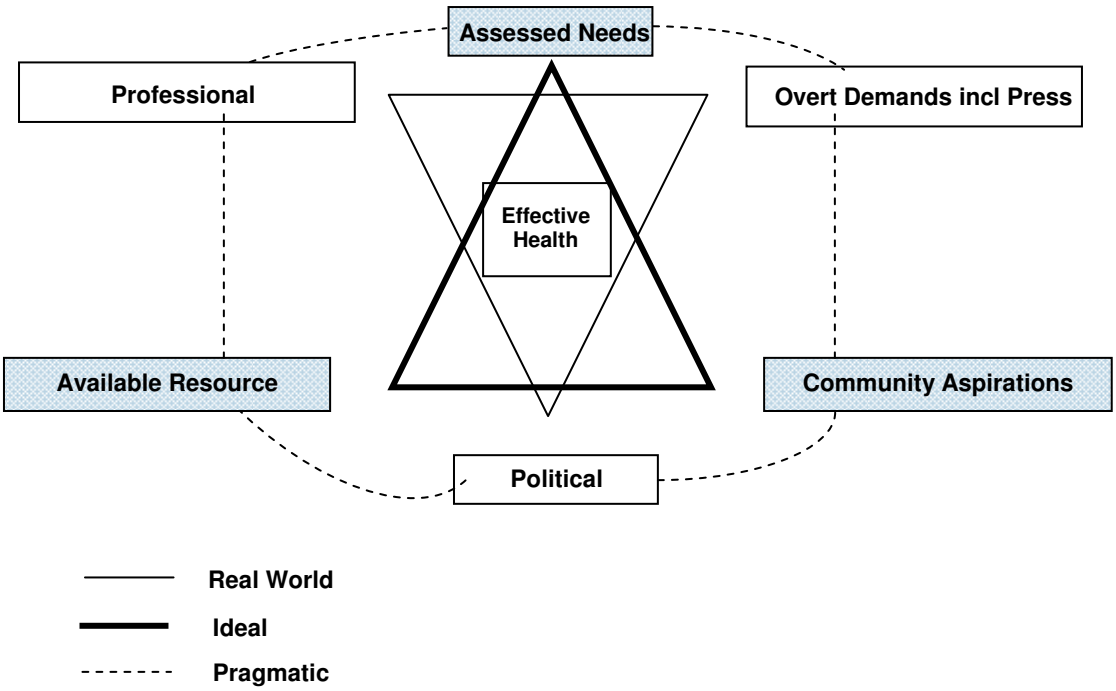
Rather than address these fundamental issues, the approach has been to find scapegoats and short term populist and diversionary (such as structural changes) solutions. I still believe that the NHS is a great system of delivering healthcare on a mass scale, but it does/can not provide best care to all- the individual vs population dilemma remains the weakest link. Let us stop claiming that NHS can provide world class services for everyone at all times – good enough is good enough.

PART TWO: SOME OBSERVATIONS ON LEADERSHIP AND MANAGEMENT

So, what have I observed and learnt over the 20 years since I left clinical practice and moved into management. Here are my main observations.

1. NHS is a complicated business – an understatement! When I started training in public health, we learnt about the 'ideal' approach whereby health needs, resources and communities aspirations should inform health policy and priorities. I then discovered the 'real world' approach whereby things in the NHS happened as a result of pressure from politicians, professionals or the pressure groups including the press. Most of my life I then spent trying to reconcile all these facets through a 'pragmatic' approach, with more or less success (Figure 1). Policy making is a messy business and reminds me of the cliché about not watching how either policy or sausages are made- one just needs to enjoy them! Most policy making starts with high ambitions and gets diluted down. Does it fit in with your experience of introducing a major policy initiative in your area of work?

