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EDITORIAL

The leadership gap: is there a crisis of leadership in anaesthesiology?

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Good leaders have vision and inspire others to help them turn vision into reality. Great leaders create more leaders, not followers. Great leaders have vision, share vision, and inspire others to create their own. (Roy T Bennett)

Medical educators and specialist colleges have always had concerns about the effectiveness of training programmes to produce specialists with appropriate skills at the fore. Typically these concerns have centred on the ability to perform tasks, unerstand key concepts and having exposure to a sufficient number of cases to produce expertise by deliberate, repeated practice.[1] However, other competencies of specialists are less well defined. How do we ensure that those who complete specialist training programmes are ready to support others, to communicate, advocate and lead the speciality? These skills have often been referred to as the 'hidden curriculum' – the skills, knowledge and attitudes expected of clinicians in a sociocultural sense, both by society and their own profession.[2]

Kalafatis et al.[3] undertook a survey among South African specialists at the completion of their training and again one year after graduation. They found a perceived deficit in leadership and health advocacy skills which improved during the first year of practice. These leadership 'meta-competences' included skills such as quality improvement, management of scarce resources, leadership in professionalism, and career planning in addition to advocacy at both an individual and a community level.

These perceived deficiencies should perhaps not be surprising. Similar studies in the UK and Europe have discovered much the same.[4,5] The transition from trainee to specialist comes with a number of other changes that clinicians may be unprepared for. They become a teacher rather than learner, a leader rather than follower, and they shoulder responsibility beyond what they have shouldered before. In anaesthesiology, that additional responsibility often means responsibility for more than one patient at a time as well as other clinicians' actions in a clinical setting. More broadly, there may be additional financial and staff management aspects that they may be unprepared for. In essence, this transition of roles is a 'liminal' stage, a stage between roles akin to a rite of passage.[6] There are common patterns and emotions associated with passing through a liminal phase in any field. It can cause great anxiety, burn out, and even feelings of worthlessness and depression.[7] Preparation in terms of what to expect and how to behave are therefore a moral imperative to support the wellbeing of clinicians through this phase.[8]

Traditionally, comparatively few resources have been produced to prepare trainees for the transition to specialist practice. In Australia, the Australian Society of Anaesthetists organise a one-day seminar titled the 'part three course' – a wordplay on the fact that training programmes have only two formative assessments. This course prepares the attendees for the financial, legal and administrative challenges of becoming a specialist in both public and private practice. The less concrete aspects of this transition, such as leadership, have been addressed by a three-day 'Emerging Leaders Conference' run for a select group of up to 30 specialists within five years of their graduation.[9] While welcomed, clearly such a niche event cannot address the general leadership deficits in the population of over 200 anaesthetists graduating across Australia and New Zealand annually.

In the USA, the American Society of Anesthesiologists sees the development of these skills as a vertically integrated curriculum.[10] Their programme consists of four modules to be undertaken at each of the steps from resident to 'physician executives'. Similarly, in the UK, leadership programmes are available for trainees and consultants to undertake if they have an interest in the topic.[11] Again, it is unclear how widespread the uptake of these programmes is. Certainly, these skills are neither formally part of the prescribed training programmes nor indeed ever assessed and, therefore, are unlikely to be seen as a priority in a system where service provision overrides personal development. Where leadership skills are taught, the focus tends to be on managerial skills at a departmental level rather than the broader suite of skills including vision and inspiration.[12]

Leaders in anaesthesiology are commonly seen as those who have exceptional clinical skills, have succeeded in research or education, or have occupied a clinical role for a prolonged period of time. Commonly, the mantle of 'leader' is only bestowed upon people with two or more of these attributes. The most prized of these appears to be longevity paired with an affable nature. Rarely are leaders in anaesthesiology judged by their qualities as a leader. Qualities that should include the ability to inspire others, develop a vision, and give constructive and effective feedback for improvement. In some fields, such as the military, leadership training is both an expected and a core part of the education programme for all.[13] Leadership is a key attribute that is taught

from the moment of induction until and arguably even after a senior position is reached. Furthermore, because everyone has leadership training, it is feasible to rotate the leadership role to ensure a diversity and freshness of approach – something that has been identified as a key attribute of corporate boards.[14]

The lack of general leadership training in anaesthesiology is problematic as much more careful succession planning of leadership roles is required. All too commonly, individuals are handed a position of leadership because of their availability and willingness to take on the role, rather than their skills. Often this is done without training, a clear understanding or a period of handover of the role.

