Clinical Leadership as a Corollary for Professional Practice and Patient Safety

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ABSTRACT: *The purpose of this study is to highlight the importance of clinical leadership in the overall improvement of healthcare delivery. In this paper it was argued that the leadership needed to transform the performance of hospitals and health systems must emanate predominantly from clinicians whether or not they play formal management roles. The study attempted to describe clinical leadership in a pragmatic manner, and emphasize the proof of its immense positive impact on healthcare performance. Clinical leadership has witnessed a significant modification from the previous viewpoint about leadership which represented an authority relationship to a process of influencing followers for whom one is responsible, by inspiring them, or pulling them towards the vision of organization and also the follower's personal goal. This model of leadership is referred to as transformational leadership because such leaders transform followers. The study recommended that to enhance clinical leadership and management capacity of the clinicians in strengthening the health sector it is imperative to organize a staff/ organisational appraisal/ performance assessment of clinicians in managed care organizations as perceived by policy makers and stakeholders. Clinical leadership is yet to attain its full potential and integration in most health systems. However, it is an essential model to adopt, for both clinicians and their patients. It assures to make available a stable and reliable framework of professional excellence.*

Key words: *Clinical leadership, Clinicians, leadership, interpersonal relations, transformation*

INTRODUCTION

In a profession where decision making cannot afford to be erroneous, it is rightly expected that proficiency, expertise and professionalism are well demonstrated in theory and practice (Wiles & Widerstrom, 2001; Nath & Clark, 2014). But if confidence is debased the bulk of the culpability goes to the medical practitioner and the systemic structure (Dennis, 2014). Over the years, investigation and prosecutions have resulted in the convictions of hundreds of proprietors, managers and staff members of nursing homes and other residential care facilities, cascading into the recovery of millions of dollars, and positive changes in training and supervisory procedures at these facilities (Hawes & Kayser-Jones, 2003). While emphasizing diminution of medical negligence it is important to prevent the patient instead of wasting time in court trials and indictments to accumulate compensations for these victims (Dennis, 2014). By preventing, it is important to make clinicians hospital managers because they hold the best interest of the patients.

Key features of managed care development have been in recent years focused largely on clinical leadership practices in attempt to increase patient's safety and improve medical performances (Penny, 2000; Swanwick & McKimm, 2011). New forms of what is now being called clinical governance is being established (Dickenson & Ham, 2008). There are high levels of commitment to the integration of clinical with financial accountability as part of the management of quality (Busari, 2013). It is clear that clinical leadership has contributed to some remarkable results (Royal College of Nursing, 2004; Mountford & Webb, 2008; Busari, 2013).

CLINICAL LEADERSHIP

But what, exactly, is clinical leadership? Clinical leadership is referred to as putting clinicians at the helm of determining and administrating clinical services, so as to deliver excellent outcome for patients and populations, not as a one-off task or project, but as a core component of clinician's professional identity (Mountford & Webb, 2008; Swanwick & McKimm, 2011a). Cook (1999) further suggests that a clinical leader can be defined as an expert clinician, involved in providing direct clinical care, who influences others to improve the care they provide continuously. Thus, although it would seem that engagement in formal organisational roles is a useful and symbolic mechanism, the complex subcultures in health care organisations and the role of informal leaders are also important (Swanwick & McKimm, 2011b).

Clinical leaders by this definition, is not an end in itself but rather a means to the end for high performing health systems (Poddar, 2013). It should not exist in a silo, detached from clinical practice it should be a core part of excellent patient care and it is not something for just a few clinicians in formal 'executive' roles it is something all clinicians should believe in and demonstrate it to some degree (Busari, 2013; Nath & Clark, 2014).

