Nursing Practice
Discussion
Leadership

What makes good leadership in healthcare? This is much debated, but team interactions seem at least as important as who the designated leader is

From leader to leadership in emergency care

In this article...

- Problems in forming clinically relevant definition of leadership
- How leadership is traditionally conceptualised in health
- Why the focus has moved from leader-centric approaches

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Historically, leadership research has focused on the qualities of people in formal leadership positions, not the processes of leadership itself. However, leader-centric approaches are unhelpful in healthcare, as good team performance is often the result of interactions between individuals, rather than the work of one person. This is particularly the case in emergency care, as shown by studies exploring how resuscitation teams work. This article discusses how shortcomings in the leadership discourse have permeated healthcare and are hindering the study of leadership. The authors suggest that focussing on what makes good leadership, as opposed to what makes good leaders, will provide a way forward.

The lack of a standardised, cohesive approach to leadership in healthcare is problematic. Leadership in nursing has long been recognised as an important part of practice, education and policy (Pickering, 1921). It used to be the domain of senior figures occupying archetypal leader positions. However, in recent years, some have argued that leadership “is an essential part of nursing practice and that all nurses’ roles are, in one way or other, leadership roles” (Curtis et al, 2011). Leadership is a ubiquitous term whose semantic boundaries have become blurred: it is referred to as something that resides with a group of select individuals, while simultaneously being a necessary attribute of all. Indeed, it is often said that failings in healthcare at individual, ward, organisational and national level are due to failures in leadership (Francis, 2013).

Additionally, the different contexts and circumstances in which leadership is required have not been properly defined. How can the long-term strategic needs of an organisation be equated with the needs of an emergency care team, even though they are all cast under the banner of ‘leadership’?

For most, leadership carries with it an implicit set of beliefs and assumptions. Everyone has their own theory about what leadership is and how it is enacted. However, the meanings attached to leadership are often treated as if they were part of a shared understanding. As Luthans (1979) argued, “Too often theorists forget that leadership or ‘influence’ are merely labels that are attached to hypothetical constructs. Too often, the hypothetical construct is treated as the empirical reality”. In other words, leadership is not a universal concept but is shaped by local, social and cultural dimensions. It means different things to different people.

Leadership in healthcare

The struggle to develop a consensus on what leadership is has lasted decades (see Box 1) and its manifestations are evident in a number of areas, most notably healthcare. Similar to leadership in general, leadership in healthcare has been

5 key points

1 Traditionally, literature on leadership has favoured leader-centric approaches

2 Reducing leadership to the acts of a few does not reflect its fluid and interactive nature

3 In resuscitation teams, there is a complex interplay of processes that is not captured by historical concepts of leadership

4 Nurses who do not see themselves as leaders may nevertheless perform leadership functions

5 By exploring leadership rather than leaders, researchers have a roadmap to describe how highly-skilled people work in adaptive teams
predominantly understood as focused on the individual. The rationale of research has been to uncover the qualities of ‘good’ leaders and how these relate to staff performance (Hartley and Benington, 2010).

Popular rhetoric, as highlighted by Collins-Nakai (2006), is that leadership is “about taking risks” and “about having the courage of one’s convictions” and “the will to act even in the face of powerful conventional wisdom, or strong opposition”. Such narratives are what Meindl et al (1985) referred to as the romance of leadership. They propose that leadership offers people a tangible explanation of complex social and organisational machineries. Bligh et al (2011) asked whether we can even “generate a theory of leadership that does not highlight leaders as the most important object of study”.

So far, the theories and methodologies used in healthcare have produced leader-centric conceptualisations – such as transactional, transformational and trait theories – of leadership, which have become the norm. This has encouraged clinicians and academics alike to seek out those who are perceived as effective leaders and idealise their attributes, often negating the contextual or systemic factors that have allowed their leadership to become effective in the first place.

This has, in turn, created the impression that health services are run by the charismatic doctor, the robust ward sister, the skilled surgeon or the inspirational manager, rather than by a collective of people and teams. As The King’s Fund (2011) recently argued, there needs to be a “move beyond the outdated model of heroic leadership to recognise the value of leadership that is shared, distributed and adaptive”.

Leadership occurs through a complex interaction of people, behaviours, socio-cultural norms and organisational factors; to reduce it to the acts of a few individuals does not reflect its fluid nature (West et al, 2014).

Leadership in emergency care

Although present in all areas of healthcare, the manifestations of leader-centric models of leadership are most evident in emergency care, and even more so in resuscitation teams. Traditional leadership theories have filtered down from organisational and management sciences and have been applied to clinical care without an appreciation of the contextual and environmental differences.

Kozlowski et al (1996) argued this two decades ago, stating: “It is difficult to apply prescriptions from existing leadership research to teams operating in complex and dynamic decision-making environments. The primary limitations of existing frameworks include their lack of conceptual grounding in the defining characteristics of the team context, relative insensitivity to team developmental processes that unfold over time, and neglect of team-level, cyclical dynamics in task complexity and workload.”

