Clinical Leadership: Reflection saves lives

For nearly a decade, the UK’s Department of Health has been encouraging healthcare organisations to focus on leadership as an essential part of enhancing quality of care for patients and service users. Typically, this has been based on the understanding that leadership either positively or negatively impacts the culture and effectiveness of teams, which, in turn, effects the quality of care they can provide. For example, leadership that is effective in creating a positive culture can lead to higher levels of employee engagement and improved patient outcomes.

Today, this understanding is even stronger, and levels of concern higher, with increasing evidence being gathered. In addition, we now have the pressing imperative to protect the quality of care provided to the healthcare workforce itself, with increasing evidence of widespread and rising stress levels. Stress experienced among employees can also reduce quality of patient care. One only needs to look at the findings of the Francis Inquiry to see how pressure on clinicians and other professionals within Mid Staffordshire NHS Foundation Trust to achieve targets, and the stress they experienced as a result, had a devastating impact. It has been described as causing Trust employees, including doctors, to switch off on some level from their values and seriously neglect people within their care. As the inquiry showed, in the same way as many other pieces of research around the world have, the major source of this stress was the leadership culture in the organisation.

With this in mind, we absolutely must focus on getting clinical leadership right if we are to care for our patients and communities in the best way possible. There are other factors that are also directly impacted by leadership culture, and which are fundamental to quality care, namely employee engagement, innovation, collaboration, and readiness for change. These too will be addressed later in this article.

Leadership approaches at odds with evidence-based requirements

In the past, and to a worrying degree still, many leadership frameworks applied to enhance clinicians’ and other professionals’ leadership have not been proven to work, or to be the right approach for making a positive impact in their context. The frameworks might look and feel right, but whether or not they have a genuine impact on the outcomes that must be addressed – quality of care, innovation, and so on being among them – remains questionable. Worryingly, this is often the case even for frameworks that are adopted by sector-level bodies.

Just a few years ago, and well after the imperative to enhance clinical leadership was announced by the Department of Health, some very concerning approaches were still being used at a national level. One such programme sought to profile existing, successful healthcare CEOs and apply their typical leadership style to the wider leadership population as the ideal. This style was aptly named “Pacesetter”, and was one in which a focus on targets was strong and constant. What seems to have obviously been missing in this analysis of what works is the stress levels of these organisations. Yes, they might be high performing now, but with such a leadership approach, how long before the pressure on individuals means that their performance is no longer sustainable? What happens then?

If we accept the evidence that leadership makes a critical difference to the quality of care (and thus the chances of a successful outcome) that is provided to patients and service users, then it clearly follows that we need to rigorously test these in the same way we would clinical procedures or prescribed drugs. This means expecting published research of validity and effect, scrutinising this research, and being

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1 This article has been modified and updated from an earlier version by Alimo-Metcalfe, B.M. and Bradley, M. in Clinical Leader with the title ‘Darzi and Leadership: Too important to get wrong this time!’
vigilant to potential side-effects that the wrong approach might case. The current, prevailing approach is conspicuously at odds with healthcare organisations’ and the Department of Health’s absolutely appropriate demands regarding strong evidence base in relation to clinical practice.

Distinguishing leadership from management

When we examine leadership frameworks in use across healthcare, we find that there has been a substantial increase in the use of competencies as the basis for them. Often, these competencies feature to the exclusion, or near exclusion of leadership, per se. Competencies or ‘skills’ are absolutely crucial for the effectiveness of anyone, whatever their job, and unquestionably for clinicians. However, it is becoming more and more evident that competencies alone are not sufficient for assessing the full range of leadership behaviours that are required for effective leadership and organisational success.

Well-known experts, Hollenbeck and colleagues criticise what they regard as the false assumptions upon which the competency approach is based, namely that,

"what matters is not a person’s sum score on a set of competencies, but how well [or as we would put it, in what way] a person uses what talents he or she has to get the job done…we see little evidence that these systems, in place for years now, are producing more and better leaders in organizations".