REVIEW OF RELATED LITERATURE

Firth-Cozens and Mowbray (2001) suggest that clinical leaders are able to directly affect the safety of their team's actions and

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outcomes which are both clearly important for quality of patient care. The researchers cite studies from areas such as airline safety (Empey, Peskett, & Lees, 2002) that illustrates the importance of leader personality type and how this impacts upon organisational culture. There is an established evidence base from high-reliability industries (Reason, 2000; Ojha, 2005) which point to the role that leadership plays in forming organizational culture and the consequences of this for patient safety. Clinical leaders are best equipped to make decisions that are in the patient's best interest and that of the profession or practice (West, 2014).

Leadership style is also cited as impacting upon quality of care in other ways. Firth-Cozens and Mowbray (2001) cite a number of studies which demonstrate links between stress of staff in teams and the quality of patient care. The authors argue that team functioning impacts upon stress levels and clinical leaders play an important role in the production of effective teams (Clark, 2012). Corrigan, Lickey & Campion (2000) demonstrated these links directly in a study of leadership style in thirty-one (31) mental health teams where clients were asked to rate satisfaction with treatment programmes and quality of life. The researchers suggested that the ratings by leaders and staff members independently accounted for about 40 per cent of variance in client satisfaction. Thus, the style of leadership adopted within mental health teams was thought to contribute greatly in terms of impact on service users this result is also corroborated by Lewis, (2013) who concluded that, doctors are well-equipped to take on managerial roles, they need to take into cognizance the potential for their various roles to conflict with each other. To mitigate this problem, consultants are likely to benefit from greater awareness of approaches to leadership in the National Health Service, as well as a regular process of reflection to ensure that their skills are periodically assessed and improved.

In a study of community health centres, Xirasagar, Samuels & Stoskopf, (2005) found that there was a significant association between transformational leadership and effectiveness in achieving organization-wide changes in clinical providers' practice behaviours. Xirasagar et al., (2005) go on to identify that transformational leadership styles have more successfully influence doctors to achieve measurable clinical goals. Current researchers have found that doctors were much more likely to be influenced by medical leaders who adopted a transformational style (Tomlinson, 2012; Lawrence & Richardson, 2014). In other words, doctors are less likely to be influenced by someone who simply occupied a particular hierarchical position, and more likely to respond to individuals who influence others through their personality and power of persuasion (Lynas, 2012; Clark, 2012; Lewis, 2013)

These standpoints on leadership style are important to note, considering that one approach to leadership which has been popular within the National Health Service United Kingdom in recent years is the transactional / transformational distinction of leadership (Department of Health, 2001). For example, the national leadership qualities framework is underpinned by the transformational model (Davidson & Peck, 2005), and other key figures within the movement have also stressed the virtues of transformational approaches, for example to service re-design, (Bevan, 2005).

Clinical leadership has witnessed a significant modification from the previous beliefs about leadership which represented an authority relationship to a process of influencing followers for whom one is responsible, by inspiring them, or pulling them towards the vision of organization and also the follower's personal goal (Felfe & Schyns, 2006; Lynas, 2012). This model of leadership is referred to as transformational leadership because such leaders transform followers (Lawrence & Richardson, 2014). Although this model of leadership is still hierarchical, it nevertheless recognizes that leaders are seen as having to demonstrate competence and professionalism in their day to day activities among patients, staff and colleagues

(Felfe & Schyns, 2006; Lawrence & Richardson, 2014). Clinical leadership represents a paradigm shift, from a model of leadership in which followers are comparatively played to the background to one in which the follower is an integral part of leadership (Alimo-Metcalfe, 1998; Busari, 2013)

According to this distinction, clinical leadership is about transforming behaviours of followers and changing organisations by using the power of influence and persuasion, rather than direct application of authority in a traditional sense (Fu, Tsui, Liu, & Li, 2010). This would seem to be potentially more effective form of influencing doctors given the professional power (Mott, 2010). Milward & Bryan (2005) illustrated that the clinical leadership model emphasize the significance of interpersonal relations between a leader and an individual follower, almost regardless of organisational context. Aside the importance afforded to followers within the clinical leadership model of leadership, few studies within the area of leadership as a whole have empirically considered the issue of followership (Corrigan, Lickey, & Campion, 2000; Collinson, 2006). Nevertheless, it is clear from the evidence reviewed that engaging clinicians in formal leadership roles is a critical success factor in evaluations of quality improvement programmes (Busari, 2013). This suggests that the development of followership is just as important as the development of leadership in health care organisations (Collinson, 2006; Lewis, 2013; West, 2014)

