Clinical Leadership in Nursing and Healthcare

Clinical Leadership in Nursing and Healthcare

Values into Action

Edited by David Stanley

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To my mum,
Marj Stanley (1926–)

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Notes on Contributors

Dr Judith Anderson, RN, BN, MHSM, MN, PhD. I have been a registered nurse for more than 20 years working in a variety of clinical, education, research and managerial positions. During this time I have completed a Bachelor of Nursing, Master of Nursing Education, Master of Health Service Management and my PhD, which was focused on change management in a small rural health service. I have been involved in translating research into practice in a variety of settings, including acute care, rural health, aged care and community health in both the public and private sectors. In these roles I have gathered knowledge and experience in implementing evidence-based practice in the clinical setting and currently work at Charles Sturt University as Courses Director.

Sally Carvalho, RGN, BSc (Hons), MSc, PG Cert HE, FHEA, RNT. My nursing career commenced in 1988 at Sandwell District General Hospital, in West Bromwich (UK), where I trained to be, and qualified as, an RGN (Registered General Nurse). As a qualified nurse I predominantly worked in Accident & Emergency (A&E) departments throughout the West Midlands. It was uncommon for nurses to study for degrees back then, but I did and I completed a Bachelor of Science in Nursing Practice and then a Master of Science in Advance Nursing Practice. The Master's degree course was very clinically orientated and it eventually led me to practise clinically in the (then) groundbreaking and clinically autonomous positions of an A&E Advanced Nurse Practitioner and Nurse Consultant. These advanced roles were a significant change in nursing culture at both local and national levels. Confident and effective leadership was required to break down barriers for a nurse to practise clinical skills, which were traditionally the domain of doctors and surgeons, particularly as I also studied and qualified as part of the first group of nurses in the West Midlands to register and practise as a Non-Medical Prescriber. A successful career in A&E also led to visiting lecturing opportunities, to teach within local universities. Eventually I took on the challenge of setting up and heading a clinical nursing team for one of the National Health Service Walk-in Centres. The leadership and management experiences from these roles led me to take a position as a Regional Lead Nurse organising and leading seven teams of nurses for a General Practitioner Out-of-Hours Service across a very large county during what was considered nationally to be a very politically sensitive time within the NHS as a whole. In all of these clinical positions I have maintained teaching links with local universities and eventually made the transition into full-time nurse education as a Senior Lecturer at the University of Worcester in 2005, where I still teach both pre- and post-registration nurses.

Linda Malone, RN, MHM, Grad Dip E Health, Gradt Cert Geront Nurs, Grad Cert Anaes and Rec Room Nurs, BN, Dip App SCi (Nurs), FACHSM, MACN. My nursing journey began in 1985 at a time when nursing training in Australia moved from a hospital-based system into the tertiary education sector. Initially, after completing my original qualification I worked in a variety of clinical

settings in both the public and private sectors, including medical, surgical, aged care, forensic nursing, primary and community healthcare, emergency and critical care and the operating theatre. During this time I worked as a nurse educator and clinical nurse specialist and then moved into nursing administration and management. Having a thirst for knowledge, I also completed a Graduate Certificate in Anaesthetic and Recovery Room Nursing, followed by a Graduate Certificate in Gerontology Nursing, a Graduate Certificate in Health Informatics and then a Master's in Health Management. With over 15 years' experience working at senior health and nursing management levels, I gained expertise in both strategic and operational management, organisational performance development, monitoring and reporting. I have considerable experience in facilitating change and the improvement and development of health services. I have a keen interest in Indigenous health and nursing workforce issues, and I am pursuing this interest by undertaking further studies at PhD level through Charles Sturt University (CSU). My commitment to the nursing profession in my current role as a lecturer at CSU is to facilitate a skilled nurse leader workforce for the future.

Dr Joanna Smith, RGN, RSCN, BSc (Hons), MSc (Hons), PhD. I am a lecturer in children's nursing and am passionate about ensuring that care is evidence based and delivered in a way that fosters effective collaboration and empowerment of the child, young person and family. I have worked in higher education for 15 years, with extensive teaching and learning experiences including curriculum development, programme management, interdisciplinary learning and supervising postgraduate research students. I have over 15 years' clinical experience, primarily caring for children with complex needs requiring surgery, which informs my teaching and research. I qualified as a Registered General Nurse in 1986 and a Registered Children's Nurse in 1987. My academic achievements began while working in clinical practice and culminated in achieving a doctorate in 2011. I am an ardent supporter of promoting and developing research skills among children's nurses and since 1999 have been an active member of the Royal College of Nursing Research in Child Health (RiCH) community, including being the elected chair of the national RiCH community from 2012–15. I am an Associate Editor of *Evidence-Based Nursing* and lead the journal's social media activities as a means of promoting evidence-based practice. I am also an Editorial Board member for the journal *Nursing Children and Young People*. My main research interests relate to the way in which health professionals work with and involve children, young people and their families in decisions about their care, in the context of children with long-term conditions. Although I have used a range of research methods, both quantitative and qualitative, I am particularly skilled in the application of thematic analysis and a framework approach.

Trish Smith, RGN, RSCN, ENB 136 (Renal Nursing), Dip Nursing, BSc (Hons), MSc. I completed my registered sick children's nurse training at Sheffield Children's Hospital in 1985 and worked there for 3 years developing an interest in renal nursing. Having completed a renal nursing course in Leeds, I crossed the Pennines and became the first nurse with both paediatric and renal qualifications to work in the children's dialysis unit at Booth Hall Children's Hospital. Over the last 28 years, based at the Royal Manchester Children's Hospital, I have developed the home-based dialysis service for children within the North West region, training over 400 children and families to manage dialysis within their own home. Advances in dialysis treatment now enable younger and sicker children to receive life-maintaining treatment within their own home with the support of specialist nurses. Having completed my Master's in Nursing in 2009, I have collaborated with colleagues in Manchester and Leeds Universities to undertake research exploring the learning and information needs of children and families with chronic kidney disease. Over the last 10 years, I have also had opportunities, along with

medical colleagues, to develop links with and visit hospitals in Sudan, Nigeria and Uganda. Teaching medical and nursing staff within their own clinical environment and with limited resources has been a challenging but valuable and educational experience.

Dr Karen Stanley, RN, BA, MSc, Post Grad Cert Education, Dip in Counselling, PhD. I am an experienced registered nurse and academic who has worked in the UK, China, Singapore, Perth, Western Australia and at Charles Sturt University in New South Wales. My latest position is within the School of Health at the University of New England in Armidale, also in New South Wales. I have worked collaboratively with a wide range of students and staff, including industry partners, and have provided support, guidance and leadership in relation to teaching, learning and assessment. In addition, I have worked within the Safety and Quality Department for the Department of Health in Perth as a Senior Project Officer. These experiences have enabled me to develop strong interpersonal skills, which I am sure have allowed me to support student and staff empowerment in the quality of their educational experiences. I have worked extensively in classroom environments and clinical education settings and have a keen interest in reflective practice and emotional intelligence. I have also recently completed my PhD, which focused on the importance of building interprofessional relationships within academia. My PhD aimed to promote a more collaborative approach to teaching, learning and research between professionals within higher educational institutions. I am committed to providing student-centred learning, as well as staff development that supports key attributes such as respect, collaboration, sharing good practice and having an appreciation of each other's roles. These are just a few of the qualities identified by professionals within my study that I believe are essential to building effective interdisciplinary relationships with staff and students.

Professor David Stanley, Professor in Nursing, RN, RM, Gerontic Cert, Grad Cert HPE, Dip HE (Nursing), BN, MSc (Health Sciences), NursD. I began my nursing career at the Whyalla and District Hospital, South Australia in 1980. These were the final days of PTS (preliminary training school) training and capping ceremonies and I entered nursing without much thought about its history or future. I completed my training as a Registered Nurse and midwife in South Australia and worked through my formative career in a number of hospitals and clinical environments. In 1993 I completed a Bachelor of Nursing at Flinders University, Adelaide (for which I was awarded the University Medal) and worked for a short time on Thursday Island before volunteering to teach midwifery for a number of years in Africa. Following this wonderful experience, I moved to the UK and worked as the Co-ordinator of Children's Services in York and as a Nurse Practitioner in the Midlands. I completed a Master's of Health Science at Birmingham University and after a short return to Australia, where I worked in Central Australia for Remote Health Services in Alice Springs, I returned to the UK to complete my Nursing Doctorate at Nottingham University in 2005. I undertook research in the area of clinical leadership. While I studied I worked as a Senior Lecturer at University College Worcester (now Worcester University). Returning to Australia in 2006, I worked at a number of universities in Perth and then Charles Sturt University, NSW, before moving to the University of New England in NSW in 2016. I am currently a Professor in Nursing, teaching undergraduate and postgraduate nursing and developing a substantial research profile.

I have had a wide and varied career in clinical roles, senior management positions and as an educator. My career has taken me to a number of countries (Thailand, Singapore, Tanzania, Zimbabwe and the UK) where I have worked in a range of different roles. My professional interests have focused on leadership and management, aged care, the experience of transition to university for first-year nursing students, physical assessment, the experience of men in nursing and the impact the media

has had on the nursing profession. I have also retained a long interest in international nursing issues and support the benefits of nurses and midwives learning more by exploring other parts of the world with clinically focused practice opportunities. I have arranged or been part of a number of international opportunities to the Philippines, Tanzania and Thailand, and have supported other international trips in a number of roles associated with international coordination.

Professor Veronica Swallow, Professor in Child and Family Health, RGN, RSCN, BSc (Hons), MMedSci, PhD. As a Registered Adult Nurse and Registered Sick Children's Nurse, I have worked in Acute Paediatrics in the UK NHS for many years as a Staff Nurse, Sister and Department Manager. I took a nine-year career break when my children were small and moved into academia mid-career, simultaneously as an undergraduate then postgraduate student and as a researcher and teacher. Having completed my PhD in 2006, I now work at the HE/NHS interface teaching undergraduate and postgraduate students about the application of research evidence to practice to promote optimum clinical outcomes for patients, and leading research in child healthcare. My research focuses on the ways in which families and health professionals work together to manage long-term conditions in daily life effectively. I currently lead the development and evaluation of complex, user-led interventions (e.g. web/smartphone apps) to promote optimum healthcare experiences for families and optimum outcomes for patients. I promote and support the active involvement of family members as co-researchers and advisers on my studies to ensure that the research is family relevant. I am a member of INVOLVE, the National Institute of Health Research Advisory Group for patient and public involvement in research, and for many years worked with the National Research Ethics Service. My multidisciplinary, international research includes a range of methods and systematic reviews. I am on the Editorial Board of the *Journal of Pediatric Nursing*. I regularly review grants for leading funders and am an active member of the International Family Nursing Association.

Foreword

In 1993 in my King's Fund–sponsored study and publication *Leading Questions*, I suggested that more attention needed to be paid to leadership training, management development and clinical leadership. It was clear then, and remains evident today, that more research related to nursing leadership and specifically clinical leadership is required. In particular, there is an urgent need to tackle the perceived leadership crisis in nursing and understand the reasons we have a gap between a talent bank of nurse leaders and a chasm in conditions under which leaders can flourish and even feel safe enough to do their job.

Leadership is not just something reserved for a few, an elite. It is within us all and distributed leadership is a vital part of what it takes to make an organisation work and succeed. We are all leaders in our own way, but we need to work in environments where the culture enables our leadership to find a foothold and thrive. This text, *Clinical Leadership in Nursing and Healthcare: Values into Action*, moves in the right direction to address my call for action. Stanley's text is based on five research studies undertaken in the UK and Australia that specifically explore the phenomenon of clinical leadership. Leadership happens at all levels and identifying who the clinical leaders are and attempting to gain an understanding of what clinical leadership means have become vital as the health service responds to the critical threats of the early twenty-first century. To address these threats, this text details what clinical leadership means and how it can be understood. As well, it offers a range of tools to enhance clinical leadership skills and places clinical leadership in the context of the challenges confronting contemporary health systems.

It is timely that clinical leadership is being re-evaluated and frameworks developed that support it, because it is clear that many health professionals have been unable to reconcile their role as leaders with their clinical expertise. Many health professionals have faced the dilemma of having to move further away from the core reason they first became health professionals, resulting in role and values confusion. These two need to work in tandem. Indeed, clinical expertise is the foundation for strong leadership in the health system. Realisation of the value that such expertise brings to the organisation needs to be given voice and made visible by nurses in a context that supports participatory governance. This text underpins an understanding of the vital place clinically focused leaders have in supporting better care, better health services and a greater focus on positive cultures within healthcare organisations.

Recent catastrophes of care and responses to them, in the NHS and across the globe, have signalled the need to foster and embrace values-based leadership as a means of enabling culture change. Stanley's text recognises the critical position that clinical leadership and clinical leaders have in all healthcare disciplines when addressing issues of change, innovation and quality initiatives in the health service. In addition, it supports and proposes a new leadership theory, *congruent leadership*, which links the leaders' values and beliefs firmly with the leaders' actions.

There is little doubt that leadership holds a central place in the facilitation of effective healthcare delivery for all health disciplines and across a wide range of clinical, managerial, educational and research-focused domains. However, it is also clear that getting the culture of care right, building greater responsiveness to patient and client needs and finding ways for clinically focused healthcare providers to develop ways to make care better relies on an understanding and application of clinical leadership. It is front-line, grassroots, clinical-level nurses and other health professionals who hold the keys for healthcare organisations to apply flexible, innovative change.

We need to think of a system of leadership within the organisation, one in which clinical leaders can use their talents and skills, feel these assets are valued and are given the time and space to progress and continually develop those skills in tune with their professional values and beliefs.

Anne Marie Rafferty
Kings' College London
May 2016

Preface

In the first edition of this book, Janelle Boston, an experienced clinician and educator in Perth, Western Australia, offered the following paragraph as part of her contribution:

> In today's rapidly changing clinical environment and ever increasing junior workforce, it is essential to develop and maintain strong nursing leaders who will be able to foster our future nurses for generations to come. As a Clinical Liaison Support Practitioner working with undergraduate nursing students, I believe it is important to lead by example striving for the best possible outcomes in clinical excellence by providing ongoing opportunities for professional growth in learning and development. For me outstanding clinical leaders are experts in their field, who share their passion and knowledge, who motivate and support their team members and provide positive direction no matter how challenging the situation.

