What is clinical leadership…and why is it important?

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Leadership development, assessment and feedback must be provided throughout the education and training of health professionals

SUMMARY

Background: The 'invitation' for clinicians to participate in leadership practices, previously considered the province of the professional health service manager, is driven by a number of international policy and professional agendas. This article, the first in a short series, considers definitions and theories of clinical leadership and management, and explores leadership roles and responsibilities of the clinician in terms of levels of engagement. Recent developments in the UK's National Health Service (NHS), the largest health care organisation in the world, are used as illustrations of how theory has informed clinical leadership development.

Methods: Narrative review and discussion.

Results: The tensions arising from the situation of health care professionals within managed health care are described. Leadership is defined alongside its relationship to management. Key theories of leadership are considered and applications of theory to practice explored. The role and usefulness of the 'competency framework' in leadership development is debated.

Discussion: Health care is delivered by complex systems often involving large numbers of individuals and organisations. The effective clinician needs to understand these pathways and systems of care if they are to be able to function effectively, and must be comfortable working both *within*, and *with*, these systems for the benefit of their patients. Engaging in leading and managing systems of health care, on whatever scale – team, department, unit, hospital or health authority – is therefore a professional obligation of all clinicians. Just as leadership is argued to be necessary 'at all levels', so 'leadership development', assessment and feedback must be provided throughout the education and training of health professionals.

INTRODUCTION

Across the globe, the role of clinicians as leaders and managers of health care is viewed as increasingly important. This has given rise to a focus on how clinical leaders can best be developed and supported to address policy agendas such as patient safety, and quality improvement. Clinical teachers working both in higher education and in practice have a key role to play in leadership development.

This article is the first in a short series about clinical leadership, and serves as an introduction for clinical teachers. It considers the policy background, and definitions and theories of clinical leadership and management, and explores leadership roles and responsibilities of the clinician in terms of levels of engagement. We have focused on medical leadership using recent developments in the UK's National Health Service (NHS), the largest health care organisation in the world, as illustrations of how theory has informed leadership development.

MEDICAL ENGAGEMENT

Over the last few decades, health systems worldwide have been subject to increased regulation and accountability, with centrally defined targets used to drive change and control clinical activities. Despite this, the implicit balance between financial power (held by government) and clinical power (concentrated at the periphery), has persisted.[1] Scratch the bureaucratic surface, and health care organisations can be described as consisting of little more than 'loose coalitions of clinicians engaged in incremental development of their own service largely on their own terms'.[2]

Such clinical autonomy is a characteristic feature of the 'professional bureaucracy',[3] in which the standards and values of professionals are set and influenced from outside the line management structures of the organisation in which they work. Doctors in particular, because of their special position in relation to patients and the public, are frequently able to confound the efforts of managers or politicians to implement system-wide change or reform through top-down processes. Medical engagement then is seen as vital to organisational performance and the implementation of change. Without it, care continues to be delivered in disconnected clinical pockets, and coordinated action to produce system-wide improvement is prevented.[4]

Engaging clinicians in the leadership and management of service becomes even more pressing in the face of a global economic downturn. Health care is expensive, and the need for improving quality of care within a shrinking resource base is a major challenge. Again, doctors hold considerable power over these scant resources, and are able to argue from an authoritative and (sometimes) evidence-based position. They occupy the moral high ground of patient advocacy, and patients want their clinicians to be involved in rationing and allocation decisions.

The 'invitation' for clinicians to participate in practices previously considered the province of the professional manager is further driven by a number of key policy and professional agendas. Box 1 summarises some of these in relation to medical leadership in England.

What is leadership?

'Leadership is like the abominable snowman whose footprints are everywhere but who is nowhere to be seen'.[8] This quote neatly encapsulates one of the problems about leadership. The literature on leadership is vast, and leadership itself is a contested concept that means different things to different people. This makes it difficult to summarise a global understanding,

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as leadership is often described within the contexts in which it is exercised. However, there are some key themes that emerge from the literature that we will describe briefly before considering models appropriate for the clinical context. References and suggestions for further reading are given for those who wish to explore these ideas in more depth.