Aside from largely missing evidence of validity of most competency frameworks, Bolden and Gosling neatly summarise the limitations of competencies in encapsulating the critical characteristics of leadership:

"a competency framework could be considered like sheet music, a diagrammatic representation of the melody. It is only in the arrangement, playing and performance, however, that the piece truly comes to life."

Thus, the critical distinction between a leader and someone who is simply a manager is not just being competent in one’s job, but in how one applies one’s competencies as a leader in interactions with others. In other words, a leader is someone who is careful to ensure that their behaviour has a positive impact on those around them, including, in this context, clinicians and other professionals, junior and senior staff, and, of course, patients, service users and their families.

Addressing the leadership deficit

Models of leadership have changed over the years, partly in response to changing social, economic, political and technological factors. As described earlier, the current focus is particularly on increasing employee engagement, enabling innovation, collaboration and readiness for change, and reducing job-related stress.

Employee engagement can be defined as having positive attitudes towards an organisation and its values, and is a measure of the extent to which employees put discretionary effort into their work. There now exists a growing mass of data gathered from around the world showing a strong and significant association between high employee engagement levels and improved organisational performance. Performance measures applied here include financial outcomes, reduced absenteeism and burnout, increased safety behaviours, quality of customer (or service user care), and lower levels of employee turnover.
The distinction between simply possessing the competencies of a good clinician, and being a clinical leader (or other such professional) with the most powerful positive impact on others, might best be described as distinguishing between the ‘what’ and the ‘how’ of leadership. Both are essential to being an effective leader, but they are different dimensions. Figure 1 below describes this relationship.

**Individuals in the A category** can be seen to be highly competent, but not very engaging in their behaviour – perhaps the kind of person who is very technically skilled, but who shows a lack of understanding, or concern, for the needs of others and the impact of their behaviour on others. This could result in low morale, confidence and effectiveness in their team, and minimal learning and innovation.

**Individuals in the B category** may be sensitive to the impact of their behaviour on others, engaging, and someone who creates a supportive environment in which all staff are valued - but they are not competent in their role. This is likely to reduce team effectiveness and may well create frustration and a lack of clear direction.

**Individuals in the C category** are the kind of manager or professional who, by acting in an engaging way, with all that entails, can use their competency as a leader in ways that are relevant to the particular individuals or situations. They are likely to have a positive impact on the motivation, well-being and discretionary effort of others. This is the combination most likely to lead to high levels of team effectiveness and quality of care.

*Figure 1: the difference between management and leadership*

What do we know about the ‘how’ of leadership?

We conducted a three-year, empirical study to investigate what distinguishes those in leadership roles at various levels of organisations who have a positive impact on the motivation, morale, and well-being of
their staff, from those whose impact is less positive, or indeed, negative. The sample comprised over 6,500 managers and professionals, inclusive of age, ethnicity, gender, level of management, and different sectors. It included a substantial proportion of clinicians, at all levels of the NHS. It has since been independently verified in the UK and countries worldwide.

The model that emerged comprises 14 dimensions of what we refer to as Engaging Transformational Leadership (see figure 2 below).

![Figure 2: Engaging Transformational Leadership](image_url)

There are at least six published, academic peer-reviewed articles supporting its convergent and discriminant validity, providing a strong evidence base that it makes a positive impact as a leadership approach. They all demonstrate that displaying these behaviours increases employees’ motivation, job satisfaction, self-esteem, job commitment, commitment to the organisational, and reduced job-related stress.

There are also major, longitudinal studies published which demonstrate outcomes such as that when teams are characterised by this leadership culture, there is a direct impact on improved productivity (achievement of targets), readiness for change, wellbeing, and innovation in teams, in addition to other benefits.

What do effective clinical leaders do?

To distil the model above to general principles, we can see that:
• The emphasis is not on heroism, but on supporting others and enabling them to display leadership themselves. At its core are two dimensions relating to transparency and integrity.