I include this again here because I am sure Janelle is on to something and I too feel that it is important to lead by example and support the clinical leaders who are experts in their field, and who share their passion. This book is for them.

The book is the culmination of a considerable effort to understand clinical leadership (and followership) and reflects the authors' personal interest in this topic. The book is primarily based on a number of extensive research projects that considered who clinical leaders are, why they are seen as clinical leaders, what the characteristics of clinical leadership might be and the experience of being a clinical leader. It is also based on my years of involvement in clinical leadership as a senior clinician (nurse practitioner) and an academic, dealing with the issue of clinical leadership from a practical, applied position or as an educator and researcher. In each case my aim has been to try to understand and share my understanding with nurses and other clinically focused health professionals from a range of disciplines.

My interest is also firmly based on my own experience of being a nurse and midwife who can recall rejoicing in the pleasure of working with effective, wonderful and inspiring clinical healthcare leaders. A number of names come easily to mind: Sister Johnson and Paul Fennell, both of whom I had the joy of working with when I was a student and then a registered nurse at the Whyalla and District Hospital in South Australia; Sister Barbra, Sister Helen, Doctor Mike and Doctor Monica, from my days as a volunteer in Zimbabwe at the Murambinda Mission Hospital; and Christina Schwerdt and Penny Rackham from my short stay as an educator on Thursday Island. There are many, many others; but I also recall the depths of facing shift after shift with 'leaders' who were never at the bedside, always at meetings or only showed up on the ward to criticise and ridicule (I won't name any, but sadly their names come quite crisply to mind too).

I was drawn to investigate this topic because of my long association with the nursing profession, and now other health professional disciplines. As well, I have held a long and passionate interest in

nursing and leadership, particularly from the perspective of promoting better healthcare. I have sought to understand and promote greater clinical-level and healthcare empowerment and support the development of insight into clinical leadership that can have positive impacts on the quality of care provided to patients and clients in a plethora of healthcare environments.

Clinical Leadership in Nursing and Healthcare: Values into Action was written for nurses and other healthcare professionals who act principally in direct client/patient care. It will be useful too for students studying health-related courses at undergraduate and postgraduate levels, and for nurses and other healthcare professionals in roles of increasing autonomy, such as nurse practitioners and specialist health providers, health professionals studying leadership (or management) and anyone who wants to maximise their contribution to health care.

The purpose of the text is to motivate and inspire, as well as to offer guidance and support for clinical leaders (or aspiring clinical leaders) to take change and innovation forward and to initiate greater quality in care or therapies and treatments. There are many books about management (and leadership) for nurse managers or healthcare managers and, while their contribution to the health service is great, this book was not necessarily written with these professionals in mind. If you are a manager of some sort and you have this book in your hand now, by all means read on, as I am sure there are lessons and messages in the text for any health professional. However, my hope when I and my fellow authors sat to write *Clinical Leadership in Nursing and Healthcare: Values into Action* was to generate an understanding of leadership for clinical leaders: leaders at the bedside or who remain 'hands on' in their interaction with clients or patients; leaders who might not have the badge, or the title, or the confidence, or the realisation, but who are leaders in the health service nonetheless. These are leaders in the eyes of the people who follow them (their junior colleagues, their senior colleagues, patients or clients, other professionals, students and learners, qualified practitioners or yet-to-be-qualified practitioners), although they might not realise it themselves. These are the key leaders who can and will have a vast impact on the provision of quality healthcare, innovation and change within the health service.

The book presents the information in three parts. First it addresses the topic of clinical leadership and leadership in general. Much of what healthcare professionals know about leadership is based on insights and writings from the management paradigm. The first chapter redresses this by outlining why clinical leadership and quality or innovation are linked. It also discusses what leadership means by describing the theories that underpin what we know about leadership. As well, it describes the difference between leadership and management; looks at the attributes and value of followers; offers a description of the characteristics of clinical leaders; and sets out a new theory of leadership: congruent leadership. This theory, developed from research specifically undertaken with a range of health professionals, is directly relevant for bedside, clinical leaders to gain an understanding about what leadership means.

The second part of the book deals with the 'tools' for developing effective clinical leadership skills and insights. Chapters in this part offer information about organisational culture, managing change, decision making, team working, reflection, creativity, motivation and inspiration, networking, delegation, how to deal effectively with conflict, the relevance of quality initiatives and project management for clinical leaders and the use of evidence-based practice. These topics are all provided so that clinical leaders can orchestrate successful change and innovation and lead effective quality initiatives.

The final part of the book addresses issues that put clinical leadership into context. The topics relate to gender, generational groups, power, politics, empowerment, oppression and how clinical leaders can (using a *congruent leadership* style) have positive impacts on the quality of healthcare and lead their patients or clients, colleagues, team mates, co-workers, organisation and the heath service in general towards a better tomorrow.

David Stanley

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I should like to thank all the students who have taken part in the clinical leadership courses and subjects I have been involved with in the UK, Singapore and Australia. Your enthusiasm and commitment to learning and improving care and clinical services have been an inspiration to me. I also thank all the paramedics, allied health professionals, ambulance volunteers and nurses who have contributed to my understanding of clinical leadership by willingly contributing to the five research studies that underpin this book.

I should also like to thank my educator colleagues who (over many years) have supported me and contributed their ideas, time and talents to the delivery of clinical leadership education: Jane Bahen (Australia), Alexandra Barnes (UK), Fiona Foxall (Australia), Helen Jones (UK), Karen Latimer (Stanley) (UK and Australia), Lina Ma (Singapore), Maria McNamee (UK), David Wall (Australia), Pippa Wharton (Australia) and I am sure there are others. I should also like to thank Phil Della, Janelle Boston and Rosealie Southwell for their contributions to the Foreword in the first edition of this book, and in particular Pippa Wharton and Fiona Foxall, who contributed chapters to the first version of the text: *Clinical Leadership: Innovation into Action* (2011).

Thank you too to Professor Anne Marie Rafferty for eagerly contributing the foreword and for supporting the direction taken with this book. I had heard of Professor Rafferty long before I met her. Her academic writing on leadership and research had significantly influenced my interest in healthcare-focused leadership and nursing scholarship. I first met her at the end of 2004 when she and others undertook to assess my doctoral thesis at Nottingham University. Her leading position in the world of nursing in the UK and her undoubted reputation as one of the most articulate and clear-thinking academics alive today promoted me to ask her to offer the foreword for this book. I am grateful and thankful that she accepted.

A special thank-you is extended to Stephen Stanley (my brother) for contributing the wonderful cartoons and illustrations used throughout the book. In Australia, Stephen is a nationally recognised cartoonist and it was a delight that he agreed to support this book with his talents and time.

Karen Stanley (my wife) deserves a second mention for proofreading the draft chapters and for her encouragement, support and understanding throughout the writing and development process.

The book could not have been developed without the initial support of Palgrave Macmillan and, although it was a shame they were unable to progress with the second edition, the book started with them and for this I am very grateful.

James Watson from Wiley took the submission forward and had the managers there take on the book's production. I am deeply indebted to the book production and procurement department at Wiley for their faith and support. In addition, Thaatcher Missier Glen for initial editorial support and Eswari Maruthu, the production editor, and the other editorial team members are to be thanked for

their wonderful work on editing the book on behalf of Wiley. particularly Sally Osborn, who undertook the final and most detailed edit to really bring polish to the text.

I should also like to thank the chapter contributors: Linda Malone, Judith Anderson and Karen Stanley from Australia, and Sally Carvalho, Veronica Swallow, Joanna Smith and Trish Smith from the UK. Each provided their respective chapters on time and with due care over the content. I could not have completed the book on time without their support and able advice. I should like to add that Fiona Foxall had planned to contribute again, but was unable to do so because of family issues. My condolences and best wishes go to Fiona during what has been a difficult and sad past year.

In the first edition, *Clinical Leadership: Innovation into Action* (2011), I neglected to acknowledge my doctoral supervisors Karen Cox and Linda Ellison (both from Nottingham University) and hope they will forgive this oversight. Karen Cox was an inspirational supervisor who prompted me to look beyond the end of my doctoral studies and keep asking the 'so what?' question, and Linda offered sound doctoral advice from an educational perspective that I found invaluable.

There are many others who have in many ways added to the completion of this project. Colleagues have offered support and encouragement, and undergraduate and postgraduate students have kept me keenly interested in the topic of clinical leadership. They have all fuelled my desire to do my best for them and remind me always that at the core of our learning is the client, patient, healthcare consumer – or person. Thank you all.

It is not only giants that do great things.

David Stanley
July 2016

Part I

Clinical Leaders: Role Models for Values into Action

Nothing in life is to be feared. It is only to be understood.
Marie Curie, Polish-born French physicist and chemist, famous for her work on radioactivity, first recipient of two Nobel prizes, first female professor, University of Paris

Clinical Leadership in Nursing and Healthcare: Values into Action suggests that clinically focused leadership or clinical leadership and administration-based or managerial leadership are not the same thing. The case for this view is set out in this first part of the book.

To support this statement, the book outlines a number of principles, frameworks, tools and topics describing how nurses and other health professionals can develop, lead and deliver effective clinical care – as clinical leaders, not as managers or as administrative leaders in the academic, political or managerial sphere. It also outlines a new theory of leadership, **congruent leadership**, which has been developed from a number of research studies exploring the nature and characteristics of clinical leadership from a wide range of different health professional disciplines, in the UK and Australia.

Congruent leadership theory suggests that leaders demonstrate a match (congruence) between the leader's values and beliefs and their actions. As such, clinically focused nurses and a range of other health professionals have moved decisively and clearly in the direction of their values and beliefs and can be seen expressing congruent leadership. They may simply have stood by their values, working not because they wanted to change the world, but because they knew that what they were doing was the right thing to do and that their actions were making a difference, if only in the life of one person.

It is timely that clinical leadership is being re-evaluated and frameworks developed that support it (Stanton, Lemer & Mountford 2010; Swanwick & McKimm 2011; Martin & Learmonth 2012; Mannix, Wilkes & Daly 2013; Storey & Holti 2013; Scully 2014; McLellan 2015; Rose 2015; West et al. 2015; Bender 2016), because it is clear that in attempting to climb the career ladder, many health professionals have faced the dilemma of having to move further away from the core reason they first became health professionals, resulting in role confusion and blurring of values (Stanley 2006c). Many have had to move into management or administrative positions or academic roles and leave their clinical roles further behind with each promotion. However, if leadership happens at all levels (Cook 2001; Stanley 2006a, b, 2008, 2011; Swanwick & McKimm 2011; Higgins et al. 2014), identifying who the clinical leaders are and attempting to gain an understanding of what clinical leadership means becomes vital.

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The first part of this book comprises five chapters. Chapter 1 deals with an exploration of the concept of clinical leadership. It explores the attributes of effective clinical leaders and outlines the rationale behind these attributes, then discusses why an understanding of clinical leadership matters now. The chapter considers what clinical leadership is and who clinical leaders are. Could a therapy team leader, who is busy telephoning staffing agencies in order to find staff to fill vacancies for a busy clinic, be the clinical leader? Could it be a nurse consultant, paramedic lead or nurse practitioner who is in the process of initiating a reform of clinically based practice on a recent research project? Could a healthcare assistant or physiotherapy aid who, day in and day out, has cared for sick and frail medical patients on a busy orthopaedic rehabilitation ward be the clinical leader? Could the bright-eyed, newly qualified occupational therapist who approaches work with enthusiasm and the hope that they are making a difference to people's lives on a busy rehabilitation day-case unit? Could it be the junior registered nurse who remains focused on essential bedside care and refuses to become drawn into the ward management issues? Or is the manager the clinical leader, as they keep staff focused on issues of quality, cleanliness and care?

Reflection Point

There are 'Reflection Points' throughout this book. These are to encourage you to pause and reflect on the topic or issues being discussed.

Start the book by pausing to reflect on who you think the clinical leaders are in your clinical area or practice location. Imagine that a relative or friend is ill and requires care in the clinical area you work in. Who are the people you would point to as clinical leaders? Who would confidently care for and lead the care for your relative or friend? What are your thoughts? Could it be any or all of the people described earlier?

Chapter 2 offers an introduction to the various definitions and styles of leadership. A spectrum of perspectives are presented to help health professionals get to grips with the concept of leadership. It is suggested that there are a wide range of views, beliefs and ideas about what leadership means, what types of leadership there are and how the types of leadership might be employed to build relationships, communicate more effectively, promote vision or values and bring about change or innovation.

Chapter 3 offers an insight into the important and often overlooked concept of followership. The concept of followership is defined, and followers' responsibilities and the attributes of effective and not so effective followers are explored.

Chapter 4 offers an insight into congruent leadership theory (Stanley 2006a, b, 2008, 2011, 2014). This theory of leadership was developed specifically from research exploring clinically focused leadership as it relates to health professionals, which is outlined in this chapter. Congruent leadership is promoted in this book as a valuable way to gain an understanding of how clinical leaders lead and why clinical leaders are seen as leaders. Examples of clinical leadership applied to congruent leadership are offered, as is a discussion about the strengths and limitations of the theory. Moreover, the relationship of congruent leadership to change, innovation, power and quality is considered.

Chapter 5 offers a discussion of the difference between management and leadership, suggesting that managers and leaders are driven and governed by a different set of values and beliefs, goals and objectives. The differences between management and leadership outlined here make it clear that

while a manager may be an effective leader and a leader may be an effective manager, their diverse drives, motivators and objectives may in fact make it very difficult for one professional to hold both sets of responsibilities successfully. Most significantly, the differences may be most evident in relation to the values that drive clinically focused health professionals, therefore attempting to combine these different roles may lead to internal conflict and ineffective care (Stanley 2006c, 2011).