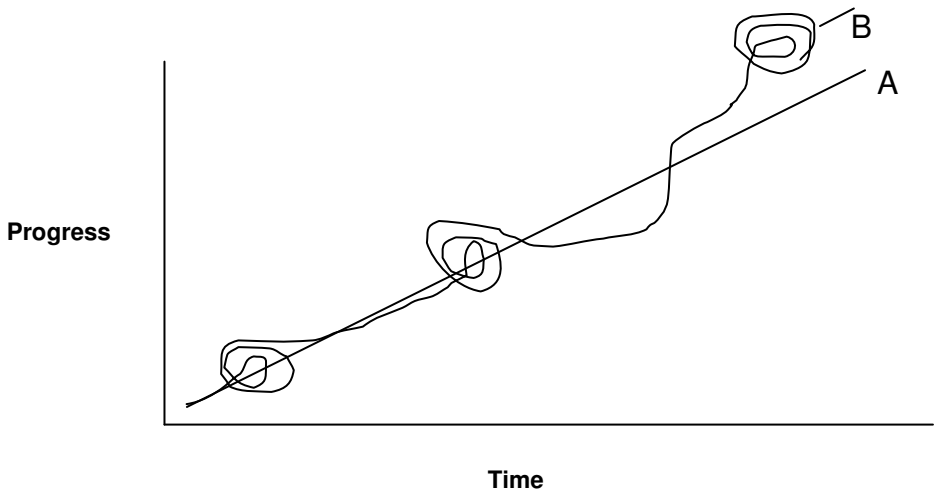
Figure 1: Making Policy: The Various Approaches



2. Change takes a long time. The way I have understood the change cycle is that things do go around in circles until a paradigm shift –either a technology or an idea - occurs and then you move to another level (Figure 2). However, one can spend a long time going around in circles and indeed it could be argued that we have been in the present cycle for 20 years with purchasing/commissioning as the organising principle of the NHS. One could go backwards in any cycle before coming out and moving forward. Infact, many times it has been a case of trying to slow down the rate of decline- just standing still, and not rolling back, can be a massive management and leadership challenge. As an

exercise, can you think of the paradigm shifting interventions? An example from the scientific world would be discovery of DNA and developments in genetics, and technologically IT has shifted the paradigm – just look at the radiology practice for example.

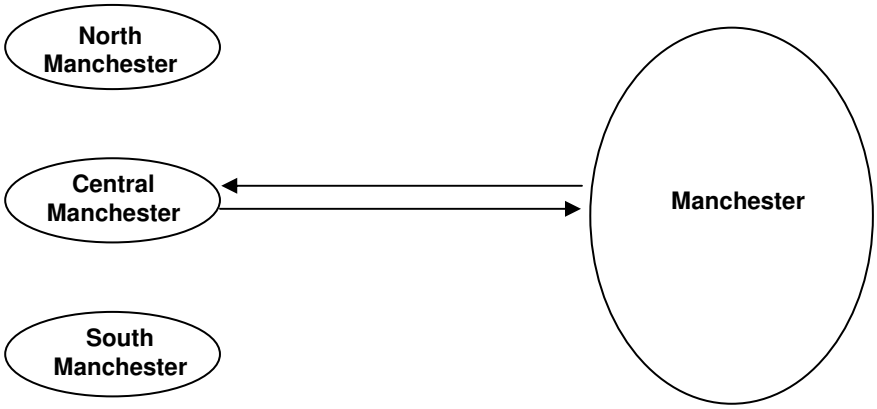
Figure 2: Trajectory Of Progress



A= Ideal
B= Reality

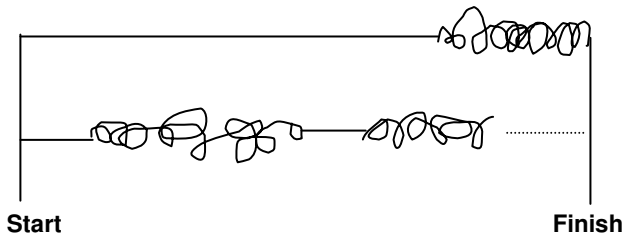
3. Structural solutions to change NHS. There remains a preoccupation with structural change as the solution to the problems besetting the NHS, and hence the constant reorganisations. In Manchester, where I have been working since 2005, we have gone from 3 to 1, to 3, to 1 health authority/PCG/PCTs over the last few decades and now are back to the Old Greater Manchester SHA footprint. Not only does this lead to loss of talent, it also causes loss of organisational memory, with the risk, nay certainty, of repeating the same mistakes. The human costs of the structural changes are enormous – although some people benefit by obtaining promotions, many others fall by the wayside. Also, during the expansion phase – as in going from 1 to 3 - many staff get promoted prematurely and end up failing (The Parkinson's Law of Promotion to their level of incompetence). Be very wary of structural approach to change management. Here is a test for you: Can you recall the 'proper' names of the commissioning organisations in your area over the last 10 years or in many cases that of the Provider. Almost everyone where I live talks of the Hope Hospital, which is actually Salford Royal Foundation Trust, and the local nursing home board still displays Salford Health Authority which has not existed for over a decade.