• It contains a persistent theme of team-working, collaboration, and ‘connectedness’, and of removing barriers to communication and encouraging the sharing of ideas, whether between individuals in one’s team, or between different teams and departments, or with outside ‘stakeholders’ and partners.

• It reflects a respect for others’ views and experiences and a willingness to take on board their concerns, perspectives on issues, and to be open to working with their ideas.

• Another persistent theme is to encourage questioning and challenging of the status quo, and to ensure this happens by creating an environment in which these ideas are sought, listened to, and valued; and in which innovation and judicious experimentation is encouraged.

• The model also includes behaviours that encourage the creation of a culture that supports individuals’ personal development, in which the leader is a role model for learning, and in which the inevitable mistakes are exploited for their learning opportunities.

Gone is the heroic approach to leadership, along with the notion of one person – the solipsistic leader – with a monopoly on the vision. It is replaced by a ‘distributed’ approach, with a commitment to building shared visions with a range of different internal and external stakeholders. Effective leaders here positively exploit the diversity of perspectives and the wealth of experiences, strengths and potential that exist within their team, department, or organisation, and with partners and other stakeholders.

Leadership in medicine – a cautionary tale

To emphasise the importance of understanding the distinction between being competent, and displaying effective leadership, we can relate these points to examples of clinical practice and even patient safety. Let us take the example of surgeons. As with other professionals in healthcare, it is not difficult to think of examples of highly competent surgeons who, although highly qualified and technically skilled, behave in ways that have a negative impact on the motivation, morale, and self-confidence of their (junior) colleagues. As undesirable as the effect might be on their colleagues, it can also have an impact on the effectiveness of their team, and ultimately patient safety.

One US study conducted by Harvard-based researchers aimed to identify what differentiated the ‘successful’ from the ‘unsuccessful’ implementers of a new technology for cardiac surgery, referred to as Minimally Invasive Cardiac Surgery, by analysing data collected from 669 heart operations in 16 hospitals.

It found that it was not the seniority of the surgeon, nor their experience nor their technical competencies that differentiated levels of success. Rather, success was associated with factors such as ‘creating a learning team’ and ‘creating an environment of psychological safety’ that fostered communication and innovation.

Teams that learned the new procedure most quickly, shared certain characteristics, such as selecting appropriate team members “not only on their competence, but also on factors such as their willingness to deal with new and ambiguous situations, and confidence in offering suggestions to team members with higher status”. They also “emphasized the importance of creating new ways of working together over simply acquiring new individual skills” and found from interviews that “teams members uniformly emphasized the importance of experimenting with new ways of doing things to improve team performance.
– even if some of the new ways turned out not to work”, and because “new technologies often render many of the skills of current ‘experts’ irrelevant”.

Neutralizing the fear of embarrassment is necessary in order to achieve the robust back-and-forth communication among team members required for real time learning. Teams whose members felt comfortable making suggestions, trying things that might not work, pointing out potential problems, and admitting mistakes were more successful in learning the new procedure. By contrast, when people felt uneasy acting this way, the learning process was stifled.

How was the environment of psychological safety provided? The answer is that it was through the actions and words of the surgeons who acted as teams leaders. For example, one surgeon told team members that they were selected not only because of their competence but also because of the input they could provide of the process. Another repeatedly told the team, “I need to hear from you because I’m likely to miss things.”

The article concluded by pointing out that teams are often led by people who have been chosen on the basis of their technical expertise or skills, rather than their ability to lead teams in ways that they become effective learning units. Such choices can lead to disaster, not least of which when they are involved in healthcare.