So Part I aims to explore clinical leadership, leadership theory, followership, congruent leadership and the difference between leadership and management. It will outline the characteristics, qualities and attributes of clinically focused leaders and help identify what they are, as well as what a health professional might look for to become a clinical leader.

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1

Clinical Leadership Explored

David Stanley

> *Find people who share your values, and you'll conquer the world together.*
> John Ratzenberger, author of *We've Got It Made in America*

Introduction

Jesse Jackson, the American political and civil rights leader, has said: 'Change isn't about processes or structure. It is about courageous people who are prepared to act.' This book is about people in the health service who are courageous and prepared to act. For me, these are clinical leaders: women and men, across the spectrum of the health service, who explore the boundaries of their practice and who press for continual improvements in quality care, increased innovation and productive changes in practice. They are leaders because they put their values into action. Others see this and follow, because they hold or aspire to the same values and beliefs.

While nursing leadership and healthcare leadership are terms that have been evident in the nursing and health industry literature for many decades, clinical leadership is a relatively new term. However, what do we know about the concept of clinical leadership and what does the term mean? This chapter sets out to explore definitions of clinical leadership, the attributes of effective clinical leaders, and attributes less likely to be associated with clinical leadership. It will also consider who clinical leaders might be, and outline the implications for health organisations when understanding and recognising clinical leaders. It suggests that if an organisation – or indeed the health service as a whole – is to adapt and develop, there is an urgent need to identify who the clinical leaders are and to understand how they see themselves or are recognised by others (Mountford & Webb 2009; Jeon 2011; Storey & Holti 2013a; Bender 2016).

Clinical Leadership: What Do We Know?

Attempts to define clinical leadership, like insights into the concept, are relatively new. There were early contributions from Peach (1995) and Lett (2002), both from an Australian perspective, and US authors Dean-Baar (1998), McCormack and Hopkins (1995) and Rocchiccioli and Tilbury (1998) added to the dialogue. Berwick (1994) and Wyatt (1995) from a medical perspective, Forest, Taichman

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and Inglehart (2013) from a dentistry perspective and Schneider (1999) from a pharmacological standpoint have also added to the discussion. Most recently and also from a medical perspective, Stanton, Lemer and Mountford (2010), Swanwick and McKimm (2011) and Storey and Holti (2013a) have offered a summary of what clinical leadership may mean. However, in spite of this growing body of literature, a clear definition remains elusive (Mannix, Wilkes & Daly 2013; Jeon et al. 2015). Fortunately, more literature is evident each year that addresses Malby's (1997) suggestion that there has been limited agreement on a definition of clinical leadership.

Harper (1995) offered one of the earliest definitions, suggesting that a clinical leader possesses clinical expertise in a specialist practice area and uses interpersonal skills to enable nurses and other healthcare providers to deliver quality patient care. McCormack and Hopkins (1995), Cook (2001b) and Lett (2002) support Harper's view, suggesting that clinical leadership can be described as the work of clinicians who practise at an expert level and who have or hold a leadership position.

Rocchiccioli and Tilbury (1998), writing from a nursing perspective, also cite excellence in clinical practice, but add that it also involves an environment where staff are empowered and where there is a vision for the future. Lett (2002) and Swanwick and McKimm (2011) suggest that a clinical leader is a clinical expert who leads their followers to better healthcare by providing a vision to those followers and so empowering them. Expert practice and a positive impact on quality patient care again feature, but each also links clinical leadership with vision, and this is at odds with the research results that support this book (Stanley 2006a, b, 2008, 2011, 2014; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015). These publications suggest that clinical leadership and vision are seldom directly linked. Instead, clinical leaders are more likely to be followed because they match their values and beliefs with their actions in clinical practice; a perspective elaborated on in Chapter 4.

Stanton, Lemer and Mountford (2010, p. 5) offer the view that anyone who is in a clinical role and who exercises leadership is a clinical leader, before suggesting that a clinical leader's role is to 'empower clinicians to have the confidence and capability to continually improve health care on both the small and the large scale'. The UK Department of Health's (2007) definition is that the role of a clinical leader is:

> To motivate, to inspire, to promote the values of the NHS, to empower and create a consistent focus on the needs of patients being served. Leadership is necessary not just to maintain high standards of care, but to transform services to achieve even higher levels of excellence.
>
> *(DoH 2007, p. 49)*

Bender (2016) recently attempted to develop a theoretical understanding of clinical nurse leader practice and suggested that the core attributes of clinical nurse leaders rest on links to clinical practice, effective communication, effective interprofessional relationships, team working and supporting other staff.

Clark (2008) and Cook (2001a) suggest that clinical leaders are in non-hierarchical positions, with Cook adding that clinical nurse leaders are directly involved in providing clinical care that continually improves care through influencing others, with Cook and Holt (2000) supporting this perspective. Clinical nurse leaders also have a relationship with quality patient care and are able to influence others, implying perhaps that they may not need to be in positions of power or those that are hierarchically significant to lead in the clinical arena. The research that supports this book bolsters such views. These authors also imply that clinical leaders must be good communicators, and that they need effective team-building skills and respect for others.

The *McKinsey Quarterly* definition of clinical leadership is one that I particularly like (cited in Stanton, Lemer & Mountford 2010):

> Clinical leadership is putting the clinician at the heart of shaping and running clinical services, so as to deliver excellent outcomes for patients and population, not as a one-off task or project, but as a core part of clinicians' professional identity.

In addition, the literature I have discovered points to a number of key elements in the recognition of clinical leadership:

- **Clinical expertise** (Berwick 1994; Harper 1995; Rocchiccioli & Tilbury 1998; Schneider 1999; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Stanton, Lemer & Mountford 2010; Swanwick & McKimm 2011; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015; Bender 2016).
- **Effective communication and interpersonal skills** (Harper 1995; Cook & Holt 2000; Cook 2001b; Stanley 2006a, b, 2008, 2011, 2014; Swanwick & McKimm 2011; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015; Jeon et al. 2015; Bender 2016).
- **Empowerment and respect for others** (Rocchiccoli & Tilbury 1998; Cook & Holt 2000; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Stanton, Lamer & Mountford 2010; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015; Bender 2016).
- **Team working or team building** (Rocchiccoli & Tilbury 1998; Cook & Holt 2000; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Stanton, Lamer & Mountford 2010; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015; Bender 2016).
- **Drive change, make care better and provide quality care** (Berwick 1994; Harper 1995; Schneider 1999; Cook 2001b; Lett 2002; Stanley 2006a, 2006b, 2008, 2011, 2014; Ferguson et al. 2007; Clark 2008; Stanton, Lamer & Mountford 2010; Swanwick & McKimm 2011; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Byers 2015; Demeh & Rosengren 2015; Stanley, Hutton & McDonald 2015).
- **Vision** (Rocchiccoli & Tilbury 1998; Cook & Holt 2000; Lett 2002; Clark 2008; Swanwick & McKimm 2011).

However, it is my contention that there is much more to understanding clinical leadership than these definitions and views.

Reflection Point
Look around the area where you work. Who would you identify as a clinical leader? Why would you select this person or people? How does your choice of clinical leader fit with the definitions already offered in this chapter?

Attributes Less Likely to be Seen in Clinical Leaders

Not Controlling

Being viewed as 'controlling' was consistently seen as less likely to be associated with the qualities of a clinical leader. Table 1.1 indicates emphatically that in the five research studies that support this book (for more on these see Chapter 4), being 'controlling' was always the attribute identified as least

Table 1.1 'Being controlling': The characteristic least commonly associated with clinical leaders.

Percentage of respondents who identified *controlling* as the attribute least likely to be linked to clinical leadership	**Study 1**	**Study 2**	**Study 3**	**Study 4**	**Study 5**
	Nurses	Paramedics	Residential care staff	Volunteer ambulance officers	Allied health professionals
	78%	84%	80%	84%	83%

Table 1.2 'Being visionary' as associated with clinical leadership.

Percentage of respondents who identified *visionary* as an attribute likely to be linked to clinical leadership	**Study 1**	**Study 2**	**Study 3**	**Study 4**	**Study 5**
	Nurses	Paramedics	Residential care staff	Volunteer ambulance officers	Allied health professionals
	72% Ranking 27th out of 42	51% Ranking 37th out of 54	20% Ranking 33rd out of 54	40.9% Ranking 38th out of 54	34.2% Ranking 36th out of 54

likely to be linked to clinical leadership. Moreover, the percentages are remarkably similar across a range of professional disciplines, cementing a disassociation between being controlling and clinical leadership.

Not Visionary

'Being visionary' was also poorly associated with clinical leadership. As with Cook's (2001a) study, having a vision or articulating a vision appeared to be unrelated and unrecognisable as a dominant feature of the qualities and characteristics for which clinical leaders were recognised.

In Study 1 the term 'visionary' was identified by 72.3% of respondents as affiliated with clinical leadership, although even with this percentage it was ranked 27th on a list of 42 words to describe the qualities and characteristics most associated with clinical leadership. In each of the five studies, being visionary or having a vision failed to be rated highly in terms of a percentage factor, or as an attribute of clinical leadership. Table 1.2 offers data from all five studies to support this view. Interestingly, the percentages seemed to drop as the studies progressed in time (from 72% with nurses in 2005 to 34.2% with allied health professionals in 2015).

These results question the significance of 'vision' or 'being visionary' as a quality or characteristic sought or seen in clinical leaders. In each of the studies, respondents were invited to list their own attributes of clinical leaders and, as such, many additional attributes were offered. However, very few related to 'vision', 'being visionary' or 'being forward thinking' (Stanley 2006a, b, 2008, 2011, 2014; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015). The lack of characteristics centred around clinical leaders being visionary was borne out by the results of the interviews or free-text comments, where 'vision' was hardly mentioned as an attribute looked for in clinical leaders, and rarely described as the motivation behind being a clinical leader.

This may be because respondents were drawn to or identify with clinical leaders who can lead them through the 'here and now' issues of busy and chaotic clinical work – who can cope with the

Table 1.3 'Creative/innovative' and 'artistic' as associated with clinical leadership.

	Study 1	**Study 2**	**Study 3**	**Study 4**	**Study 5**
Percentage of respondents who identified *creative/innovative* as an attribute likely to be linked to clinical leadership	Nurses	Paramedics	Residential care staff	Volunteer ambulance officers	Allied health professionals
	76.5% Ranking 25th out of 42	51% Ranking 32nd out of 54	60% Ranking 27th out of 54	59.0% Ranking 27th out of 54	56% Ranking 22nd out of 54
Percentage of respondents who identified *artistic* as an attribute likely to be linked to clinical leadership	13% Ranking 41st out of 42	24% Ranking 50th out of 54	0% Ranking 54th out of 54	42.5% Ranking 48th out of 54	8.5% Ranking 50th out of 54

demands of each day as it comes, rather than postulate and pontificate about how things could or should be. Clinical leaders were seen and selected if they had their values on show and stood on a solid foundation of care and compassion that governed and drove their practice standards. Clinical leadership is therefore defined in action, as clinical leaders mobilise their values and beliefs to guide and direct what they do when faced with challenges and critical problems in the clinical area (Clark 2008; Stanley 2006a, b, 2008, 2011, 2014; Edmondstone 2009; Stanley, Cuthbertson & Latimer 2012; Forest et al. 2013; Stanley, Latimer & Atkinson 2014; Scully 2014; McLellan 2015; Stanley, Hutton & McDonald 2015).

Not Shapers

Cook (2001a) saw clinical leaders as 'creative', identifying the typology of 'shapers' to describe them (see later in this chapter). In each of the five research studies that influence this book, creativity was rarely identified as a defining characteristic of a clinical leader. As indicated in Table 1.3, being 'creative/innovative' or 'artistic' was seldom ranked highly on the clinical leader attribute list.

Artistic was ranked second only to 'controlling' as the characteristic least associated with clinical leadership in the first study among nurses and was continually ranked near the end of the order in all the other studies. Higher percentages of respondents did still consider being 'creative/innovative' a feature of clinical leadership. However, this failed to be as strongly associated with clinical leadership as other attributes, and in interviews with clinical leaders or in other data sources, creativity and innovation were seldom expressed as an attribute worthy of note (Stanley 2006a, b, 2008, 2011, 2014; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015).

I have struggled with this aspect of the results since my initial publications. Rolfe (2006), who wrote a commentary on the 2006 article (Stanley 2006b), was likewise unsure of the validity of the results, given that creativity was ranked so low. However, this feature of the results has been confirmed again and again with each subsequent study (see Table 1.3). I am sure that some clinical leaders are creative and that being creative is a substantial skill for clinical leaders to employ, but I am now sure that being creative is not something that others look for in their clinical leaders. Creativity does remain a key attribute that clinical leaders should aspire to, and it is of particular relevance if clinical leaders are to influence innovation or change or to find new ways to bring their values into practice. Chapter 9 elaborates on the issue of creativity and identifies a number of strategies that clinical leaders can employ to bolster their creative capacity.

Attributes More Likely to be Seen in Clinical Leaders

While the previous section has focused on the attributes less likely to be recognised in clinical leaders (control, vision and creativity), this section addresses the attributes that the five research studies, and others, have identified as being directly linked to clinical leaders.

Cook attempted to identify the attributes of effective clinical leaders by focusing not on nurses at the 'hierarchical apex of the organisation … but on those nurses that directly deliver nursing care' (2001a, p. 33). His study focused on nurses who were not deemed to be in conventional nursing leadership positions, but who displayed many of the attributes of highly effective leaders. Following his data analysis, he produced a table that set out the clinical leaders' attributes – described as 'typologies' – with associated constraining and facilitating factors related to each attribute.

Cook (2001a) recognised clinical leaders or 'discoverers', who had a desire to improve the care they provided, and 'valuers', who valued both themselves and those around them and were able to empathise with their colleagues and patients. 'Enablers' encouraged others to see what needed to be done and assisted them to do it; 'shapers' possessed the 'creativity' to generate new ways of working and were able to help others make decisions; and 'modifiers' supported and helped others with the process of change. Cook indicates that his 'research identified aspects of leadership that are unique to clinical nursing' (2001a, p. 36), but suggested that further research was required to identify these with confidence.