Several research studies corroborates these findings, suggesting that leadership is ultimately a social function (Dash & Garside, 2007; Iheonunekwu, Anyatonwu & Eze, 2012; Lawrence & Richardson, 2014) and that within healthcare systems leadership roles are not defined in hierarchical administration, but rather as management components within a complexly related subsystem which form the wider healthcare business and social ecology (Kuhnert & Lewis, 1987; Kark, Shamir, & Chen, 2003; Gopee & Galloway, 2009).

A study of medical leadership in English primary care reached comparable conclusion. Sheaff, Rogers, Pickard, Marshall, Campbell, Sibbald, Halliwell, & Roland, (2003) examined the implementation of clinical governance in a number of primary care groups and trusts, focusing in particular on the informal techniques that primary care organisations use to engage clinicians in the process of clinical governance in the absence of direct formal powers to do so. These researchers found that clinicians who took on the role of clinical governance played vital part in the development of this policy. Sheaff, Rogers, Pickard, Marshall, Campbell, Sibbald, Halliwell, & Roland, (2003) reported that managers exercised influence over primary care by proxy by working with and through clinician's clinical governance leads. The latter used a range of soft governance techniques, most importantly the threat of intervention by non-clinicians to persuade clinicians to become involved in clinical governance activities.

Sheaff and colleagues (2003) in corroboration of the aforementioned observe also that local professional clinical leaders act as a 'boundary' layer, both transmitting managerial imperatives and priorities from lay managers to their fellow-professionals yet also attempting to conserve a degree of independence for their profession. Such influence as local medical leaders have on their colleagues is exercised through a combination of knowledge-management, collective self-organization and the implication political threats rather than overt financial, administrative over regulatory controls' (Dash & Garside, 2007).

Leadership is about the process of influence rather than purely relating to formal hierarchical appointment the range of individuals who might be considered leaders needs to be extended beyond formal positions (Empey, Peskett, & Lees, 2002). Mohapel and Dickson (2007) revealed that because of the complexity of healthcare systems in differences in perceptions, cultural and systemic senses, effective leadership act at three different levels:

- Leadership of self
- Leadership of others (teams, direct reports)
- Leadership of organisations within systems

Leadership of self or personal leadership refers to the embers of influence that one has to change oneself (Mohapel & Dickson, 2007). Adjustments must appeal to clinicians at an individual level in order to change the behaviours of clinicians in general (Swanwick & McKimm, 2011b). Leadership of others relates to concepts of supervisory leadership which may relate to both formal structural leadership positions and also less formal, influential processes (Mohapel & Dickson, 2007). That is, leadership in a structural sense may be symbolic as well as practical but individual personality traits are also important in persuading and inspiring others and both may combine to influence cultural factors (Mohapel and Dickson, 2007). Leadership of organisations effectively refers to strategic leadership. Mohapel and Dickson (2007) suggest that strategic leadership is one of the key elements in increasing physician engagement, but is insufficient without the other two aspects.

BARRIERS TO CLINICAL LEADERSHIP

Several barriers to clinical leadership have been identified by authors, for example Oxtoby, (2013) stressed that for years, men dominated medicine and women faced numerous obstacles to advancing their careers. Oxtoby (2013) finds those barriers seem to be breaking down, allowing more women clinicians to realize their full potential. Currently, women hold some of the most senior jobs within the profession, including Dame Sally Davies, chief medical officer, Clare Gerada, chairman of the Royal College of General Practitioners, and Sue Bailey, president of the Royal College of Psychiatrists, who was recently named one of Health Service Journal's "most inspirational women in medicine".