Figure 3: NHS Reorganisations In Manchester



4. Culture, culture, culture. Despite what others may say, it does take time to bring an idea to fruition; you have to basically work on organisational cultural issues, and that is not easy or quick. Indeed I would argue that things take a certain amount of time, unless there is a disruptive intervention that changes the paradigm. What however happens is that there are two types of people: one who starts running (doing) as soon as they hear the idea and others who think (plan) it through (Figure 4). The time spent on planning, and especially thinking through the cultural issues, can pay dividends (albeit it depends on the nature of the problem). First out of the box and first into the trap (and making mistakes) has to be balanced against being labelled as the luddite/ blocker. Creating the impression of doing something is quite rampant, especially given short attention spans. Can you identify the two types of people in your organisation and see their career trajectories and whether they have been successful? Have they managed to produce lasting changes?

Figure 4: Two Approaches To A Task

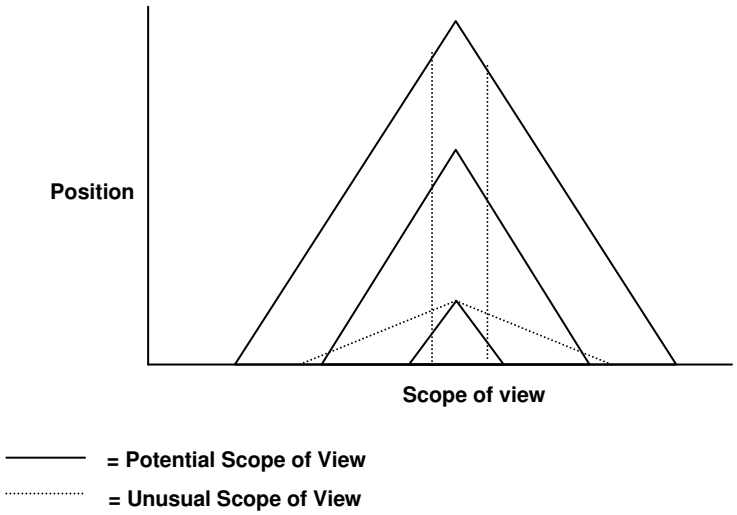


= Planning

= Doing

5. To be an effective leader, you need the position, the vision and the ability to take action (Figure 5). Basically, you need to be high enough to see the big picture, but just because one is high up one may not see the wider picture and remain tunnel visioned. The 'Helicopter' view does give you the height and the broader view but unless you can then use the information, by taking action, it remains just that – a view. So, one has to keep eyes/ears open, think creatively and be decisive. Also lookout for that person, who may not be high up but has that broad vision. Taking the broader view is not easy, however, since the emphasis increasingly has been on targets and delivery. None the less, you will find those people who can combine both: they can 'feed the beast' of bureaucracy and create enough space and time to be creative. Have you been fortunate enough to have worked with someone like that?

Figure 5: Position and scope of view



6. In making change happen, there is a balance between science and art. You need your facts – however they are a necessary but not sufficient condition to create change. You also need the art of persuasion and change management. Indeed, it is not a two steps process but takes several iterations between data and persuasion whereby you systematically address the concerns being raised through more study and more talking. The people who are being subjected to change will go through the stages of denying the problem exists at all, denying that the problem exists locally (even though it may exist elsewhere), criticising your data, and even if you come up with a solution arguing that it wont work here before acceptance. You have to address the What Is In It For Me (WIIIFM) Test, which is not always monetary benefit, and you need a clear negotiating strategy. Have you seen these stages? And more to the point do you see them in yourself (we all do it)?