Many clinical leadership attributes were identified in the five research studies (Table 1.4), although ten were most prominent. Many are also interrelated and interdependent, so it would be unusual if a clinical leader who was considered clinically competent and clinically knowledgeable was not also seen as a role model in their clinical area. However, each of these attributes has been singled out and will be explored separately as a way of establishing a complete map of a clinical leader's attributes.

Table 1.4 Attributes most likely to be associated with clinical leadership.

	Study 1	**Study 2**	**Study 3**	**Study 4**	**Study 5**
Attributes	**Nurses**	**Paramedics**	**Residential care staff**	**Volunteer ambulance officers**	**Allied health professionals**
Clinical competence	95.2%	96.2%	100%	90.1%	83.7%
Approachable	97.3%	96.2%	100%	90.1%	83.1%
Empowered, motivated/ motivator	94.1%	86.5%	80%	77.0%	72.6%
Supportive	94.1%	91.3%	100%	77.0%	75.2%
Inspires confidence	93.0%	85.6%	40%	85.2%	52.1%
Has integrity/is honest	87.2%	93.3%	100%	78.6%	83.1%
Role model for others	Not covered in this study	93.3%	80%	88.5%	79.8%
An effective communicator	Not covered in this study	89.4%	100%	86.8%	88.3%
Visible in practice	85.6%	85.6%	100%	65.6%	55.0%
Copes well with change	90.9%	79.8%	100%	73.7%	76.9%

Clinical Competence/Clinical Knowledge

One of the key elements of clinical leadership relates to the clinical leader's ability to remain credible and competent in the provision of clinical care. High numbers of participants in all five studies, as well as information from Jonas, McCay and Keogh (2011), Mannix, Wilkes and Daly (2013), McDonnell et al. (2015) and Bender (2016), supported this perspective. Clinical leadership appears to be firmly embedded in the domain of clinical activity. Clinical competence was clearly linked to clinical experience and the confidence that others saw in the clinical leader's ability. It meant being able to show or to do – as well as to know or to teach others about – clinical issues. Interestingly, being an 'expert' in their clinical field was not specifically mentioned, although this was a central feature of the characteristics identified by Cook (2001a) and by Berwick (1994), Stanton, Lemer and Mountford (2010) and Schneider (1999) in relation to clinical leadership from a medical, pharmacological and nursing perspective, respectively.

Clinical leaders were identified as clinically competent – that is, as credible in their clinical field and working in a 'hands-on' capacity (Stanley 2006a, b, 2008, 2011, 2014; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015) – and were therefore recognisable because they possessed a set of knowledge that was specific to their clinical field. While this knowledge base may extend into a broad range of topics or areas, clinical leaders were often identified because they knew, and could do well, the 'stuff' central to their clinical area and practice.

One nurse said, 'You've got to be knowledgeable, but you've also got to have knowledge that's applicable to the area that you work in.' Effective clinical leadership rested on sound clinical knowledge that extended into having knowledge not just about clinical issues, but knowing how teams worked, how individuals worked and about relationships between people. One study respondent said that it was about being 'aware of people's limitations … aware of who works well together, who needs a lot of support and who doesn't. Who needs time effectively on their own and who doesn't and who needs continual prompting and back up.'

Approachability

Approachability was rated very highly as a clinical leader attribute. This was exemplified by an allied health professional who described a clinical leader as one who is 'supportive, fair, reasonable, willing to change, understanding and approachable'. Ineffective clinical leaders were described as being 'basically dictators', while effective clinical leaders had a more relaxed approach and saw staff as 'equal in their own right'. Poor clinical leaders were described as being 'bossy, they try to control things, they make changes without talking to people and they don't listen', while many respondents reacted well when a clinical leader 'valued' them, or made 'staff feel they were there for them', or when clinical leaders were 'approachable, friendly and understanding'. These views were supported by Cook (2001a), Clark (2008), Edmondstone (2009), Mannix, Wilkes and Daly (2013) and Bender (2016).

Empowered/Motivator or Motivated

Clinical leaders and front-line professionals were identified because they were confident, a view supported by Van Dyk, Siedlecki and Fitzpatrick (2016), or because of their enthusiasm and their ability to make others feel confident. Clinical leaders were motivated and able to motivate others because they showed

> belief in what you're doing … because I know people who are higher, you know a higher level than me are not necessarily good leaders … they're not … they don't necessarily have any belief in what they're doing.

Clinical leadership was seen to be about empowering people to perform better, deal with quality care (Jonas, McCay & Keogh 2011) and sow the seeds to let others take the lead.

Supportiveness

Being supportive was linked to being approachable, with a high number of respondents suggesting that effective clinical leaders needed to support others in their team. This attribute was also identified as important by Mannix, Wilkes and Daly (2013) and Bender (2016), who saw support as a central role of building and sustaining effective teams.

Inspires Confidence

Linked to being motivational, inspiring confidence was suggested by a large number of respondents as central to the attributes of clinical leaders. In support of this view, an allied health professional suggested that a clinical leader is one whom 'others view as the best example of excellent performance and that motivates others to grow and succeed'.

Integrity/Honesty

Being honest and having integrity are linked to attributes of approachability and being supportive. Being seen as honest was consistently rated highly as a clinical leader attribute. Edmondstone (2009) added that clinical leaders needed to enjoy the trust and respect of their colleagues to be successful. One allied health professional described an ideal clinical leader by saying 'they should not be a bully and have clear understanding of people's roles and responsibilities', they should have 'integrity, be honest and be transparent'.

Role Model

In addition to clinical competence and clinical knowledge, clinical leaders were also identifiable because – unlike managers and, to a lesser extent, leaders – in general respondents viewed them as role models (Watson 2008). Clinical leaders had their standards of practice on show and others indicated that it was the ability of a health professional to care effectively for their patients or clients that made them stand out as a clinical leader. One respondent indicated that being a good clinical leader meant 'being a good role model, making sure that your practice is evidence-based, that you pick up on poor standards of care and you pick up on problems and identify them'. Another added, 'a good manager may not lead by example, whereas a good clinical leader would'. Clinical leaders were seen as 'someone you would look up to', 'people that have been inspirational or people you've thought, "oh that's what I really want to be like"'. These views were supported by Cook (2001a), Watson (2008), Mannix, Wilkes and Daly (2013) and Bender (2016).

Effective Communicator

High numbers of study respondents and information from Cook (2001a), Clark (2008), Edmondstone (2009), Jonas, McCay and Keogh (2011), Mannix, Wilkes and Daly (2013) and Bender (2016) indicate that a central attribute of clinical leadership is effective communication. This meant that clinical leaders needed to be 'extremely good at explaining things at the right level that you understand', as one study respondent said. Clinical leaders were also respected if they listened and effective communication was fundamental if clinical leaders – who were not managers or titled leaders – were to influence their colleagues. One respondent indicated that 'the ward manager has

got the title and therefore they manage and are seen to be leaders because of the title, but there are other people that lead by virtue of their opinion'.

Visible in Practice

Although this was less evident than some of the other attributes, in order to be an effective role model clinical leaders needed to be visible, available and present. One respondent indicated:

> If you want information, or if you want the best way to do something on the ward at that moment you're not going to get, or you don't have time to go looking for matron or phoning the nurse consultant, who's maybe in the middle of a clinic and can't come up until …
>
> *Because they're not around?*
>
> … because they're not around. I want somebody right there on the ward.
>
> *So, is being a clinical leader about being visible and present?*
>
> I think it does help to have leadership on the ward, that is visible … I think you need clinical leaders on the ward where they can be utilised and their knowledge shared and lead from the front.

Another respondent supported this view: 'to lead it is very, very difficult, very time-consuming and exhausting and I think you have to … give of yourself, and that's why you have to be visible'. Clark (2008) agrees and adds that visibility means that clinical leaders were present in the clinical area: not just that they were there, but that they were engaged and involved. When another respondent said of a colleague that she was 'an ideal clinical leader' because 'she is very visible', it captured all the characteristics and attributes discussed here. Visibility implied clinical competence, clinical

knowledge, effective communication, support, empowerment and motivation, being open and approachable and acting as a role model. Not being visible, or being unable to be involved in patient/client care activity, was seen by some respondents to place the person in a difficult position, or one that weakened their clinical leadership potential or clinical credibility.

Copes Well with Change

Finally, clinical leaders were also identified as being able to cope well with change, a view supported by Mannix, Wilkes and Daly (2013). Dealing well with change is recognised as a key attribute in the modern health service and is one that is valued in clinical leaders.

Other Attributes

Over the years I have shared my views on clinical nurse leadership attributes and found considerable support for the characteristics I offered. However, I have always been keen to explore further attributes. After many discussions to solicit further views and based on my own and others' research, the following attributes are also worthy of consideration:

- courage
- ability to make decisions
- ability to offer direction
- sense of humour
- persistence and determination
- dynamism/energy
- calmness
- positivity
- empathy
- change facilitation
- passion

These additional characteristics enhance an understanding of clinical leadership and can be seen to add a further perspective to the characteristics and attributes required to grasp what makes an effective clinical leader.

Values: The Glue that Binds

Values can be described as deeply held views that act as guiding principles for individuals and organisations (Pendleton & King 2002; Clark 2008; Gentile 2010). When they are stated and made explicit – or even if they are inferred from observable behaviour, then followed – they form the basis of trust in any relationship; and if values are stated or shown and not followed, then trust can be harmed. Values also relate to where individuals or organisations stand on a range of issues and point towards actions or statements that reflect what is important to that person or organisation.

Antrobus and Kitson (1999, p. 750) identified 'understanding self and having a clear understanding of values, purpose and personal meaning' as part of the skills repertoire that they identified for effective nurse leaders. Cook (2001a) also saw clinical nurse leaders as 'valuers' who empathised with others and who tried to gauge their own and others' feelings. However, in the data from the research for this book, clinical leaders described themselves as being driven by their values and 'passion' for

high-quality patient care. Ultimately, holding and demonstrating values and beliefs emerged as a strong attribute of clinically focused leaders, with clinical leaders being identified if they were seen to demonstrate their values or had their values on show. Therefore they were followed not because they had control, or for their vision and creativity (although they may have had these attributes), but because their values and beliefs were the driving force behind their ability to engage in critical problems and face the challenges of clinical care.

Being creative and having a vision remain central to the successful application of transformational leadership (Frankel 2008; Marriner-Tomey 2009), although they appeared not to be features for which clinical leaders are recognised (Stanley 2006a, b, 2008, 2011, 2014; Stanley, Cuthbertson & Latimer 2012; Scully 2014; Stanley, Latimer & Atkinson 2014; McLellan 2015; Stanley, Hutton & McDonald 2015). There is a view that values are inextricable from vision, although Pendleton and King (2002) declare that it may be even more important to know where you stand (a values-centred position) rather than where you are going (pertaining to vision). This implies that values are rooted in understanding an individual's and organisation's principles, while vision is about being able to drive through or respond to changes in the future.

Clinical leaders are identifiable because of where they stand and how they behave when dealing with patients and colleagues. When facing challenges in the clinical arena, they are recognisable because they display their principles about the quality of care and they deal with patients in a 'hands-on' fashion, living out their values in the actions of clinical care. They stand apart from novice clinicians, poor decision makers, staff who are 'hidebound', managers who are tied up with other functions and those who are less visible in the clinical environment. They may be experts in their clinical field, but they are recognised not necessarily because of their expert practice, but because when faced with challenges and critical problems their actions are directed, and their leadership is defined, by the values and beliefs that they hold about care, healthcare and respect for others.

Who are the Clinical Leaders?

In the past, leadership studies were very much focused on leadership at the high end of the organisational hierarchy, shining a light on the academic, political and management domains (Antrobus & Kitson 1999). The proliferation of these studies and literature has to some extent overshadowed leadership by others, at other levels of the health service, although this trend has slowed and the lack been redressed in recent years. Indeed, as a nurse practitioner in the late 1990s, it was the lack of appropriate literature or studies about clinical-level leadership that spurred me on to my own research journey in the topic of clinical leadership. It is now clear that leadership is everyone's business (Ogawa & Bossert 1995; Cook 2001a; Jonas, McCay & Keogh 2011; Higgins et al. 2014). Because clinical-level leaders are central to the provision of healthcare, they have found themselves more and more the focus of leadership studies and the recipients of leadership education. Burns (2001) supports these views and believes that in a chaotic healthcare environment, front-line leaders are not only required at all levels, they may understand the environment's complexities even more than executive leaders removed from direct operations.

The success and appeal of television programmes like *Undercover Boss* support this view, and demonstrate the value of understanding the workplace from a front-line staff perspective, what Mintzberg (1983) calls the 'operating core' of a healthcare organisation. However, clinical leadership has historically been less valued than senior management and, as such, health service management has dominated the leadership debate in health to the detriment of clinical, bedside or front-line leadership. Clark (2008, p. 30) suggests that organisations should be tapping into 'the leadership skills and potential of all front line staff to deliver high-quality, safe and effective care to patients and service users'.

Indeed, when I began my clinical leadership research journey as a student at Nottingham University, doctors and nurse consultants were identified as the clinical leaders. Allied health professionals were not even considered in the mix, and to a large extent leadership training or education was the domain of those in identified hierarchical management positions.

The five studies that support this book confirmed that clinical leaders exist in vast quantities and at all levels within all clinical areas. The 188 questionnaire respondents in the initial study nominated 326 people as clinical leaders, and in the 4 clinical areas of the focused interviews, the 42 nurses interviewed nominated 130 people as clinical leaders, most of whom (although not all) were middle-level nurses or lower. Clark (2008, p. 30) also suggested that 'some nurses may not think of themselves as leaders because they equate leadership with authority or with specific job titles rather than as a way of thinking or behaving'. Nevertheless, as the study results show, health professionals see clearly that their clinical colleagues are leaders – and rightly so.