A common starting point is to compare and contrast the practices of *management* and *leadership*. This helps to clarify some unique features of both activities, namely leadership as being about setting direction, influencing others and managing change: with management concerned with the marshalling and organisation of resources and maintaining stability. This approach tends to denigrate management as boring and unsatisfying: who would want to 'manage' when they can 'lead'? In reality, most clinical leaders are appointed to management positions from which they are expected to lead, such as a hospital medical director. Current theorists see leading and managing as distinct but complementary activities. Both are important for success, and the separation of the two functions – management without leadership and leadership without management – is seen as harmful.[9]

Leadership is conceptualised differently according to the pre-

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Box 1. Case study: medical leadership in the NHS

After three decades of increasing managerialism in the UK's National Health Service, the focus of government attention has recently shifted to 'engaging' clinicians. In 2007, a talented London surgeon, (now Lord) Ara Darzi, was appointed as health minister, and under his leadership the English Department of Health launched a wave of policies encapsulated in their policy document *A High Quality Workforce: NHS Next Stage Review*.[5] Darzi's vision was to put quality at the heart of health service provision, and for clinicians to accept three key roles: practitioner, partner and leader. This new emphasis on clinical leadership, which other successful health providers (such as Kaiser Permanente in the USA) have adopted, has since captured the national imagination. The subsequent publication of a UK-wide *Medical Leadership Competency Framework* by The Academy of Medical Royal Colleges with the NHS Institute for Innovation and Improvement,[6] and the creation of a National Leadership Council, have further embedded clinical leadership as central to the onwards development of the NHS. Following a change of government in May 2010, there has been no lessening of this emphasis on a professionally led health service,[7] with the dissolution of central health care management structures and the introduction, in England at least, of general practitioner (GP)-led commissioning.

occupations of the time, the socio-political system in which leadership is exercised and differences in cultural norms and values. In the first half of the twentieth century, leadership theory revolved around personal qualities that you either had – usually in conjunction with a Y chromosome – or had not. These 'Great Man' theories emphasised characteristics such as charisma, intelligence, energy and dominance. Several major literature reviews in the 1970s failed to consistently identify personality traits that differentiated leaders from non-leaders. More recently there have been shown to be weak positive correlations between successful leaders and three of the 'big five' personality factors – extraversion, conscientiousness and openness to experience – a weak negative correlation with neuroticism, and no relationship with the degree to which the leader is 'agreeable'.[10] Psychometric tests reflecting such research are often used in the selection of senior health care leaders. Trait theory has also made a comeback in recent years with the emotional intelligence-based theories of Daniel Goleman and others.[11]

From the 1950s onwards, attention shifted from the personal characteristics of leaders to their behaviours or styles. These tended to consider two aspects, relating to how leaders made decisions, and their primary focus of concern. Decision-making style models include Tannenbaum and Schmidt's,[12] in which styles range from autocratic to abdicatory. Blake and Mouton plotted concern for task and concern for people along the *x*- and *y*-axes of a 'managerial grid'.[13] These models introduced the idea that leadership behaviours could be consciously chosen and modified, but little indication was given as to what sort of behaviours worked best in which circumstances. This was addressed through the rise of contingency theories, including Hersey and Blanchard's situational leadership model,[14] which asserted that leaders needed to adapt their style to variations in the competence and commitment of their followers. John Adair's popular 'three circles model' extemporised on this theme,[15] suggesting that depending on the circumstances the focus of a leader's attention should be distributed flexibly between the task, the team and the individual. These models can be very helpful for clinical leaders, who need to balance the needs of patients and team members within resource constraints and management targets.

A synthesis of personality traits and behaviours can also be seen in leadership models that emphasise values, ethics and morals. Greenleaf's servant leadership model has been highly influential throughout public services, stressing the 'human' face of leadership and 'people work'.[16] In the 1980s, the focus shifted to a consideration of how to cope in environments of continuous change, which is highly relevant to the health sector. Various authors highlighted that the existing models were managerial or transactional, useful to plan, order and organise at times of stability, but inadequate at describing how to lead people or organisations through periods of significant change. A new paradigm emerged, that of transformational leadership.[17] Here, leaders release human potential through the empowerment and development of followers. Vision and values are clearly stated and the organisation and the work of individuals within it are aligned to the achievement of longer-term goals. Transformational leadership has proved an enduring model, incorporated into many public sector frameworks such as the UK's NHS Leadership Qualities Framework.[18]

The informal, dispersed or distributed leadership approach argues that no one individual is the ideal leader in all circumstances. The locus of leadership is dissociated from the organisational hierarchy, and all members, not just those with an overt management function, can take a leadership role, such as leading a clinical team, chairing a multidisciplinary case conference or leading an emergency clinical situation. Leaders are emergent rather than pre-defined, and their role is contingent on relationships rather than individual characteristics. The model makes a key distinction between leaders and leadership in which organisations may be 'leaderless' but 'leaderful', or indeed vice versa.[19]

The most current leadership theories are those derived from systems and complexity theory, which occupy positions on a spectrum from instrumentalism – through the manipulation of systems through simple rules and interventions, e.g. 'give patient's their own budgets and see what happens', or waiting targets for emergency medicine departments – to more nihilistic models that consider leadership as a purely descriptive process of pointing out 'what is going on out there'. The other current dominant models in the public sector are those of collaborative, shared and engaging leadership, which emphasise working across boundaries and the short-range relationships between leaders and followers,[20,21] highly relevant to integrated health services, which may be led by different health professionals.