7. Early wins – or low hanging fruits. To get support you have to demonstrate progress, nothing succeeds like success. However, it is getting more difficult to find the low hanging fruits. Just because there is a good idea or indeed something that does work very well in many places, may not work in yours. Why do not you make an inventory of best practice in various aspects of your speciality? I can bet two things. One, that you will find that almost every known best/innovative practice is working somewhere in the country and second, there will not be a single place where all of these will be working!

8. There are the 'Talkers' and there are the 'Doers'. The real leaders are people who set clear direction for a course of action and can see through the execution/implementation. Can you recall the spin masters, who identify a trend and jump on the bandwagon, make loud proclamations and fail to deliver? There is a syndrome : Mistaking Articulation for Action (MAFA) to describe this group of people. One of the biggest problems now a days is that everybody has read the same books (sic) and can pontificate- you need to get behind the words, and see whether they have any experience of making things happen. The Doers will be the ones walking the talk, networking, identifying the real change champions, removing barriers to change and slowly influencing the culture of the organisation.

I am sure that there are other fundamental management/leadership observations; the above is not an exhaustive list, and neither am I trying to be judgemental. Yes, I am a fan of 'Dilbert' and enjoy the conspiracy theory just like any other person in the NHS, but I do not make the above observations as criticisms. To me these things just are, they are a fundamental part of the NHS culture, and human nature, and in terms of making progress one has to acknowledge and learn to deal with these issues/behaviours. I have had the privilege of working with some of the best and not so good people, and both were equally useful experiences in terms of enriching me and making me more effective.

PART THREE: WHAT NEXT THEN, AND WHY DOCTORS SHOULD GET INVOLVED

The NHS is probably the most challenging management assignment in the public sector in England, and may be internationally. Not only does it raise eyebrows amongst clinicians when I tell them about some of the highly ambitious programmes like Connecting for Health, Agenda for Change or indeed clinical governance, even the most experienced management gurus from health and other sectors including academics find it a tough call. Indeed the scale of current reforms, with projected savings of 20% of the budget, has been unheard of anywhere- and the chief executive of the NHS, Sir David Nicholson, has described them as the biggest change programme in the world and one which can be seen from the satellites!

So, why bother to be a manager in the NHS? I think the answer goes beyond the usual one of 'it is there and because someone has to do it'. In my view, albeit some may say biased since I chose to work in the NHS (being from overseas), it is simply that when working well the NHS is the best health system. When you have seen the anxiety and helplessness of common people faced with ill health in some countries, you do start appreciating the security that the NHS provides. And, death, and illness, being the only certainty in life, sooner or later all of us will come in contact with the NHS, and so there is that selfish angle also.

In my case the transition to medical management was somewhat easier in one sense, given that public health training exposes you to quite a bit of management. None the less, moving from consultant in public health medicine to a director of public health post (in 1994, when these were the most senior medical posts in districts) was 'character building' (or scary). Three things made it easier.

First was the advice of a senior director of public health. During an informal conversation soon after taking up my post, he brought me down to earth by pointing out that the buck stopped with me. I could no longer talk about 'Them doing it to us" (the usual staff reaction whereby management gets the blame)! He reminded me that I was now them, and had to take responsibility. This was quite a powerful message and brought home the reality that people now looked to me for answers, and I had no one else to blame, and nowhere to hide.

Second was my first time-out with the new Board. At the end of the facilitated Board retreat (one of the things that boards do is to take time out from day to day work to reflect and think strategy), I was asked by a non-executive director about two take home messages. My answer was: a) Think health – not just illness and consider prevention and b) Think Purchaser – since this was at the start of purchaser provider separation, and I was keen that we did not get bogged down in operational management. My chief executive could not contain himself and offered his two take home messages: a) Think money- NHS was all about money (*sic*) and books must be balanced and b) Think Regional Office – you have to make sure that you do what you are told. This became my guiding principle from then on; I realised that unless I focussed, and delivered, on the stuff that mattered I would not be able to pursue my more lofty (I did want to change the

world!) ambitions. Although not quite what I wanted to hear, I realised how important his intervention was; this was a 'defining moment' for me, and the advice has stood me in good stead over the years.