The initial study and the four that followed demonstrated that clinical leaders were to be seen at all levels, with nominations offered for doctors, other health professionals, area managers, directors of nursing, clinical nurses, registered nurses and even healthcare assistants; although again, mid-level health professionals who were focused on clinical activities received the most recognition as clinical leaders. No direction was given on the questionnaires about whom to nominate and only 8.8% of all nominations in the initial study were for medical staff – a figure that might stun Stanton, Lemer and Mountford (2010) or Swanwick and McKimm (2011), or others who write about the pivotal place of medical professionals as clinical leaders.

Medical professionals may be clinical leaders, but it is equally the case that any health professional, at any level, who has the attributes identified in this chapter and who is followed because they have their values and beliefs on show and match these to their actions, may be seen as a clinical leader.

From a nursing perspective, the mid-level registered nurse was the candidate most likely to be viewed as a clinical leader by their colleagues, both senior and junior. The results (Stanley, 2006a, b) also showed that differences exist between specialist units and general wards; in the latter, lower-level registered nurses followed mid-level registered nurses in being commonly nominated as clinical leaders. In specialist clinical units, as well as mid-level registered nurses, more senior registered nurses or clinically based specialist nurses were common candidates for selection. Moreover, significantly fewer clinical leaders were identified in non-specialist clinical areas. It was worryingly noted that clinical areas that commonly took new graduates and neophyte practitioners into their first experiences of healthcare had fewer clinical leaders in place to support them. However, the attributes that identified clinical leaders were the same, regardless of the clinical area in which they worked.

There was little support for managers to be seen as clinical leaders. If a manager had an element of 'control' built into their role, or if they had minimal clinical engagement, they were seldom identified as a clinical leader.

This is not a new point and publications for some time have drawn attention to the tension between clinical leadership responsibilities and management functions (Rafferty 1993; Christian & Norman 1998; Antrobus & Kitson 1999; Stanley 2000; Firth 2002; McCormack & Garbett 2003; Thyer 2003; Stanley 2006c). The main focus of the conflict was between the clinician's desire to remain clinically focused and the need to be able to maintain the management and resource capabilities of their clinical area. For many allied health professionals this was a common feature of their clinical leadership/management dichotomy. A research transcription extract demonstrates this point:

> The main one I think is really the issue from the [organisation's] point of view … the [organisations] want to implement schemes or whatever which I don't feel are in the best interests of the patients or staff … for example the [organisations] are trying to have [middle-level nurses] carry a hospital

> bleep, now I disagree with that because I feel my role should be ward-based, clinically based and I don't want to see my role as managing the hospital.

This highlights the observation that clinical leaders are selected because they have their values on show. As such, when health professionals are promoted away from the clinical area or lose direct client contact, many face a crisis of conscience as they struggle to remain rooted to their core professional values while being directed and drawn into areas of management and administration that are often either removed from or in conflict with their values and beliefs about patient/client care (Stanley 2006c). Even if this is not the case and a crisis of conscience is avoided, others may recognise the 'controlling' elements in their role and this may diminish their identification or effectiveness as a clinical leader.

Clinical leaders, therefore, are not identified because of their position, job title, role in the health service or badge. They can be in any clinical area and involved in any aspect of patient care or clinical service. They are rarely found in offices, removed from clinical contact or interaction with clients or patients, and they are generally experienced health professionals focused on their desire or 'passion' for developing a high standard of care and best-quality service.

Clinical leaders are recognised for having their values and beliefs sit behind their actions and interventions. They are not recognised for their vision or creativity (although some are creative and visionary). They are found across the spectrum of health organisations, often at the highest level for clinical interaction, but not commonly at the highest management level in a ward or unit team, and they are seen in all clinical environments.

Reflection Point
Do you need to have a title or hierarchical role to be an effective clinical leader? Why might this matter? Discuss this with a senior colleague. What are their views on this question?

Clinical Leadership Defined

The definition offered in this book is that clinical leaders are clinical experts in their field and are followed because they match their actions with their values and beliefs about quality patient care. In addition, it is suggested that the attributes of effective clinical leaders are those of clinical competence, clinical knowledge and effective communication, and that they are empowered motivators, role models, visible in practice, supportive, have integrity, are inspirational, cope well with change and are open and approachable.

It is suggested that clinical leaders can be found in all areas of care and that they are seldom managers, or even the most senior health professional. Instead, clinical leaders are identified in large numbers and represent the clinician who is visible in practice with their values and beliefs about care on display.

Reflection Point
When in your career have you undertaken leadership training? Was it at an undergraduate or postgraduate level? Or has your employer, recognising the value of having clinical-level leaders who understand the value of leadership instruction, sent you on or supported you to undertake further training? Speak with your clinical colleagues. What leadership instruction have they received?

Why Clinical Leadership Now?

Why should we consider clinical leadership at this time and in this context? When I was a student nurse in the 1980s, no one mentioned 'leadership', let alone 'clinical leadership'. Indeed, I recall a strong element of subservience running as an undercurrent through the profile of our nursing curriculum and within our training, suggesting that doctors were nurses' leaders and their betters, and that we did not need to make decisions or think too much. I can recall, too, the beginnings of a quiet rebellion as nurses abandoned their nurses' cap and moved to competency-based assessment, university-based education, new roles, new dress codes and new titles. Yet the subservience was evident, nonetheless.

So why has clinical leadership become an issue for current and future health professional students and practitioners?

A New Agenda

Leadership development is being seen as central to the development and modification of the health agenda (Stanton, Lemer & Mountford 2010; Swanwick & McKimm 2011; Mannix, Wilkes & Daly 2013; Philips & Byrne 2013; Rose 2015; Townsend, Wilkinson & Kellner 2015; West et al. 2015; Bender 2016). The UK Department of Health said as long ago as 1999 that it required staff who can establish direction and purpose, inspire, motivate and empower teams around common goals, in order to help produce improvements in quality, clinical practice and service (DoH 1999), and nothing has changed to modify this requirement. Similar calls to action are evident in other parts of the world where leadership development is seen as central to the development of the healthcare agenda. Leadership is needed at all levels (DoH WA 2004) and it is suggested that clinical leadership needs to be increased, that clinical networks for change need to be initiated and that growing change management and leadership skills are essential for all health professionals (DoH WA 2004; Martin & Learmonth 2012; Storey & Holti 2013b; Scully 2014; Byers 2015; McLellan 2015; Rose 2015; West et al. 2015).

Changing Care Contexts

It is recognised that the context of healthcare is changing. Care provision is no longer solely in the domain of the acute hospital. Therefore, as new healthcare environments are developed, new ways of working with new roles and staff mean that new approaches to care and greater innovation are required. The development of nurse practitioners, for example, and wider skill sets for allied health professionals and paramedics offer examples of how the healthcare environment is developing. Patients can now be treated and cared for in a range of clinical areas and environments by experienced and skilled health professionals, who can prescribe care and implement clinical decisions based on their critical thinking.

Change Equates to more Leadership

There is also a recognition that the health service needs more staff with greater leadership (as opposed to management) skills and insights (Stanton, Lemer & Mountford 2010; Byers 2015; McLellan 2015). This is partly in response to the realisation that the more change there is, the greater is the need for leaders (Kotter 1990). It is also an acknowledgement that until quite recently there has been under-investment in leadership training and leadership development and even a lack of discussion about clinical leadership within healthcare (Rafferty 1993; Hurst 1997; Lett 2002; Stanley 2008; Martin & Learmonth 2012; Storey & Holti 2013a; Scully 2014; Byers 2015; McLellan

2015; Rose 2015; West et al. 2015). I would suggest that the core reason for a surge in leadership, and clinical leadership in particular, is the realisation that change, innovation, the development of quality care and the links between values and care, compassion and quality are all based on effective leadership. While management is essential, the development of grassroots, front-line leaders opens up genuine opportunities for a positive impact on innovation, creativity and change.

More Emphasis on Quality

As Francis (2013) shows, there is a pressing need to do better, often with limited resources (Storey & Holti 2013a; Scully 2014; McLellan 2015; Byers 2015; Rose 2015; West et al. 2015). The drive to improve quality and support the integration of quality improvement sits at the heart of a need to generate more effective clinical leadership. In the UK, initiatives such as the 'Payment by Results' scheme mean that care providers are rewarded for the volume of work they do and are assessed against an ever-stricter quality reporting mechanism (Stanton, Lemer & Mountford 2010). An emphasis on quality supported by the adoption of clinical governance strategies also places more pressure on clinicians to continuously improve the quality of care.

Clinicians are best placed to address quality initiatives, change and innovation in clinical practice. Linking all of these is the realisation that if care is to improve and develop, then change and innovation in practice are required. It is often the clinician, working with clients, other colleagues, relatives and patients, who is best placed to identify inefficiencies, bottlenecks and problems, and who can identify the most appropriate solutions for these issues. Clinicians are indeed the 'operational core' of the health service (Mintzberg 1983).

Therefore, if the health service is to grow, support innovation and initiate change, it needs leaders with skills and talents to take their ideas and projects forward. In the clinical arena, it is clinical leaders who are in an ideal position to fulfil this role and who are ideally situated to support other clinicians to develop the health service. Clinical leaders, however, need the skills, attributes, tools and techniques to initiate and manage change effectively, and the personal will and abilities to recognise themselves as 'change agents' and as a force for positive growth in the health service.

Case Study 1.1

Vivian Bullwinkel is rightly regarded as a clinical leader. Read about her and consider how holding on to her values during her struggle in difficult conditions was central to her survival and shaped her ensuring career as a health professional leader.

Female leaders: Vivian Bullwinkel

Vivian was born in 1915 and began her education in Broken Hill, New South Wales before training as a nurse and midwife in 1934. At the outbreak of World War II she travelled to Melbourne with a view to joining the war effort. Enlisting took time, and while she waited for an opportunity to contribute she worked as a nurse at the Jessie MacPherson Hospital in Melbourne.

In May 1941, Vivian volunteered for the Australian Army Nursing Service (AANS) and was posted to Singapore, the bastion of the British Empire in the Far East. She served at the 2/13th Australian General Hospital and with other Australian nurses she cared for wounded Allied soldiers, often under difficult conditions as the war reached closer. By early February 1942, the Japanese army was on the brink of taking Singapore. Vivian boarded the SS *Vyner Brooke* with 65 other nurses fleeing the Japanese

(Continued)

Case Study 1.1 (Continued)

advance, but the ship was struck by Japanese aircraft a few days later and sank. A large number of passengers, including Vivian and many of the nurses, made it to shore on the island of Banka (now part of Indonesia). The nurses surrendered to the occupying Japanese army; however, the following day they were ordered to walk out to sea, where they were machine gunned. Vivian was shot and injured, but survived by feigning death until the Japanese had moved off. Twenty-one nurses were murdered.

Following the massacre, Vivian dragged herself back to the beach, the sole survivor of the atrocity. In the jungle just off the shore she discovered a wounded British soldier and for several weeks they both hid in the jungle, scavenging food and managing their wounds as best they could. However, their deteriorating condition forced them to surrender. The British soldier died shortly afterwards. Vivian and other Australian nurses spent a further three and a half years in captivity, being starved, tortured, refused medical care or treatment, and moved from one jungle camp to another. Death was a constant threat, but Vivian's determination to survive and willingness to offer others compassion and companionship saw her survive to be released at the war's end.

Following World War II, 'Sister Bullwinkel' served with the Australian army in Japan in 1946 and 1947 before resigning from the military at the rank of captain. In 1955 she joined the Citizen Military Forces and served until 1970, reaching the rank of lieutenant colonel. In addition, she spent 16 years as matron and 7 years as Director of Nursing at Melbourne's Fairfield Hospital. She retired in 1977, married Colonel F.W. Statham and moved to Perth, Western Australia, where she died in 2000.

Vivian was awarded the Royal Red Cross Medal in 1947 for services to the veteran and ex-prisoner of war communities, to nursing, to the Red Cross Society and to the wider community. She was appointed a Member of the Order of the British Empire (MBE) in 1973, was awarded the Order of Australia (AO) in 1993, and was also a recipient of the Florence Nightingale Medal.

In 1993 she returned to Banka Island to unveil a shrine to the nurses who were murdered there. She survived multiple difficulties and challenges during her years of captivity and if persistence and determination are invincible, Vivian Bullwinkel is surely the personification of this tenet.

Challenge: Can you recognise any of the attributes of a clinical leader in Vivian's story? How might these attributes have contributed to her survival as a Japanese prisoner and her ongoing career success?

Summary

- Change and quality in the health service are not all about processes and structure, they are also about courageous people who are prepared to act.
- The main attributes of clinical leaders are approachability, empowerment and motivation, being visible in practice, clinically competent and clinically knowledgeable, has values and beliefs on show, has effective communication skills, copes well with change, has integrity, is supportive, inspires confidence and is a positive clinical role model.
- Clinical leaders are not identified because of their position, job title, role in the health service or badge.
- Clinical leaders can be found in any clinical area and are involved in any aspect of patient care or clinical service.
- Clinical leaders are generally experienced, clinically focused health professionals driven by their desire or 'passion' for developing a high standard of care/service.

- Clinical leaders are the people at the 'coal face' (operating core) and are in the best position to identify change initiatives and to drive change or quality in clinical practice.
- Five research projects that explored who clinical leaders are, why clinical leaders are seen as such and what the experiences of clinical leaders are sit at the heart of this book and the theory presented here.
- Clinical leadership and the clinical leader's time have come. There is a new agenda in the health service focusing on innovation, change and a drive for quality. Care practices and the context of care provision are changing. There is a recognition that greater change needs stronger leadership and that leaders can come from any stratum of the health industry. Indeed, effective change, quality improvements and innovation may be more successful if they are initiated and developed by clinicians who are empowered to lead.

Mind Press-ups

Exercise 1.1

If you can, approach a person who you feel is a clinical leader. Explain to them that you see them as a clinical leader and ask them how they feel. Were they shocked, surprised, delighted? How did they respond to your announcement?