However, apart from the barrier identified by Oxtoby, several other barriers exist and they are enumerated below;

Bureaucratic Procedures in Hospitals

Bate's (2000) empirical study in an NHS hospital demonstrates the resilience of professional official procedures, and the role of professional networks within these bureaucracies. As such, it provides a link to a wider body of work on the significance of combined leadership in health care organisations, and the role by clinical micro-systems (LaRowe, 2004). A related theme is the need for there to be constellations of leadership in place to support major change programmes (LaRowe, 2004). In Bate's research, consultants did not accept the legitimacy of management within the hospital, as a result were able to undermine managerial power. Bate reports that the hospital had developed into one which was characterized by sub-cultures which existed in isolation. This was described as particularly problematic when change processes needed to be inculcated involving more than one department, as this inevitably led to tensions and often a circumstances of 'grid-lock' between these departments and their associated sub-cultures (Batalden, Nelson, Mohr, Godfrey, Huber, Kosnik, & Ashling, 2003).

Managers vs. Clinicians: Legitimacy of the Non-Clinician

Clinicians and managers are perceived as being at loggerheads, where the managers should have had degrees of latitude to make changes, but in practice, due to the way healthcare organizations function, it tended to be the clinicians who held the power and the managers were afraid to challenge this too far lest they should face a vote of no confidence (Batalden, Nelson, Mohr, Godfrey, Huber, Kosnik, & Ashling, 2003). As doctors refused to accept the legitimacy of the management system, they were able to confound it. Bate

(2000) suggests that this was not a problem that could be dealt with exclusively by structure (and as archetype theory suggests, structures are often the result of the underpinning values of an organization) for clinicians were already undermining current structures and refusing to be controlled in a hierarchical fashion. Instead a networked community was worked towards where doctors became involved as they could see that the costs of not being involved would outweigh the costs of being involved.

In emphasizing the role of networks rather than hierarchies, and of partnership between doctors and managers in a loose framework, Bate is echoing other work that highlights the importance of involving a large number of people at all levels of the organization, not just those in formal positions of authority (Hewison & Griffiths, 2004). Ferlie and Shortell (2001) who suggest that sole reliance on the charismatic individual as a source of leadership is a mistake, especially in multiple-stakeholder-based systems such as health care, where different groups may expect different management styles. Notions of collective leadership and team leadership seem to be crucial to engagement in medical leadership.

Constellations and Collective Leadership

The significance on constellation of leadership and collective leadership has reflected in the literatures. Within the context of hospital reform in Australia and the UK, Degeling, Kennedy, Carnegie & Holt, (1998); Degeling, Maxwell, Kennedy and Coyle, (2003) found that lay managers were more receptive to concepts of change and would more readily support change, responses of medical and nursing managers were rather different. Even as medical and nursing staffs are willing to recognize concerns of the health authority, they nevertheless wanted to preserve what they regarded as being essential for maintaining the vocational, inter-subjective and normative orientations of their involvement in patient treatment. In this case, medical staff had sufficient power and autonomy by virtue of their roles to block or support change as they saw appropriate. This illustrates the complex sub-cultures which different medical staff are also a part of. Leadership at the very top level is not sufficient and middle managers and clinical managers specifically are imperative in leading reform through social processes (Degeling et al., 1998; Degeling et al., 2003).

Degeling is one of few researchers identified during this review who overtly considers the leadership-followership dialectic in clinical settings. Degeling et al., (1998) acknowledges that leadership is not directly a outcome of some kind of official power or position of hierarchy but relates to the capacity of individuals to perform their roles in a manner which portends as culturally effective to the sub-culture. Moreover, leadership and followership are partial social processes a leader is not simply a leader due to an official status, but due to their ability to influence and change behaviours of others. Although Degeling and colleagues (2003) recognize the importance of engaging doctors in leadership on an individual basis, they acknowledge that this is an insufficient condition for reform (Degeling, Maxwell, Kennedy, & Coyle, 2003).