Finally, I realised that I needed help, and between the above chief executive and some very knowledgeable and experienced colleagues and staff, I started learning. The most important thing I guess to impart here is that I had the insight (albeit partly drummed into me!), and humility (hard), and therefore asked for, and was given, help.

And frankly, it has been worth it. I would be untruthful if I said it has been 'fun' all the time; of course there have been frustrations. But as in medicine where after a while in your career most things become routine and one goes almost on autopilot with occasional moments of suspense and exhilaration, so in management there are boring or bad times and there are good times when you know you are really going to make that big difference. The thought of that major system change, with its potential to touch many lives, and not just one patient, is what kept me going. This is not the place to talk about whether I did, or did not, achieve such changes; in any case it will be for others to comment. However, in my attempts I did learn a few things about management and leadership in the NHS.

So, what are the lessons; what can I tell others that will make (or break) one a successful leader? Here is my list:

- Passion - be passionate about what you want to do. Unless one believes in what one is trying to do, there can not be progress.
- Perseverance – However, passion needs to be complemented by staying power. 'The harder I try, the luckier I get' phenomenon. Execution really sets apart dreamers from doers.
- Courage – Do not fall in the 'paying mortgage and school fees' trap; looking for security is tempting but also can shackle. Have the courage to challenge things. Although it is not easy in the NHS to question authority I found that actually you acquire more power if this is done well. So, the only thing to fear is fear itself.
- Act sooner – There is a 'right' time and although it is a judgement call and often one only sees it in hindsight, timing should be explicitly considered. Act when you think you are right.
- Do not seek permission – not necessarily 'act and then justify' all the time. Clearly there are times when that is essential, just as there are times for seeking permission. However, undue deference to authority can be damaging.
- Do not complain – work with the cards you have been dealt; and not keep thinking if only things were different. Anybody can lead when everything is in place! Leadership is about making things work despite problems.
- Respect – Do enjoy working with colleagues, most of them really want to do a good job, and need to be respected. Do empower others, and you will be surprised at how much you get back in return.
- Do not resist change, use it - I am struck by the fact that the Chinese word (in fact two words) for change is Wei-Chee which is danger and

opportunity. The leadership challenge is not to resist change (with some exceptions) but turn them into opportunity. Do not be afraid to compromise (up to a certain limit), and buy time.

- Work: life balance – do make time to smell the roses. Nobody ever said "I wish I had spent more time working" on their deathbed! Do not think that you can be good at work but ignore other aspects of life. Most really successful (at work) people enjoy life.
- Invest in yourself. The most important person is You! If you do not constantly improve yourself, you won't be effective. Over the years I have been through the Judge Institute's International Health Leadership Programme, the King's Fund led Realise Your Potential Programme and the Common Purpose Matrix Programme, alongside many psychometric assessments and other self-development courses.

Turning then to the issue of medical leadership, good managers do already, and want to, work with clinicians and especially doctors. But is it a case of leaving things as they are, or should there be a paradigm shift with doctors taking on a much more active role. In my view, we do need that shift and doctors should get involved.

Apart from the fact that most practising doctors, once trained and in substantive posts, tend to stay in the area and hence have a stake in the community, there are other reasons why doctors should get involved with policy making and management. Almost all health care expenditure is ultimately driven by the decisions made by doctors, and hence should we not be putting them in the positions to influence, and take responsibility for, these decisions? And they can be natural leaders. Good management and leadership require the same qualities as that needed to be a good doctor. Here are the ten qualities associated with a good doctor:

* Asking questions – to find out what is wrong with the patient
* Listening – and the patient will tell you the diagnosis
* Empathy – seeing it from the patient/carer's point of view
* Making a decision- despite uncertainty, making a diagnosis
* Commitment – to getting the best for the patient
* Ingenuity – finding workarounds for the patient, when hitting brick walls
* Value for money – only ordering tests when needed, and overall using resources well
* Team working – by being part of multi-disciplinary teams
* Curiosity – seeking to develop through life long learning and CPD
* Crisis management - taking charge in emergency

Now, guess what is needed to be a good leader? A good doctor is by extension a good leader. Doctors are taught and trained to do these things from the beginning- it starts in the medical school. Yes, there is some formal knowledge and techniques that help with management and leadership but much of that can be acquired or can be provided by other colleagues on your team. Just as people make positions – so eminent people get to eminent posts, positions – by giving responsibility – also make people (the colloquial 'makes a man of you') .