Perhaps the argument shouldn't just be how we train our leaders in anaesthesiology, but how the medical profession develops leaders from the very moment they start medical training. Such preparation for leadership must include the new view of leadership as a collaborative, rather than hierarchical, venture. In general, followers like their leaders to be accessible, to listen to them and to 'lead by example' by seeking to understand their stresses and frustrations.[15] As Kalafatis et al.[3] noted, these skills are 'non-technical' skills involving emotional intelligence, communication, cooperation and negotiation. Crucially, leaders must not only know their colleagues and charges but also know themselves and their own likely biases.

Apart from leadership, health advocacy was perceived as a deficiency in Kalafatis et al.'s[3] study. Advocating for communities, particularly poor and disadvantaged communities, should be a core topic of study for all health professionals. Again it makes sense that this sense of responsibility and purpose starts before specialist training. Arguably, one could say that these skills are similar to or even merely an extension of leadership roles. Rather than providing leadership, mentorship and advocacy for a group of colleagues in a similar situation, health advocacy is the leadership of the community or an individual to achieve more than they might have thought possible. The skills are broadly the same, along with a generous helping of social responsibility.

Kalafatis et al.[3] show us that we have a long way to go in developing leadership and advocacy training for all graduates of specialist programmes. We must follow Bennett's advice given at the beginning of this article and develop systems that create the leaders of tomorrow, for us to truly be great leaders ourselves.

References

1. Ericsson KA, Krampe RT, Tesch-Römer C. The role of deliberate practice in the acquisition of expert performance. Psychol Rev. 1993;100(3):363-406. https://doi.org/10.1037/0033-295X.100.3.363.
2. Mulder H, Ter Braak E, Chen HC, Ten Cate O. Addressing the hidden curriculum in the clinical workplace: a practical tool for trainees and faculty. Med Teach. 2019;41(1):36-43. https://doi.org/10.1080/0142159x.2018.1436760.
3. Kalaftis N, Sommerville TE, Gopalan PD. Do South African anaesthesiology graduates consider themselves fit for purpose? A longitudinal study. South Afr J Anaesth Analg. 2021;27(3):125-132. https://doi.org/10.36303/SAJAA.2021.27.3.2479.
4. Morrow G, Burford B, Redfern N, Briel R, Illing J. Does specialty training prepare doctors for senior roles? A questionnaire study of new UK consultants. Postgrad Med J. 2012;88:558-65. https://doi.org/10.1136/postgradmedj-2011-130460.
5. Dijkstra IS, Pols J, Remmelts P, Brand PL. Preparedness for practice: a systematic cross-specialty evaluation of the alignment between postgraduate medical education and independent practice. Med Teach. 2015;37:153-61. https://doi.org/10.3109/0142159x.2014.929646.
6. Land R, Rattray J, Vivian P. Learning in the liminal space: a semiotic approach to threshold concepts. High Educ. 2014;67(2):199-217. https://doi.org/10.1007/s10734-013-9705-x.
7. Westerman M, Teunissen PW, Jørgensen RL, et al. The transition to hospital consultant: Denmark and the Netherlands compared on preparedness for practice, perceived intensity and contextual factors. Med Teach. 2013;35:481-90. https://doi.org/10.3109/0142159x.2013.774332.
8. Westerman M, Teunissen PW, Fokkema JP, et al. The transition to hospital consultant and the influence of preparedness, social support, and perception: a structural equation modelling approach. Med Teach. 2013;35:320-7. https://doi.org/10.3109/0142159x.2012.735381.
9. ANZCA. Emerging Leaders' Conference [Internet]. 2021. Available from: https://www.anzca.edu.au/fellowship/information-and-opportunities-for-new-fellows/emerging-leaders-conference. Accessed 17 May 2021.
10. ASA. Lead the Leader: Leadership Development Suite [Internet]. 2021. Available from: https://www.asahq.org/education-and-career/leadership-development. Accessed 17 May 2021.
11. Johnston C, Turpin N, Wynn-Jones W. Medical leadership in perioperative practice: I. BJA Education. 2016;16(6):203-8. https://doi.org/10.1093/bjaed/mkv041.
12. Souba WW. The leadership dilemma. J Surg Res. 2007;138:1-9. https://doi.org/10.1016/j.jss.2007.01.003.
13. Kolditz T. Why the military produces great leaders [Internet]. Harvard Business Review; 2009. Available from: https://hbr.org/2009/02/why-the-military-produces-grea. Accessed 17 May 2021.
14. AICD. Principle 3 board composition. Not-for-profit governance principles. 2nd ed. Sydney, Australia: Australian Institute of Company Directors; 2019.
15. Scemama PH, Hull JW, Riou B. Developing leaders in anesthesiology: a practical framework. Anesthesiology. 2012;117(3):651-6. https://doi.org/10.1097/ALN.0b013e3182632358.