Exercise 1.2

What are your experiences of leadership development from your undergraduate or formative healthcare education? Do you feel well prepared and instructed in leadership theories and techniques? Ask some colleagues how they learnt about leadership and what they understand leadership to be.

Exercise 1.3

Draw a 'mind map' with the word 'leadership' in the centre. You could start the map here and build or add to it as you progress through the book or over the trajectory of your studies.

Exercise 1.4

Who are your leaders? Who might you direct an alien or stranger to if they asked you to take them to your leader?

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2

Leadership Theories and Styles

David Stanley

The brain can be hired. The heart and soul have to be earned.
John Christensen, ChartHouse Learning

If I have seen further it is by standing on the shoulders of giants.
Sir Isaac Newton, letter to Robert Hooke, circa 1675

Introduction: Leadership – What Does It All Mean?

Leadership has long been a feature of educational, business, industry, military and medical or health service debate. A plethora of books, journal articles, web pages and papers has resulted offering a wide variety of theories, definitions and perspectives about how to recognise effective leadership, develop better leaders, promote change or innovation and promote more effective organisations. Although the focus of this book is clinical leadership and leadership related to healthcare professionals, it will draw on concepts, definitions and theories of leadership from business, industry, educational and military perspectives. In addition, it will explore leadership related to healthcare and care in the clinical setting to support a better understanding of clinically focused leadership.

This chapter attempts to define leadership. Leadership can be a vexed and convoluted concept and it is commonly seen as linked to theories of management and associated with elevated hierarchical positions and power. This book is not specifically directed at titled leaders, people in authority, managers or senior managers. Indeed, leadership and leaders are considered to be different from management and managers (Zaleznik 1977; Kotter 1990; Stanley 2006, 2011). While it is acknowledged that they are related, for the purposes of this book concepts of management are not explored or considered, although the differences between management and leadership are discussed in Chapter 5.

Many people from a range of different groups have been interested in discovering more about leadership and for a long time the nature of leadership has been extensively researched (Swanwick & McKimm 2011). Chinese and Indian scholars have studied and written about leadership. It is referred to in the Old Testament and numerous mythical stories from civilisations across the globe address the act of leadership. Confucius wrote about leadership and Plato, who lived between 427 and 347 BCE, wrote in *The Republic* about the value of developing leadership characteristics by describing the attributes required to navigate and command a sea vessel (Adair 2002a). In almost any field of endeavour, from leading large corporations or massive armies to leading the editorial committee of a

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monthly committee newsletter, a clinical area or the local junior football club, leadership and the experience of being a leader are common themes.

Theories and definitions of leadership abound. Stogdill (1974, p. 7) believes that 'there are almost as many different definitions of leadership as there are people who have attempted to define the concept'. Northouse (2004, p. 2) also indicates that as soon as 'we try to define leadership, we immediately discover that leadership has many different meanings', while Bennis and Nanus (1985, p. 4) feel that in relation to leadership, 'never have so many laboured so long to say so little'.

Here is a smattering of quotations about leadership to help enhance your insight:

> Leadership is the capacity to translate vision into reality.
>
> *(Warren G. Bennis, President, University of Cincinnati, University of Maryland Symposium, 21 January 1988)*

> The key to successful leadership today is influence, not authority.
>
> *(Kenneth Schatz, Managing by Influence, Prentice-Hall, 1986)*

> A leader is a dealer in hope.
>
> *(Napoleon Bonaparte, 1769–1821, Emperor of France, Maxims of Napoleon)*

> I am certainly not one of those who needs to be prodded. In fact, if anything, I am a prod.
>
> *(Winston Churchill, 1874–1965, UK Prime Minister, writer and Lord of the Admiralty, speech in Parliament, 11 November 1942)*

> Charisma becomes the undoing of leaders. It makes them inflexible, convinced of their own infallibility, unable to change.
>
> *(Peter F. Drucker, management consultant and writer, Wall Street Journal, 6 January 1988)*

> Leadership is practiced not so much in words as in attitude and in actions.
>
> *(Harold Geneen, CEO of ITT, Managing, Doubleday, 1984)*

> The reward of the general is not a bigger tent, but command.
>
> *(Oliver Wendell Holmes, Jr, 1841–1935, US Supreme Court Justice, 1917)*

> The rotting fish begins to stink at the head. (Italian proverb)

> When the best leader's work is done the people say, 'We did it ourselves.'
>
> *Lao-Tzu, 604–531 BCE, Chinese philosopher and founder of Taoism, Tao Te Ching)*

> If the blind lead the blind, both shall fall into the ditch.
>
> *(New Testament, Matthew 15:14)*

> More than knowledge, leaders need character. Values and ethics are vitally important.
>
> *(Oscar Arias, former president of Costa Rica, humanitarian, June 2001)*

Box 2.1 The parable of the blind men and the elephant

Three blind men were asked to lead an elephant and, in the process, to describe what the elephant might be like by touch alone. The first grasped the trunk and declared that an elephant must be like a giant snake; the second felt the rough hide and said that the elephant must be like a giant warthog; and the third grasped the tusk and said that an elephant must be like an enormous walrus.

The point of the parable is that taking only a part of an elephant cannot lead to a complete understanding of the beast. I have always wondered, though, how these three blind men knew what a snake, a warthog and a walrus felt like in the first place. I guess you can only take a parable so far.

Leadership Defined: The Blind Man's Elephant

An understanding of leadership is central to understanding the experience of clinically focused leaders. As such, it is useful to begin with an exploration of the terms 'leadership' and 'leader'. As the quotations show, defining leadership can be like the parable of the blind men and the elephant, and in many respects the definition offered depends on which part is grasped (Box 2.1).

There is a wide variety of beliefs, definitions and perspectives of leadership, which is a complex process with multiple dimensions (Northouse 2004; Jones & Bennett 2012). Because of this, a number of definitions are explored here to elaborate on the concept of leadership and offer a prelude to understanding clinical leadership. These are taken from a wide range of fields and perspectives and support considerable breadth in the definition of leadership.

Fiedler (1967), who primarily studied military and managerial leadership, felt that the leader has long been considered to be the individual in the group with the task of directing and coordinating the group's activities. Others view leadership from a personality perspective, a power relationship perspective, as an instrument of goal achievement (Bass 1990) or as the process of influencing people to accomplish goals (Grossman & Valiga 2013; Northouse 2004).

Leadership can also be described as achieving things with the support of others (Leigh & Maynard 1995) and Wedderburn-Tate, writing from a nursing perspective, feels that the leader's function is to get others to 'perform at consistently high levels, voluntarily' (1999, p. 107). This is in keeping with President Eisenhower's view that leadership is the art of getting someone else to do something you want done because he wants to do it (Stanton, Lemer & Mountford 2010, p. 3). These definitions imply that influence is a factor.

Fiedler (1967) and Dublin (1968) suggest that leadership is more than influence and propose that it is the exercise of authority and the making of decisions. They see the leader as the person who has formal authority (power) and functional capacity over a group. Maxwell (2002), however, supporting Leigh and Maynard (1995) and Wedderburn-Tate (1999), feels that this is going too far and that leadership is influence – nothing more, nothing less. Stogdill (1950) also considers that leadership and influence are related, but believes that there may be more than just this. He proposes another view, that leadership is the process of influencing people or the activities of a group to accomplish goals. This perspective brings in the concept of influence and acknowledges that people without formal power can exercise leadership. Leadership is also seen as 'a talent that each of us has and that can be learned, developed and nurtured. Most importantly it is not necessarily tied to a position of authority in an organisation' (Grossman & Valiga 2013, p. 18).

As well as goal setting and influence, leadership is an important element in effecting change (Stogdill 1950). Kotter (1990, p. 40) supports this, indicating that 'leadership is all about coping with change'. However, Bennis and Nanus describe a leader as 'one who commits people to action, who

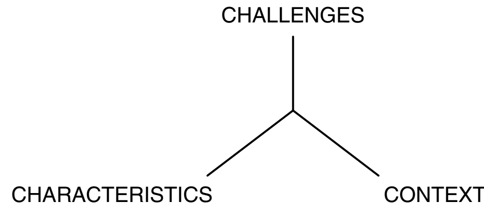

Figure 2.1 The three domains of leadership. **Challenges** are the critical tasks, problems and issues requiring action **Characteristics** are the qualities, competencies and skills that enable us to contribute to the practice of leadership in challenging situations **Context** is the 'on-site' conditions found in the challenging situation. Source: Pedler, M., Burgoyne, J. & Boydell, T., *A Manager's Guide to Leadership*, © 2004. Reproduced with the kind permission of The McGraw-Hill Companies. All rights reserved.

converts followers into leaders and who converts leaders into agents of change' (1985, p. 3). Lipman, from a business/management perspective, defines leadership as 'the initiation of a new structure or procedure for accomplishing an organisation's goals and objectives' (1964, p. 122).

These views appear to suggest that change is central to leadership and they rest on the assumption that leaders function within an organisation where change, rather than stability, is the goal. Pedler, Burgoyne and Boydell (2004), also from a management perspective, indicate that while leadership includes elements of the leader's character and the context within which the leadership takes place, it focuses on the critical tasks that the leader must perform, the problems and challenges that leaders face. Again, defining leadership by the leader's ability to change or respond to challenges, Figure 2.1 demonstrates these ideas.

Leadership has also been viewed as attending to the meanings and values of the group, rather than just the authority, function, challenges and traits of the leader. Covey (1992) describes what he calls 'principle-centred leadership' and Pondy (1978) similarly proposes that the ability to make activities meaningful and not necessarily to change behaviour, but to give others a sense of understanding of what they are doing, is at the core of leadership. Therefore, the act of leading is about making the meaning of an activity explicit:

> Unlike the supposed individualistic leadership of the past, now leadership is influenced by the impact of the immediate and surrounding context … the contention put forward is that [the] organisational context provides the parameters within which current leadership is contained.
>
> *(Kakabadse & Kakabadse 1999, p. 2)*

From this perspective it can be argued that the task of the leader is to interpret and clarify the context and thus provide a platform for communicating meaning within the activity.

As a result, leadership becomes more about selecting, synthesising and articulating an appropriate vision for the follower (Bennis, Parikh & Lessem 1995). Greenfield takes this concept of vision further by implying that rather than just clarifying meaning or making the activity meaningful, leadership is about setting meaning, describing leadership as

> a willful act where one person attempts to construct the social world for others … leaders will try to commit others to the values that they themselves believe are good and that organisations are built on the unification of people around values.
>
> *(Greenfield 1986, p. 166)*

Similarly, Bell and Ritchie (1999) and Day et al. (2000), from an education perspective, commonly refer to the 'head teacher' as the person within a school who is responsible for 'establishing core characteristics' (Bell & Ritchie 1999, p. 24), for committing others to their values and for setting the overall aims for the school.

However, no one definition can be considered wholly right or wrong and there are a multitude of others that have not been outlined here. Therefore, adding to the already numerous definitions may seem irresponsible, although I offer a definition nonetheless, as a way of identifying how leadership is understood within the context of this book. This is:

> Leadership is unifying people around values and then constructing the social world for others around those values and helping people get through change.

Like the blind men describing an elephant, there is considerable overlap and blurring at the edges of these varied perspectives, and perhaps an eclectic view of leadership may prove most beneficial, with Duke suggesting that 'leadership seems to be a gestalt phenomenon; greater than the sum of its parts' (1986, p. 10).

No One Way

So leadership has been studied in many fields of endeavour and by many scholars and individuals for a very long time. Rather than this resulting in a clear and unequivocal understanding, many different and sometimes opposing definitions have evolved and still exist (Swanwick & McKimm 2011; Jones & Bennett 2012; Rigolosi 2013). These varied definitions could easily lead to confusion or unsettle our concept of leadership. Instead, I feel that they function like the dishes at a banquet, each individual dish adding to the glory of the collective whole and each offering something that helps explain what leadership is and how leadership can be understood.

However, definitions alone offer only a taste of the meaning of leadership. As with the blind men in their understanding of the elephant, a wider view may be more helpful. To this end, this chapter now explores the theoretical perspectives of leadership and brings a greater array of dishes to the banquet.

Leadership Theories and Styles

In order to clarify information about leadership and leaders, it is both prudent to consider the theories of leadership that are prominent in the literature, and important to explore the concepts, theories and styles of leadership that have previously been developed and described. They are not proposed as a linear progression, although the later theories have grown from, or are at least a reaction to, earlier ones. The following pages offer only an introduction to leadership theories, but it is hoped that they set the stage for a consideration of congruent leadership in Chapter 4 and for clinical leadership in the overall context of this book.

The Great Man Theory: Born to Lead?

The 'great man theory' (Galton 1869) is one of the earliest theories of leadership. It suggests that leadership is a matter of birth, with the characteristics of leadership being inherited or, as Man (2010)

suggests, assigned by divine decree. Bennis and Nanus explain this theory by saying that 'those of the right breed could lead; all others must be led' (1985, p. 5).

Therefore, individuals born into 'great' families were considered to be infused with the skills and characteristics of a leader, and indeed some individuals born into the 'right' family did accomplish great things and changed the course of human history. However, the idea that leaders are born and not made lost credibility after a number of significant changes in the fabric of western society, (Grossman & Valiga 2013). The French and Russian Revolutions and World War I are examples of the types of changes that led people to see that leaders could come from any stratum of society. As such, the great man theory, dominated by an old leadership culture, literally died out as those who supported it were replaced by a new breed of self-styled leaders.

The Big Bang Theory: From Great Events, Great People Come

The 'big bang theory' proposes that calamitous circumstances provide the elements essential for the creation of leaders. Leaders, it suggests, are created by the great events that affect their lives (Grossman & Valiga 2013). Again, the revolutions of the 19th and 20th centuries and World War I are cited as examples of major calamitous circumstances, but this type of event could as easily be a local disaster (such as the floods in Yorkshire in 2015 and fires in the state of Victoria in 2009 and 2015), a family crisis or a personal catastrophe. Bennis and Nanus explain this by saying that 'great events made leaders of otherwise ordinary people' (1985, p. 5), suggesting that it is the situation and the followers that combine to create the leader. The lives of a number of great political and military leaders might be used to substantiate this theory of leadership, with the life and presidency of Abraham Lincoln offering a sound example of a poor person's rise to prominence during the dramatic events of mid-18th-century America (McPherson 1988; Carwardine 2003; Gallagher et al. 2003). The rise to power of Napoleon Bonaparte following the after-effects of the French Revolution are another. The theory that otherwise ordinary people become great leaders because of great events may be true for some leaders, but, as with Lincoln and Bonaparte, much of the leader's success may be attributable to their hard work and knowledge in preparation for the great events that are common features of many people's lives.