One such example was described in an article which appeared in The Independent newspaper\(^1\). It concerned the case of a 39 year old woman dying as a result of medical error in what was regarded as a routine operation. The woman, Emily Bromiley, was being operated on because a sinus problem turned into an infection of her eye socket. At the independent investigation, conducted by Professor Michael Harmer, a former president of the Association of Anaesthetists of Great Britain and Ireland, it transpired that Emily’s death was avoidable. It found that there was no shortage of knowledge, equipment or manpower in the theatre at the time – an ENT consultant, two consultant anaesthetists, and four nurses were present – to manage the emergency that presented shortly after Emily was anaesthetised. When her airways collapsed, all three consultants attempted to intubate, “But there was an obstruction…”

The consultants appear to have become fixated on intubation as the only option. What made the situation worse was that two of the nurses stated that they “knew exactly what needed to happen”. It transpired that one had brought tracheotomy equipment into the theatre but was not acknowledged, and another booked an intensive care bed but was led to understand that she was overreacting and so cancelled it. “Both of these nurses knew how to save Emily’s life, but they didn’t know how to broach the subject with their bosses”.

At the inquest, Emily’s husband said, “This was not a case of one man being incompetent. The team made mistakes as a whole. It was a failure of the system”. Such tragedies serve to emphasise the critical importance of leadership, including most importantly in the NHS, clinical leadership.

The age old question – are leaders born or made?

Our vast experience of working in healthcare and other sectors to support leadership development and culture change suggests that while some leaders might be described as “naturally” adopting the more effective approaches described in this article, we also find that it can be developed among managers who haven’t had the same exposure to positive role-modelling or encouragement of more effective leadership.
We also have evidence from qualitative data gathered from colleagues of individuals who have undertaken leadership development, as well as from statistical analyses comparing pre- and post-intervention 360-feedback ratings of individuals’ leadership behaviours as rated by others anonymously, that significant changes are perceived to have occurred according to other raters.

As part of doctors’ revalidation in the UK, they are required to receive multi-source feedback (MSF) on their performance every few years, including data from 360 assessments. This is a wonderful opportunity for doctors to benefit from the process, and, handled well, it would be beneficial to roll MSF or 360-feedback out across all clinical and other professions in healthcare.

Key to the transformation of individuals’ leadership effectiveness is individuals’ openness to feedback from others as to the effect of their behaviour on them. The use of 360-feedback is crucial in providing rich and relevant data, but the instrument must be based on evidence-based models of what leadership involves, and not on a tool which may seem right (otherwise known as having ‘face validity’) but is not supported by academic research into its validity.

Clinicians, not surprisingly, are more convinced by rigorous data than by merely the exhortation that practices such as 360-feedback can increase their effectiveness – as both colleague and leader. This task is made easier when research data are provided of the impact of leadership on clinical effectiveness (including team effectiveness). A danger is that adoption of a 360-feedback instrument which has not been supported by academic research may increase cynicism, rather than confidence in its use, and not have the positive effect hoped – or worse.

Conclusions

We do not underestimate the importance of competencies (or indeed of targets); they are essential pre-requisites for effective leadership and clinical practice. However, as research has established, simply having practitioners who possess leadership competencies will not result in high quality health outcomes. What healthcare needs is leaders and leadership cultures of performing competencies in an engaging way.

This will enable the best quality outcomes for patients and service users by helping to ensure that teams communicate and interact in such way that it makes the best use of the skills, experiences and ideas of all working together. We now have evidence that an engaging approach to leadership significantly predicts effectiveness of healthcare teams, plus high morale and wellbeing. It seems to us that it is beholden on healthcare organisations to stand by their own proclamations that research evidence should form the basis of best practice in healthcare.

It is also important that organisations scrutinise practices of recruitment, appraisal, development, and performance management in relation to leadership, to enable this to be embedded in the culture. As the Harvard study described above concluded:

“Those responsible for choosing team leaders need to re-think their own approaches … appointing a team leader solely on technical competence … can lead to disaster; we’ve all known superstar technocrats with no interpersonal skills … senior managers need to look beyond technical competence and identify team leaders who can motivate and manage teams of disparate specialists so that they are able to learn the skills and routines needed to succeed”.

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References

8 Alimo-Metcalfe, B and Alban-Metcalfe, J, (2008) Engaging leadership: Creating organisations that maximise the potential of their people, CIPD.