It has been said that when Griffiths introduced his idea of management in the NHS in the 1980s, he had hoped that doctors will take on the mantle, and was disappointed to see very little appetite amongst doctors for these roles. Few years ago I had a conversation with the CEO of the Mayo Clinic (USA) about clinical engagement. At the time (I have not been there for some time now), the tradition was that the Clinic tended to be clinically led, with a doctor as CEO, and with physicians being in the majority at the Board, and all committees were led by physicians. And they relied heavily on good administrators to execute plans, and ensure that clinicians added value by bringing in the clinical dimensions and by providing leadership and not get bogged down in administrative detail and bureaucracy.

I have often thought of that conversation over the years and more lately wondered whether we can ever get the true clinical engagement that we have been aspiring to, unless we revisit how we organise ourselves in the NHS. I note the comments made by some senior NHS policy experts about the undermanaged NHS, but do not agree that the answer is more managers. NHS has become dominated by professional managers, and whilst there are some good examples of successful CEOs in the NHS who have fully engaged their clinicians this is more by personality, rather than a system design. In reality the NHS works on hierarchy, and non-medical CEOs can, and do, dominate, and we end up with parallel universes in the NHS. The management universe driven by Top Down mandates, need to manage money and activity, and focussed on short term issues, versus the clinical universe of patients, services and seemingly increasing bureaucracy. I am not necessarily arguing that CEOs should be medics although that is the case in many successful healthcare organisations in the US (I googled the Top Ten US hospitals and 8-9/10 are led by doctors/one nurse) and in India now where I travel extensively (with Dr Prathap Reddy of the Apollo Group as the best known figure followed by Dr Devi Shetty made famous by the Cameron visit in 2010, for example). But we do need better dialogue between the two universes and we need to move to co-development and co-delivery through better clinical engagement, including by taking risks and putting some doctors in charge.

At this stage, I am conscious of provoking what I have called the ‘ego’ reaction; there is the more familiar ego issue whereby experts will put down what I have said because they know better, but the more worrying bit for me is the other EGO- Eyes Glaze Over- problem. Of course there are many reasons why we can not talk about medical leadership only and why what I have suggested above can not be done in the NHS. Why single out doctors, what about nurses and other clinical professionals who can be equally good (or bad)? They all can also claim that they have the above qualities. In any case doctors are not interested or not trained, or indeed that doctors have too much vested interests and can not be impartial? I do not wish to switch anyone off and certainly do not wish to upset managers and other clinical colleagues. I value the contributions of all parties, since all my successful projects relied on such joint working. What I am trying to provoke is a debate- I fundamentally do not believe that our current approach to leadership and management in the NHS is relevant or effective for the changes that are needed, and that strong medical engagement is essential. And that overall, less professional managers and more medical leaders within a well

designed, and hopefully stable, administrative system will deliver the necessary efficiencies and a more effective NHS. “The thinking that got you into this mess won’t get you out of it” – the famous saying by Einstein – is very apt for the current situation of the NHS.

I remember that Sir David Nicholson had expressed a desire to see at least one clinician on every CEO vacancy shortlist, but am not sure what has happened to this plan. In fact in this current reorganisation due process of appointments seems to have been completely forgotten. My assessment is that we have a vicious cycle whereby the doctors are reluctant to take charge (and I do not mean about their special projects but about the big picture stuff) anyway, and then the system shies away from giving them the responsibility, hence reinforcing the problem. The old clichés of ‘stuffing their mouths with gold’ or ‘reaching for their wallets’ have been overtaken by ‘doctors have no accountability/responsibility, and can always go back to their clinical work, and hence can not be trusted’; such expressions/views should have no place in modern discourse about how to ensure a sustainable NHS.