FROM THEORY TO PRACTICE

So how can clinical teachers use leadership theory to inform their practice in clinical education and training? Some teachers may be involved in running formal leadership development programmes for specific groups of learners; however, all teachers need to be aware of the broad base of leadership attributes, knowledge and skills that learners require. Just as leadership itself operates 'at all levels', so 'leadership development', assessment and feedback must be provided throughout the education and training of health professionals. This poses a major challenge, which we shall examine in future articles in this series.

The attention being given to clinical leadership worldwide has given rise to many competency frameworks. In the UK, the Medical Leadership Competency Framework has been developed specifically for doctors, with the explicit intention that it should be embedded nationally in all curricula and at every level of education and training.[6] See Box 2 and Figure 1.

Box 2. The NHS Medical Leadership Competency Framework

The Medical Leadership Competency Framework describes five domains of activity focused around 'delivering the service' (see Figure 1). The launch of the framework has been supported by many activities aimed at embedding it in all undergraduate and postgraduate curricula, and in 2010 a national e-learning support platform (LeAD) was launched.

The Framework draws from a range of theories and approaches including the development of personal traits, working with others and the need to develop leadership 'at all levels'. The focus of the Framework is on leadership that is 'nearby', 'engaging' and 'shared'. This echoes many research findings that clinical leadership is particularly important at the level of clinical microsystem or team. Whilst clinicians need to be involved and engaged in major system change and improvement, the Framework emphasises leadership with a small 'l' - leadership on a day-to-day basis with the willingness to take responsibility and lead clinical teams in the best interests of patients.

The e–learning content in the LeAD sessions focuses on the concepts of shared leadership: this emphasises teamwork and collaboration, and the learner acting as an agent for change. The resource includes ideas for tutors, trainers and experienced staff on how to further develop the knowledge and skills of trainees (http://www.e-lfh.org.uk/projects/lead/index.html).

Figure 1. Medical leadership competency framework

Whereas competency frameworks may be of value in raising the awareness of leadership within organisations and individuals, it is in their application that issues arise. They should not be seen as a comprehensive recipe for personal or organisational success, but as a 'lexicon' with which individuals, organisations, consultants and other agents can debate the nature of leadership, and the associated value relationships within their organisations.[22]

CONCLUSION

Kouzes and Posner assert that leadership is an observable, learnable set of practices.[23] This assumption underpins the proliferation of competency frameworks and highlights the difference between traits and competencies: a trait being something innate or inborn; a competency being an intended and defined outcome of learning. However, the predominant emphasis in such frameworks is on the development of the individual, and this may be at odds with our increasing awareness of the emergent and relational nature of leadership. Reading literature and attending leadership courses is an investment in human capital, but in the complex context of health care, there may also be a need to invest in social capital, to foster interprofessional communication and learning in the workplace, and to develop co-operation and collaboration within and across organisations.

Health care is delivered not by individuals, but by complex systems working in concert, often involving large numbers of individuals and organisations. The effective clinician needs to understand those pathways and systems of care, and if they are to function effectively in the twenty-first century, must be comfortable working both within and with

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those systems for the benefit of their patients. To retreat back into the cosy confines of the one-to-one clinical relationship is no longer enough. Engaging in leading and managing systems of health care, on whatever scale – team, department, unit, hospital or health authority – is not an option, it is a professional obligation for all clinicians. The NHS provides an interesting case study of bringing clinicians on board, with a sustained attempt at creating the conditions for this to be possible. In medical and clinical education, we have an obligation to ensure that the next generation of clinicians are engaged, and have the knowledge, organisational skills and appropriate behaviours to deliver and improve systems of health care provision. Improving health care depends on changing systems, not just working harder within them.

Forthcoming articles in the Clinical Leadership mini-series

- Leadership in practice: challenges and solutions
- Designing and providing effective leadership development programmes
- The clinical teacher as leader: educational leadership

Further reading

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