From an Australian standpoint the notorious career of the bushranger Ned Kelly could be viewed from the perspective of the big bang theory. A series of calamitous personal and family events during Ned's early life resulted in his decision to take up a life of crime, and ultimately he led a small group of outlaws who committed a series of robberies and murders across the countryside of northern Victoria. The theory argues that without the events that sparked Ned's behaviour and reactions, he is unlikely to have risen to prominence in his chosen field and become Australia's most notorious bushranger.

Trait Theory: The Man, not the Game

The 'trait theory' of leadership rests on the assumption that the individual is more important than the situation. Therefore, it is proposed that identifying distinguishing characteristics of successful leaders will give clues about leadership (Swanwick & McKimm 2011; Grossman & Valiga 2013). Rafferty (1993) and Jones and Bennett (2012) refer to this as the constitutional approach, where part of the assumption is that if great leaders cannot be trained or taught, they can at least be selected, linking this with attributes of the great man theory.

A large number of studies in the early part of the 20th century (Yoder-Wise 2015; Northouse 2004) were initiated to consider the traits of great leaders. However, as Bass (1990) indicates, while a number of traits did seem to correspond with leadership, no qualities were found that were universal to

Table 2.1 Leadership traits.

Stogdill 1948 (cited in Northouse 2004, p. 18)		**Mann (1959, p. 253)**	
Intelligence	Alertness	Intelligence	Masculinity
Insight	Responsibility	Adjustment	Dominance
Initiative	Persistence	Extroversion	Conservatism
Self-control	Sociability		
Stogdill 1974 (cited in Northouse 2004, p. 18)		**Kirkpatrick and Locke (1991, p. 52)**	
Achievement	Persistence	Drive	Motivation
Insight	Initiative	Integrity	Confidence
Self-confidence	Responsibility	Cognitive ability	Task knowledge
Cooperativeness	Tolerance		
Influence	Sociability		
Smith (1999, p. 6)		**Grossman and Valiga (2013, p. 5)**	
Early loss of a parent		Abundant reserve of energy	
Escape from squalor		Ability to maintain a high level of activity, better education	
First-born child		Superior judgement	
Tall		Decisiveness	
High energy levels		Breadth of general knowledge	
Work long hours		High degree of verbal facility	
Can manage with little sleep		Good interpersonal skills	
Introverted and psychologically on edge		Self-confidence	
Outsiders coming from beyond the group they lead		Creativity	
Enormous self-belief		Above average height and weight	

all leaders. Stogdill (1948), who undertook a major review of universal leadership traits between 1904 and 1947, concluded that no consistent set of traits differentiated leaders from non-leaders in a range of work environments and situations. The traits that he identified in 1948 and again in 1974, as well as others identified by Mann (1959), Kirkpatrick and Locke (1991), Smith (1999) and Grossman and Valiga (2013), are listed in Table 2.1.

The descriptive words on these lists indicate that trait theories have evolved and changed with time, but all remain unable to capture any great degree of consistency between the traits identified. Stogdill found in 1948 and again in 1974 that the traits that lead to success may differ according to the situation the leader is in, as well as the personality of the leader. Therefore, the traits themselves could be seen as misleading, although it has been proposed that the leader's characteristics play a critical part in effective leadership (Northouse 2004). It is also suggested that possession of all the traits is an impossible ideal and that there are a considerable number of cases where people who possess a few, or even none, of the principal traits achieve notable success as leaders (Stogdill 1974).

The disadvantage of trait theory is that it does not lead to a comprehensive theory of leadership and it neglects both the impact of the situational context within which the leader operates (Stogdill 1948; Northouse 2004) and the impact of the leader's personality (Mann 1959). Rafferty (1993) also points out that trait theory ignores or under-estimates the degree to which the leader's role could be structured by issues of class, gender or racial inequalities and that it assumes a passive role for the followers.

Trait theory developed as an elaboration of the great man theory and remains central to what Grint (2000) describes as 'the arts of leadership'. However, the investigation and establishment of trait theory developed in line with business and management development in the early 20th century

(Northouse 2004), where it was hoped that once the appropriate qualities and traits were identified, a potential leader could be hired who demonstrated these traits, or who could be supported in acquiring them through study and experience (Bernhard & Walsh 1990). Then, if the appropriate conditions prevailed or could be predicted, appropriate people (who showed the relevant traits) could be selected or trained for the leadership situation.

While it is possible to acquire some (but not all) of the traits, this theory remains divorced from the notion that leadership (in isolation from the traits) could be learnt and, as such, it found limited purchase with the liberated and increasingly educated masses of the western world. Therefore, as community values altered and research about leadership increased, other perspectives of leadership developed (Lett 2002).

Style Theory: It's How You Play the Game

Studies of leadership and management and their relationship to productivity and group behaviour resulted in what are generally called style theories (Handy 1999; Adair 1998; Northouse 2004). Style theories explore how leaders behave, what they do, how they act, as well as how groups respond, with leaders being described as either democratic, paternalistic, laissez-faire, authoritarian and/or dictatorial (Handy 1999; Lett 2002; Northouse 2004; see Table 2.2). As these words were found to have an 'emotive connotation', aspects of style theory are also described as 'structuring and supportive styles' (Handy 1999, p. 101), and much of the literature related to style theory emphasises the benefits or drawbacks of one or other approach to motivating a group (usually of subordinates to the leader).

Early investigations of style theory were undertaken by the Ohio State University, where a Leader Behaviour Description Questionnaire (LBDQ) was developed and tested in educational, military and industrial settings. Leaders, they concluded, exhibited either *structuring* behaviour, which defined

Table 2.2 Management/leadership styles.

Autocratic: characterised by being highly directive, viewed as having a right to manage.	
Good points: clear objective, single-minded, based on orders, no thinking required.	**Negative points:** diminished autonomy, problem if the vision is false or off, power vacuum if the leader leaves, no debate, no opportunity to experience power before promotion.
Paternalistic: characterised by a caring but overprotective, interfering manager. Manager knows best, may consult, but always decides. High degree of support but no corresponding responsibility or autonomy.	
Good points: followers/employees may feel 'cared for', may foster a sense that they belong or have a team or esprit de corps.	**Negative points:** stifles autonomy. High reliance on the manager/organisation, even for basic human needs (like some 1970s Japanese companies – when some employees were off sick they felt so lost without their work they were encouraged to come in and spend their time, even if ill, with their colleagues and co-workers).
Democratic: characterised by discussion, debate and shared vision.	
Good points: promotes a shared vision, ownership of outcomes and problems, involvement of the whole team, flatter structure employed.	**Negative points:** can allow the more vocal or more outspoken to dominate; mob may rule and may be wrong. Can lead to ineffective decision making.
Laissez-faire: characterised by an easygoing, non-directive and non-hierarchical approach.	
Good points: promotes autonomy, self-survival, self-direction, individuality, freedom, and self-expression.	**Negative points:** assumes everyone is willing or capable of leadership, or that people are happy to be left to their own devices. This approach can lead to chaos or anarchy.

the work context and role responsibilities of subordinates, or *consideration* behaviour, which focused on building relationships such as trust and respect with subordinates. These studies were elaborated on by the University of Michigan with an approach more focused on the leader's behaviours in relation to the performance of small groups (Northouse 2004). By the 1960s, Blake and Mouton (1964) had developed the 'managerial grid' (now called the leadership grid) as a model to support organisational leadership and management training, by exploring how leaders (managers) could help organisations reach their potential through developing either support for production or concern for people.

The management/leadership grid (Blake & Mouton 1964; Blake & McCanse 1991) can be used to explain how leaders or managers within an organisation function by focusing on the relationship between two factors: concern for people, and concern for production or results.

Concern for people deals with how a manager or leader supports people within an organisation as they try to work towards their goals. This can be achieved by focusing on issues of trust and commitment, motivation, working conditions, fair play and the promotion of strong social support structures (Blake & Mouton 1964). *Concern for results* addresses how the manager/leader achieves various tasks and can include factors such as policies, sales figures, quality targets and other activities and processes concerned with production or the organisation's goals. The original grid was developed as a nine-point scale on which one represents minimum concern and nine represents maximum concern. By plotting the scores from the vertical and horizontal axes, various leadership/management styles could be identified.

The style theory approach to leadership is not designed to instruct leaders in how to behave, but it is useful in supporting leaders (managers) in identifying the major components of their behaviour. However, the theory failed to elaborate on why some leaders were successful in certain situations and not in others.

Different organisations require different styles of management or leadership at different times, depending on their approach, their goals and their stage of development. Many authors use different terms (democratic = participative), but often they end up describing the same thing. It was Kurt Lewin who in 1948 set out the three basic leadership/management styles of autocratic, democratic and laissez-faire. Since then, other terms have been used and other views expressed. Here are some of them:

- **Supporting:** where leaders pass day-to-day decisions to the follower. The leader facilitates and takes part in decisions, but control is with the follower.
- **Delegating:** leaders are still involved in decisions and problem solving, but control is with the follower. The follower decides when and how the leader will be involved.
- **Directing:** leaders define the roles and tasks of the follower and supervise them closely. Decisions are made by the leader and announced, so communication is largely one way.
- **Coaching:** leaders still define roles and tasks, but seek ideas and suggestions from followers. Decisions remain the leader's prerogative, but communication is much more two way.

The leadership style that individuals use will be based on a combination of their beliefs, values and preferences, as well as the organisational culture and norms, which encourage some styles and discourage others. Examples of these styles are:

- charismatic leadership
- participatory leadership
- situational leadership
- transactional leadership
- transformational leadership
- the quiet leader

Clearly some of these relate to leadership theories, and this is where the matter of styles and theories becomes intertwined. Tannenbaum and Schmidt (1958) suggest that there are seven leadership styles, Tayeb (1996) claims that there are four styles and Morgan (1986) proposes six styles of leadership (and management). Confused yet? I'd be surprised if you weren't. Goleman, Boyatzis and McKee (2002) consider that there are six styles – coaching, visionary, affiliative, democratic, pace-setting and commanding – although as you will see from any internet search for "leadership styles", there are many more.

Situational or Contingency Theory: It's about Relationships

To address the failure of style theory and to elaborate on why some leaders are successful in certain situations and not in others, Fiedler (1967) proposed the 'situational' or 'contingency theory' of leadership (Wedderburn-Tate 1999), which was popularised by Hersey and Blanchard in 1988 (Swanwick & McKimm 2011). Here, Fiedler (1967) and others (Tannenbaum & Schmit 1958; Vroom & Yetton 1973; House & Mitchell 1974; Hersey & Blanchard 1988) believed that leadership effectiveness depends on the relationship between the leader's task at hand, the leader's interpersonal skills and the favourableness of the work situation. Fiedler (1967) found – after what has more recently been criticised as limited research (Handy 1999) – that leaders were more effective if the situation within which they were trying to function was more favourable to them or even, surprisingly, less favourable. The three factors (Handy 1999, pp. 103–5) relate to:

- the degree of trust and respect that the followers have for the leader
- the clarity of the objectives to be achieved
- the degree of power in terms of whether the leader could reward or punish the followers or if the leader had clear organisational backing.

From Fiedler's perspective, the key to understanding leadership is to be able to adapt the leadership approach to complement the issue being faced, or to determine the appropriate action based on the people involved and the prevailing situation (Adair 1998). Adair also offers an example of how situational leadership might be applied by describing the actions of a group of survivors following a shipwreck:

> The soldier in the party might take command if natives attacked them, the builder might organize the work of erecting houses and the farmer might direct the labour of growing food … leadership would pass from member to member according to the situation. (1998, p. 15)

Central to Fiedler's (1967) work was the ability to analyse how the leader could use power and influence without losing respect and credibility with the subordinate group. Tannenbaum and Schmit (1958) felt that organisations could help more by either structuring the task, improving the formal power of the leader or changing the composition of the follower group to give the leaders a more favourable climate within which to work. Vroom and Yetton's (1973) decision tree model (Box **2.2**) also recognises the relationship between the leader, the followers and the task at hand, and proposes that there are five types of leadership style to choose from, decided by answering a series of questions.

Criticism of both Vroom and Yetton's decision tree model and Fiedler's situational–contingency model includes that leadership is more complicated than a series of questions and broader than the extent of the relationship between three central factors (Adair 1998). Handy (1999) also feels that even the pleasingly rational decision tree is not complicated enough to fully describe and address the convoluted nature of leadership decision making.

Blanchard, Zigarmi and Zigarmi suggest that the development of situational leadership has been in support of the activity of management: that it is used as a 'practical approach to managing and

Box 2.2 Vroom and Yetton's decision tree model

The leader has five styles to choose from. These are:

AI You solve the problem or make the decision yourself, using information available to you at the time.
AII You obtain the necessary information from your subordinate(s) then decide on the solution to the problem yourself.
CI You share the problem with relevant subordinates individually, getting their ideas and suggestions. Then you make the decision.
CII You share the problem with your subordinates in a group, then you make the decision.
GII You share the problem with your subordinates as a group, then together you make the decision.