Finally, in the spirit of learning from case studies, I am also asked about my future plans. I am afraid that the current round of reorganisation is one too many for me- there is only so many times one can and should have to go through such changes. But that does not mean I am going (full time) fishing! I am afraid I am of the generation (predisposition) that do not stop work- God will retire me! I still have the passion and energy (and I hope time) to try and make a difference, and accordingly I am considering my third career after the clinical and public health/medical management phases. I am looking for a more diverse, portfolio, career whereby I can pursue my service/academic, philanthropic and international interests and yet make a difference- my motto is ‘Do good, have fun and make money’!

In closing, in the new NHS in the 21st century there is all to play for. Successful medical leadership will be crucial and doctors can and should rise to the challenge. Just practice what you do as a good doctor, surround yourself with good people, delegate properly and hold people accountable. And be surprised at what can/will be achieved.

ABOUT THE AUTHOR

Rajan Madhok is notionally the Medical Director (he is actually on sabbatical and will be taking redundancy next year) at NHS Manchester. A medical graduate from Delhi, India, he has been in the west since 1980. He initially trained as an orthopaedic surgeon in the NHS and then switched to public health. Over the years he has held increasingly senior leadership positions in the NHS including being the medical director/director of public health at a strategic health authority, and also worked in the IT sector.

He is currently the Joint Coordinating Editor of the Cochrane Bone, Joint and Muscle Trauma Group; Chair of the Open Access Education Initiative Charity (peoples-uni); Overseas Advisor to Indian Confederation for Health Care Accreditation; Chair of the Greater Manchester Comprehensive Local Research Network and Health Innovation and Education Cluster; Chair of the Salford Combined Hospitals CAB; Chair of the British Association of Physicians of Indian Origin; Chair of the Clinical Leaders Network Race Equality Leadership Action (CLN-REAL) Initiative; Council Member of the General Medical Council; and a Founding Member of the Global Association of Physicians of Indian Origin. He was a Visiting Scientist at the Mayo Clinic, USA in early 1990s; Milroy Lecturer at the Royal College of Physicians in 2003; acted as the India Envoy of National Patient Safety Agency during 2008-9; and was a finalist in the TSB Asian Jewel Health Category in the northwest in 2009.

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I had been thinking of writing this piece after discussions with many colleagues and friends for some time but kept procrastinating. The impetus came when Dr Hemadri asked me to speak at his leadership development course in Scunthorpe in early 2011, and I am afraid I used his group of participants to review and refine my thinking. That experience further encouraged me to share my reflections more widely. The time for writing, always the problem, became available thanks to yet another NHS reorganisation with system paralysis, and the opportunity to take part-sabbatical from the full time role as the medical director.

'Standing on the shoulders of giants' has certainly been true in my case. I have had the privilege of working with great colleagues: clinical and managerial, over the years, and at various levels. I am grateful to them all, they are too numerous to name here and there is a danger that I may miss some so I have decided not to mention any. But they know who they are (and will hear from me at Xmas) and they have my gratitude. In my case the customary acknowledgement of the long suffering wife and kids is certainly needed – so thank you Lisa, Tara, Aaron and Ryan.

Parts of section three were published in the BMJ Careers rapid responses recently.

My views on the recent changes in the NHS can be viewed on the following:

http://www.bmj.com/content/342/bmj.d2219/reply#bmj_el_256587?sid=5b719fb3-b962-4c14-9611-e9e527886eb4

http://www.bmj.com/content/342/bmj.d4050/reply#bmj_el_263296?sid=5b719fb3-b962-4c14-9611-e9e527886eb4

http://www.bmj.com/content/342/bmj.d905/reply#bmj_el_255718?sid=5b719fb3-b962-4c14-9611-e9e527886eb4

and

Madhok R. Clinically integrated care: The new single organising principle?
BMJ 2011;342:doi:10.1136/bmj.d2405 (Published 18 April 2011)"