Faculty of
Medical Leadership
and Management

The assessment of leadership development in the medical undergraduate curriculum: a consensus statement

Dr Tim Swanwick and Professor Judy McKimm

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This consensus statement derives from a workshop convened by the Faculty of Medical Leadership and Management in October 2019. The event brought together representatives from universities from across the UK together with practice educators, leadership developers, and representatives from the General Medical Council, business schools, other healthcare professions and the wider public sector; we acknowledge their significant input to this statement.

Introduction

In medical schools throughout the UK there is now a sustained effort to embed leadership and management in undergraduate programmes. But this is not straightforward. Concerns remain about the place of leadership in a 'crowded curriculum'; surfacing leadership learning from the often muddy waters of professionalism can prove difficult (Hardy and Neve 2019); and the ability of faculty, both in university and practice settings, to meaningfully address the subject matter of 'leadership' may be limited. Above all, universities 'require the flexibility to tailor their leadership development offer in line with the philosophy and structure of their undergraduate medical programmes' (Till et al 2017).

Progress is, however, being made. In 2018 the Faculty of Medical Leadership and Management (FMLM) published an indicative undergraduate curriculum (Peake *et al* 2018) based on a 'Medical Leadership Competency Framework' (NHSIII and AoMRC 2010) drawn up almost 10 years previously. The curriculum is part of a wider programme of work being led in partnership with the UK Medical Schools Council and the NHS Leadership Academy. Subsequent publications have provided further guidance and showcased best practice in student selected components, electives and intercalated degrees, and a national programme of faculty development including newsletters, webinars and workshops has addressed issues such as personality profiling, online learning and clinical placements. To support implementation of the curriculum, FMLM has also established a kite-marking scheme through which medical schools can be accredited against their ability to deliver the indicative leadership curriculum. (FMLM 2019)

Why assess leadership?

Fundamental to the social accountability of medical schools is an undertaking to produce a 'fit for purpose' product. All doctors will assume a leadership role of some sort during their career, so making leadership learning and assessment explicit in the curriculum, with clear statements of intent, and weaving leadership development throughout the undergraduate programme, normalises leadership as a core clinical activity and helps prepares students for their future working lives.

A key curriculum driver for medical schools is to meet the outcomes and standards set out by the General Medical Council (GMC). 'Leadership and team working' is now a key domain within Outcomes for Graduates (GMC 2018) thus providing leverage for champions of leadership learning to press for its inclusion in the curriculum on regulatory grounds. But while the teaching of leadership may be relatively uncontentious, assessment remains challenging, reflecting the generic challenge of assessment within all the domains of professionalism (including leadership) as well as how best to assess this particular domain at undergraduate level.

However, because assessment drives learning, if we *don't* assess, then we run the risk of leadership being crowded out within the curriculum by other more established disciplines and clinical specialties.

A number of other reasons for assessing leadership have also been identified. From an individual student perspective, inclusion of leadership (management and followership) helps to provide a more holistic (and realistic) preparation for professional practice and development. Because leadership development is very much about personal growth, longitudinal assessments can help unlock and activate student awareness; solidify learning; drive student learning and engagement; build a sense of achievement/development; grow self-awareness and self-insight, and develop a student's personal leadership approach, skills and style. The skills and insights gained through leadership assessment can thus enable students to take better control of their learning, and life, and for faculty, may help in identifying students who may need help and support, both now and in the future.

What should we assess?

If leadership is a process of social influence, occurring in a group context towards the achievement of a common goal (Northouse 2004) how should we approach this in the undergraduate context where students carry little, if any, managerial accountability?

As an underpinning body of knowledge, and to help students see the relevance of leadership to their practice, it is helpful to apply some theory and evidence to practice in ways that are meaningful at this stage of professional development. Assessment should then follow at a standard that is appropriate to level, in line with GMC requirements, and matched with later postgraduate expectations.

Another major consideration is how to assess leadership within the more general domain of professionalism, ensuring that the distinct features of 'leadership' are included, whilst acknowledging that many aspects of leadership such as teamworking, reflective practice, organisational and system awareness and quality improvement are part of 'being and becoming' a professional. It is important therefore that leadership 'champions' work closely with professionalism leads to embed leadership within written and practical assessments of professionalism.

The FMLM 'indicative curriculum' provides a blueprint of key leadership topics and how they might be assessed throughout the curriculum. In structuring assessment, these topics need to be delineated into knowledge (e.g. the structure of the healthcare system), skills (e.g. project management, influencing skills), professional behaviours (e.g. teamworking) and personal development (e.g. self-awareness, resilience and emotional intelligence). The latter aspect is most challenging. Personal and professional values and attitudes (e.g. honesty, integrity) can manifest as leadership behaviours, including compassion and inclusion (two fundamental requirements) and assessments need to be developed to measure students' ability to recognise these behaviours in others and themselves.

When should we assess leadership?

Assessment of leadership capabilities should start early and be underpinned by relevant conceptual frameworks.

Assessment should also be continuous, longitudinal and integrated - every learning event has leadership development potential - and take a spiral approach to reflect the ongoing acquisition of complex skills, application of knowledge and personal development.

A combination of both formative and summative assessment should be used, and schools will need to determine the balance between them. We suggest that formative assessment should run throughout the programme, whereas summative assessment in leadership specifically (as opposed to 'professionalism' assessments) would seem to be particularly relevant for assessing knowledge in the early stages of the programme, and skills and behaviours towards the end as students prepare for the next stage of their education and training.