In support of this, studies observing leadership in real resuscitation episodes (Klein et al, 2006; Sarcevic et al, 2011; Xiao et al, 2004) have repeatedly found that leadership does not always take strict hierarchical, formal modes. Rather, the who, when and how of leadership depends on circumstances, such as the severity of patient illness, the experience of team members in the room, how well they know each other, and a whole range of socio-behavioural factors. During emergency resuscitation, there is a complex interplay of leadership and team processes that is not captured by historical conceptualisations of leadership.

Research is now moving away from focusing on the individual who occupies the position of leader towards who in the team is displaying leadership. Leadership thus becomes something functional and clinically relevant, rather than a collection of loose concepts. This aligns with McGrath’s functional theory, which proposes that the leadership role “is to do, or get done, whatever is not being handled by group needs” (McGrath, 1962). By exploring leadership rather than leaders, researchers have a roadmap for conducting studies that empirically describe how highly skilled people function in complex-adaptive teams.

Informal nurse leadership

Recent studies – conducted in the simulated (Sadideen et al, 2016) and real environment (Rydenfält et al, 2014) – have observed the leadership behaviours of all team members. They have found that senior nurses often display leadership without being in designated leader roles. When recognising the needs of the team, nurses can transiently display leadership functions that resonate with their peers and colleagues (Lloyd et al, 2015). This creates a sense of followership that pulls team members towards these nurses. Leadership, in that sense “is co-created in social and relational interactions between people” (Uhl-Bien et al, 2014).

This is conceptualised in the social identity theory of leadership (Hogg et al, 2012), which proposes that people who engage in prototypical leadership behaviours have disproportionate influence over the group’s identity and actions. In practice, this means that senior nurses who fit the group’s leadership prototype will function as leaders without being named as such.

In a large ethnographic study at a trauma centre, Klein et al (2006) observed that “nurses are lower in the formal hierarchy... but nurses exert considerable informal influence”. Their rich interview data reveals how nurses exercise leadership within teams and hierarchies: “We can gently tell the docs what we think. Nurses have more autonomy here than in other areas of the hospital. The nurses are very experienced here, and there’s usually so much going on that you’re left to handle things by yourself.”

Such a sentiment is likely to be expressed by nurses who may not see themselves as leaders, but perform leadership functions nevertheless. This is a silent form of leadership, one that is not captured when focusing on the individual who is the leader on paper. In many circumstances, this hidden work of nurses...
Leadership is one of the strongest predictors of how health services perform. It goes unnoticed (Wolf, 1989), despite the fact that their informal acts of leadership will shape team performance. These subtle dynamics should be further investigated using more varied methodologies in order to bring balance to the literature, which is currently leader-centric.

Future research
This critique of leadership should not undermine its importance, as leadership – or the lack of it – is one of the strongest predictors of how health services perform. In the United States, the Joint Commission (2016) found that failings in leadership were the second highest root cause of significant adverse events, contributing to over 1,900 errors during the preceding three years. In the UK, the Mid-Staffordshire public enquiry cited over 850 times ‘leaders’ or ‘leadership’ as being central to good care (Francis, 2013).

In its 2015 annual report, the Care Quality Commission concluded that 94% of services rated as ‘good’ or ‘outstanding’ also had good or outstanding leadership, whereas 84% of services rated as ‘inadequate’ also had inadequate leadership. This suggests a causal relationship: poor leaders equal poor leadership, which equals poor performance. Researchers and clinical staff have to question this: is it possible for an individual to be a good leader but see their efforts suppressed by a negative culture? Can a team provide high-quality care even if leadership is suboptimal? Can good performance be explained by mechanisms other than the actions of a good leader?

Leadership is undoubtedly important, so these difficult questions need to be asked. The main barrier, paradoxically, is that those who have responsibility for asking them are nurses, doctors, and academics who themselves are leaders and, as such, are likely to have internalised the leader-as-individual paradigm.

Conclusion

Despite a huge amount of empirical and theoretical work, the study of leadership is ‘curiously unformed’ (Hackman and Wageman, 2007). Healthcare has inherited a leader-focused approach, which means our understanding of the phenomenon remains shallow. This is likely to contribute to the regular pattern of failings caused by poor leadership. The inadequacy of the leader-centric approach is most evident when studying emergency care: here, solely observing the formal team leader risks neglecting the dynamic, adaptive processes that are behind high-performance team functioning.

We suggest refocusing the enquiry lens on leadership – who is displaying leadership, how leadership is adapting over time, and which team dynamics promote or discourage good leadership – rather than on leaders. Reframing investigations in this way will not only better reflect how resuscitation teams function, but also provide a template for understanding leadership in other areas of healthcare.

References

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