These authors highlight the important role which senior management and policy makers also play in setting the scope for middle management to act within. Senior management defines what is institutionally achievable and may potentially undercut the actions of middle managers (Firth-Cozens & Mowbray, 2001). Medical leaders will only be able to transform a sub-culture if their actions are legitimated by the wider system. Therefore, clinicians might be engaged in leadership at certain levels, any processes take place within limits of scope which are set by the institutional system (Degeling, Maxwell, Kennedy and Coyle, (2003). That is, leadership is not a purely individual trait which is influenced by the characteristics of a person, but involves a complex process between different systems, cultures, sub-cultures and complex mixes of

accountabilities. This clearly stands as a quite different stance towards leadership than those cited by Firth-Cozens and Mowbray (2001) where the leaders are solely those within official positions of authority, and suggests would require quite a different approach to leadership development (i.e. developing an individual's ability to influence others not necessarily via a top-down demonstration of power, but through other processes). Examples such as those from Firth-Cozens and Mowbray, (2001); Degeling et al., (2003) and the clinical micro-systems studies suggest that leadership is a social process and leaders influence followers through social processes. Leading change is a complex and dynamic process, but medical leaders might influence followers by resonating with and drawing upon certain aspects of culture and professional identity.

What this also suggests is that due to the strong professional underpinning of the majority of clinical identities that this process of transformation may be more successful if those leading change efforts are clinical or medical leaders themselves (Baumeister, Campbell, Krueger, & Vohs, 2003). However, such leadership will be deficient because effective leadership involves a constellation of leaders from various backgrounds and at different levels who might influence a range of sub-cultures in diverse ways, though within a context where there is top management leadership and support. The importance of effective followership is again underscored by this analysis. Silversin and Kornacki (2000) similarly emphasize the critical role of followers in their analysis of physician leadership in the United States.

Poor Sensitization and Planning

However, clinical leadership has been observed to be a major factor affecting the performance of health system which is attributable to the weakness in leadership role of health managers and policy makers (Firth-Cozens & Mowbray, 2001; Mott, 2008; Busari, 2013). To enhance clinical leadership and management capacity of the clinicians in strengthening the health sector it is imperative to organize a staff/ organisational appraisal/performance assessment of clinicians in managed care organizations as perceived by policy makers and stakeholders (Mohapel & Dickson, 2007). Health policy makers and other stakeholders including directors, project and program managers, and the heads of department under the ministries of health, hospital administrators, chief executive officers of civil society groups including non-governmental organisations, leaders of national health based associations and health directors and managers in uniform services need to be sensitized on the gains of adopting clinical leadership practices.

When summed making clinicians' organisational leaders is a huge and costly task (McKinsey, 2008). Is it worth it? Especially given the many competing demands on clinicians' time? They and others will rightly seek evidence of the link between clinical leadership and a health organization's performance, both clinical and financial. Proof of a direct correlation will remain elusive, thanks to the inherent complexity of health systems, whose performance is affected by multiple, overlapping variables of which clinical leadership is only one (Busari, 2013).

In conclusion, the assessment of healthcare systems have often demonstrated that most healthcare organisations have mission and goals and these are not formally linked to planning(Woolnough & Faugier, 2002). In addition, healthcare organisations should have annual human resource plan, because most of the them signify that the plan is not always linked to healthcare leadership responsibility, staff supervision work, work planning, performance review, job classification system, and relationship with unions, clinician-patient compensation, labour law and organisational planning among others (Hewison & Griffiths, 2004). Other reports indicate that inadequate funding of development programmes and trainings is a common problem in health sector of most low-to-middle-income countries particularly in Africa and Asia (Adano, 2006; Asante & Hall, 2010).

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