On entry into postgraduate training, assessments such as situational judgement tests, where there are no absolute right and wrong answers, provide an ideal opportunity to further embed targeted questions on leadership, itself a practice rich with nuanced decision-making.

How should we assess?

Factual knowledge can be summatively assessed through applied written knowledge tests (e.g. extended matching or single best answer) and application of knowledge through project reports, case studies, essays, significant event analyses, reflections on workplace observations and/or their own practice, or application of leadership models or frameworks to practice. Training will be required to prepare students for assessment using these different modalities. Portfolio assessments can provide the basis for more longitudinal developmental assessment, and assessors should consider the absence of negative indicators as well as positive evidence of effective leadership, management or followership. Leadership leads need to work with various leads of other curriculum areas to review assessments and identify area where specific aspects of leadership knowledge can be included.

Leadership skills can be assessed in practical assessments such as the OSCE (summative) or simulations (formative or summative); both particularly helpful vehicles when it comes to capabilities such as team working. Again, working with 'professionalism' colleagues on the domain will help identify how leadership can be woven into such assessments, considering aspects such as management of specific clinical situations (e.g. knowing when to lead, when to follow) and communication skills. Here, leadership leads may need to work with clinical skills leads and other staff involved in running OSCEs or simulations to advise on aspects specifically concerned with leadership. Assessment of leadership in relevant situations can be carried out by academic and clinical faculty (including doctors and other health professionals), peers, near-peers and patients, trained in assessment and feedback.

Work-based observations (e.g. direct observations of skills) using fragments of work (e.g. leading part of a ward round) as the substrate to test leadership behaviours and multi-source, or 360, feedback are probably the most authentic ways to assess leadership in practice. As mentioned above, formative assessments and feedback on leadership development and skills in practice should be punctuated by summative assessments. In a similar way to assessment of practical skills, workplace assessment can be carried out routinely and formatively by a wide range of faculty, peers and patients. Peer-assessment by other students and/or Foundation doctors is probably most appropriate in team-based or group work settings, through multisource feedback. Multisource feedback is also very helpful from other members of the healthcare team. Higher stakes summative assessment of leadership, management and followership (in relation to teamworking, self-management and prioritisation for example) should be carried out by workplace assessors who are appropriately trained and aligned in approach.

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Because feedback on leadership performance (because of its intensely personal nature) is exposing and potentially confronting, it should be discussed with someone expert in feedback and pastorally aware. If a portfolio is used which gathers multiple perspectives from assessors, then (particularly if the feedback is less than positive) a person with whom the student has an ongoing relationship e.g. a mentor, might be more appropriate. Multiple perspectives can helpfully contribute to a portfolio of evidence collected across the continuum of basic medical education but, to be useful for the student's own leadership development, should be approached in a similar longitudinal way to how the educational supervisor role is conceptualised in postgraduate medical education.

Additional considerations

A number of areas for further debate remain in this contested, and for undergraduate medical education, relatively new area. The first, highlighted above, is the relationship between 'professionalism' and 'leadership' teaching, learning and assessment. This will largely be resolved at local level, being dependant on the structure, ethos and delivery of the curriculum, the influence and expertise of the various leads and the way in which professionalism is currently learned, taught and assessed.

Secondly, as with professionalism (Hodges et al 2010), we are addressing three discourses in defining 'leadership', as:

- an individual characteristic, trait, behaviour or cognitive process
- an interpersonal process or effect
- a socially constructed way of acting or being

We would add that medical students are in the process of developing their medical professional identities, which may or may not include seeing themselves as leaders. These factors and discourses pose a fundamental challenge with an inherent tension. Assessments (particularly if summative) need to be able to specify 'acceptable' and 'unacceptable' leadership behaviours, so that these can be measured. However, such behaviours are socially constructed, vary across cultures and times, and therefore assessments tend to be subjective. We can only assume cognitive processes, values or personality traits and identity formation from behaviours and observation of the impact of one individual 'leader' on others often struggles to take account of underpinning factors of influence.

Thirdly, whilst it is helpful that the in the UK, the GMC (in *Outcomes for Graduates*) has recognised that leadership development has a theoretical base, this raises a host of issues for further exploration. For example, which of the myriad of leadership theories, concepts and models would we deem appropriate for students to learn about to the extent that they could be summatively assessed upon? Because the curriculum is so crowded, there is also a real risk of reductionism e.g. a foregrounding of one or two models. In a rapidly evolving, socially constructed area such as leadership, summative assessment on theories and concepts may feel inappropriate.

This also relates to the stages of training in that there might be identifiable 'stages' of leadership learning that might be more appropriate (say) to Year 5 than Year 1. This needs further discussion.

The fourth consideration involves achieving an appropriate balance between summative and formative assessment. This is particularly pertinent in the context of high-stakes assessments such as standardised licensing assessments and it is important therefore that the leadership 'voice' is involved in the development and implementation of assessment items that involve leadership. Care must be taken to ensure that aspects of leadership, management and followership are measurable and relevant to the stage of training/education. And if reflection is to form a major element of assessment, then students will require support in relation to frameworks to help them reflect and what constitutes 'good' reflective' writing. For leadership aspects that relate more to personal development, much of the assessment will need to be formative. And, as with all assessment, but particularly important for those subjects that lie in the professionalism domain, where students are underperforming there should be clear processes for remediation.

Finally, the costs and benefits of training and maintaining an informed and skilled faculty need to be identified, alongside the kind of training that faculty need to help them deliver and assess this vitally important area of the undergraduate medical curriculum.

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