The seven questions, which could be set out like a decision tree, are:

1) Is one decision likely to be better than another? (if not, go to AI)
2) Does the leader know enough to take it on her or his own? (if not, avoid AI)
3) Is the problem clear and structured? (if not, go to CII or GII)
4) Must the subordinates accept the decision? (if not, then AI and AII are possible)
5) Would they accept your decision? (if not, then GII is preferable)
6) Do subordinates share your goals for the organisation? (if not, then GII is risky)
7) Are subordinates likely to conflict with each other? (if yes, then CII is better)

Source: Handy 1999, pp. 103–5.

motivating people' and that it has been 'taught to managers at all levels of most of the Fortune 500 companies as well as to managers in fast-growing entrepreneurial organisations' (1994, p. 8). As a result, theories of leadership and management remained closely intertwined and, although Zaleznik (1977) and Kotter (1990) make it clear that management and leadership are different, many of the perspectives and theories that developed to explore and explain leadership grew from a desire to understand human resource management, improve employee and workforce production, and support the development of managers.

Reflection Point

Think about any outstanding leaders from your experience as a clinician/student. Reflect on their influence on you and write a short commentary about what it was about these people that made them stand out as leaders. Also reflect on the great leaders in your discipline. There may be some obvious ones that come to mind, and some you may know personally. Make a list of three great leaders in your discipline from across the globe. You should find an abundance of them! Finally, after considering the information here (and after reading Chapter 4), if given the opportunity to publish the definitive definition of leadership, what would you write?

Transformational Theory: Making Change Happen

In an attempt to understand the distinction between leadership and management – and to address the question of why some leaders are able to inspire their followers even when the situation is less than ideal – the theory of 'transformational leadership' was developed (Northouse 2004). The term was coined by Downton (1973) and later adopted and developed by House (1976) and Burns (1978),

who really secured its distinctiveness by firmly linking leaders' and the followers' motives. It was Bass (1985), while seeking to identify the distinctions between leadership and management, who later refined the theory and felt that transformational leadership motivated followers to do more than was expected by providing an idealised influence, inspirational motivation and vision. Transformational leadership is also strongly associated with the qualitative studies of Bennis and Nanus (1985) and, more recently, of Fuda (2014). These scholars also sought to tease out the differentiation between management and leadership, with transformational leadership seen as connected to a process of attending to the needs of followers, so that interaction between them raised the motivation and energy of both. Transformational leadership is therefore about challenging the status quo, creating a vision and sharing that vision, with successful transformational leaders being able to establish and gain support for their vision, while being consistently and persistently driven towards maintaining momentum and empowering others (Kakabadse & Kakabadse 1999; Swanwick & McKimm 2011).

Bennis and Nanus (1985), expanding on Burns' (1978) theory, identified four themes that they felt were pivotal to effective transformational leadership:

- **Vision**, or the ability to have a dream and actually deliver on it.
- **Communication**, or the ability to articulate the vision so that it steals into the imagination and minds of followers.
- **Trust**, or the ability of followers to feel that their leader is consistent, has integrity and can be relied on.
- **Self-knowledge (self-knowing)**, or what Bennis and Nanus describe as the ability to 'know their worth … trust themselves without letting their ego or image get in the way' (1985, p. 57).

In effect, 'self-knowing' is about looking for the fit between who the leaders are, and who they need to be to fulfil the task. Handy (1999, p. 117) aligns 'self-knowing' with 'emotional wisdom' and Goleman (1996) and Goleman, Boyatzis and McKee (2002) elaborate on this aspect of leadership, connecting it to the concept of 'emotional intelligence' where a person is able to motivate themselves, be creative and perform at their peak, sensing what others are feeling and handling relationships effectively. The transformational leader need not be associated with status or power and is seen as being appropriate at all levels of an organisation. In effect, their role is to communicate a vision that gives meaning to the work of others. Crucially, the role of the transformational leader is reconstruction of the context in which people work, removing the old and replacing it with the new.

The interdependence of followers and leaders within this theory has meant that transformational leadership has found favour in care-related and teaching fields (Day et al. 2000) and, according to Welford, 'transformational leadership is arguably the most favourable leadership theory for clinical nursing in the general medical or surgical ward setting' (2002, p. 9). Thyer also feels that it is 'ideologically suited to nurses' (2003, p. 73), and Goertz Koerner (2010) identifies Florence Nightingale as an ideal example of a transformational leader. Sofarelli and Brown (1998), Freshwater, Graham and Esterhuizen (2009), Weberg (2010), Marshall (2011), Swanwick and McKimm (2011), Casida and Parker (2011), Hutchinson and Jackson (2012), Jones and Bennett (2012), Tinkham (2013), Ross et al. (2014), Lavoie-Tremblay et al. (2015) and Weng et al. (2015) also indicate that transformational leadership is a suitable leadership approach for empowering nurses or supporting them within an organisation. The NHS Confederation (1999) takes the view that transformational leadership is best suited to the modern leadership of the NHS. In addition, Weng et al. (2015) suggest, in a substantial Taiwanese research study, that there is a significant correlation between transformational leadership and innovation within the nursing workforce. Casida and Parker (2011), in a study in the USA, likewise propose that leaders who demonstrated a transformational style were seen to be making an extra effort, achieving greater satisfaction and being more effective. Moreover, Lavoie-Tremblay

et al. (2015) found that supportive leadership practices were able to have an impact on increasing retention and improving patient care.

Transformational leadership is strongly connected to the process of addressing the needs of followers, so that the process of interaction increases their motivation and energy (Bass 1990; Jones & Bennett 2012). While this is significant, transformational leadership has also gained favour because it is related to the establishment of a vision and adapting to change. Nevertheless, as Hutchinson and Jackson (2012) state, the attachment of nursing (and other healthcare disciplines) to transformational leadership theory without robust critical review or empirical exploration limits how leadership may be conceptualised in healthcare. Rafferty (1993, p. 8) warns that the 'charismatic' element of transformational leadership can be 'potentially exploitative' if the leader takes advantage of conflict in the needs or values system of followers. However, it is in this area of potential weakness that Kakabadse and Kakabadse (1999) see the power of transformational leadership, as it offers the leader the opportunity to penetrate the soul and psyche of others, increasing the level of awareness that motivates people to strive for greater ends.

Reflection Point

You may think this a little odd, but ask a child what they think leadership means. Then ask some older members of your family or society. Do they differ? If so, how do they differ? Why might these people take the perspectives they do?

Transactional Theory: Running a Tight Ship

Burns (1978) describes 'transactional leadership' as the antithesis of transformational leadership, indicating that transactional leadership exists where there is an exchange relationship between leader and followers (Jones & Bennett 2012). Here, the role of the transactional leader is to focus on the purpose of the organisation and to assist people to recognise what needs to be done in order to reach a desired outcome through a reward/punishment motivator (Jones & Bennett 2012). Kakabadse and Kakabadse (1999) describe transactional leadership as the skill and ability to deal with the mundane, operational and day-to-day transactions of organisational life. 'Keeping meetings to their time limits, ensuring the agenda is adhered to, and conducting appraisals of subordinates' (Kakabadse & Kakabadse 1999, p. 5) are but a few examples of what they call 'transactional management'. Transactional leaders, in order to lead, need to effectively manage the more routine tasks, partly in order to retain their credibility, but also to keep the organisation on track (Burns 1978).

Criticism of this approach is that it relies on procedures, technicality and hard data to inform decision making, with Day et al. (2000, p. 4) describing it as a form of 'scientific managerialism' that relies on the assumption that leaders are in a position to control rewards. It is also criticised by Rafferty because it relies on the assumption that human behaviour is driven by motivation for reward and an incentive system, and because it is prone to being 'more conservative than creative' (1993, p. 8). The rationale behind transactional leadership is that in order for leaders to function effectively they should be able to control the context within which they are required to lead; in effect, managing their environment and limiting change.

Authentic/Breakthrough Leadership: True to Your Values

'Authentic leadership' (Bhindi & Duignan 1997; George 2003; Avolio & Gardner 2005; Cantwell 2015) and 'breakthrough leadership' (Sarros & Butchatsky 1996) are more recent leadership

theories. Both of these perspectives on leadership point to an approach where leaders are thought to be true to their own values and beliefs, and the leader's credibility rests on their integrity and ability to be seen as a role model, because of these values and beliefs. The 'breakthrough' leader and the 'authentic' leader respect and listen to others and are guided by their passion and meaning, purpose and values (Sarros & Butchatsky 1996; Bhindi & Duignan 1997; George 2003; Avolio & Gardner 2005; Cantwell 2015).

In 2005, the American Association of Critical-Care Nurses published a statement aimed at helping establish healthy work environments. The basis for this was a list of six 'standards':

- skilled communication
- true collaboration
- effective decision making
- appropriate staffing
- meaningful recognition
- authentic leadership

Authentic leadership is described as the 'glue' used to hold a healthy work environment together (Shirley 2006), with leaders being encouraged to engage with employees and promote positive behaviours. Wong and Cummings (2009), writing from a nursing perspective, also suggest that authentic leadership is a suitable theory for aligning future nursing leadership practice. Writers such as Gonzalez (2012) have taken authentic leadership further and describe what they call mindful leadership, where leaders employ self-awareness and self-leadership principles while being mindful of their impact on others.

Servant Leadership: A Follower at the Front

In keeping with some of the key elements of authentic leadership, 'servant leadership' focuses on the leader's stewardship role and encourages leaders to 'serve' others while staying in tune with the organisation's goals and values (Swanwick & McKimm 2011; Jones & Bennett 2012). The concept of servant leadership was coined and defined by Robert Greenleaf (1977), who stated that servant leaders rely less on hierarchical position and more on collaboration, trust, empathy and the use of ethical power.

A number of nursing authors have emphasised the relevance of servant leadership as a model to support the development of nursing and healthcare leadership, because its focus is both on promoting user involvement and on patients as the foundation of the health service and the most important group that leaders 'serve' (Anderson 2003; Kerfoot 2004; Swearingen & Liberman 2004; Campbell & Rudisill 2005; Peete 2005; Robinson 2006; Thorne 2006; Walker 2006; Swanwick & McKimm 2011; Jones & Bennett 2012). It is also valued as a model to support staff and influence current staff retention issues that are producing nursing workforce shortages (Swearingen & Liberman 2004). Hanse et al. (2016, p. 232), in a significant Swedish study, were able to show that nurse managers who demonstrated servant leadership had stronger 'exchange relationships' in terms of 'empowerment', 'humility' and 'stewardship' with followers. Their results reinforced the notion that servant leadership was relevant and suited to service-orientated organisations, with benefits for supporting, valuing and developing people.

Servant leadership is also valued because its key principles (Spears 1995; Box 2.3), which support caring and compassion, seem to fit appropriately within current and dominant values that are parallel with healthcare and nursing. Eicher-Catt (2005), however, believes that servant leadership is a

Box 2.3 Ten principles of servant leadership	
Listening	Conceptualisation
Empathy	Foresight
Healing	Stewardship
Awareness	Commitment to the growth of people
Persuasion	Building community

myth that is unworkable in the real world, that it fails to live up to its promise of being gender neutral and in fact – because of the paradoxical language and apposition of 'servant' and 'leader' – that it accentuates gender bias, so that it ends up supporting androcentric patriarchal norms. There is also an argument put forward by Avolio and Gardner (2005) that servant leadership has not been developed from an empirical base and is therefore purely theoretical.

Reflection Point

Reflect on the ward, unit, clinic or clinical area that you are on now. What management/leadership style does the ward manager, clinical manager, therapy team leader (or whatever they are called) adopt? Discuss this (tactfully) with them. What style do they feel they have adopted? Are you both in agreement?

The Right Leader at the Right Time

The essence of the great man, trait and style theories of leadership is that the individual leader is critical, but the context is not. Therefore, as long as the right leader with the appropriate leadership qualities is found or selected, the leader will be able to lead, under any circumstances. These theories imply that organisations, businesses, the military and other groups should concern themselves with the search for and development of leaders rather than be preoccupied with the context within which they have to operate. Indeed, this has been the approach taken by many organisations and much of the literature related to leadership from a military, political, spiritual and business base revolves around describing the lives and achievements of highly regarded military generals (Fest 1974; Grabsky 1993; D'Este 1996; Hibbert 1998; Useem 1998; Grint 2000; Krause 2000; Adair 2002a); political juggernauts (Mandela 1994; Harvey 1998; Danzig 2000; Adair 2002a; Carwardine 2003; Gallagher et al. 2003); religious figureheads (Carson 1999; Grint 2000; Adair 2002a); and captains of industry (Banks 1982; Lacey 1986; Clemmer & McNeil 1989; Allan 1992; Branson 1998; Useem 1998; Danzig 2000; Grint 2000; Krause 2000; Kouzes & Posner 2003).

Situational or contingency theory, and to a small degree the big bang theory of leadership, imply that both the individual and the context are fundamental. These theories describe the leader as being aware of their own leadership skills and of the context within which they lead, so that they can plan for the degree of alignment between their leadership approach and the situation they are in. For example, where a crisis occurs and a strong leader is available, this leader can step forward to lead and only step back (if required) when the situation changes and the context is no longer conducive to

their vigorous approach. Leadership is arrived at by supporting the leader in being self-aware and by situational analysis, so that, in effect, certain situations demand certain types of leader. Skilful leaders may be able to adapt their style to suit particular situations and, as such, the leader's behaviour or actions may change to suit the situation at hand. These theories of leadership found favour in, and developed from, research and literature derived from management and business perspectives (Blanchard, Zigarmi & Zigarmi 1994; Adair 1998; Adair 2002b; Northouse 2004); and transformational and transactional theories of leadership also developed as researchers sought to explore the differences between leadership and management (Bennis & Nanus 1985; Bass 1990).

If leadership is seen to be about unifying people around values, and then constructing the social world for others around those values and helping people get through change, identifying a leadership theory that will facilitate people or practitioners to understand the application of leadership in their clinical environment or situation is important. To this end, the chapter 4 explores the elements of leadership as they relate to the practice of clinical nurse leadership and leadership for health professionals. In support of this, another theory, congruent leadership, is proposed and explored further.

Case Study 2.1

Elizabeth I is known as a leader who survived and prospered because she was able to blend her style and approach to leadership over the course of her life. Read about Elizabeth and consider the challenge that follows.

Female Leaders: Elizabeth I

Arguably England's greatest queen (notwithstanding a full assessment of the current reigning monarch, Elizabeth II), Elizabeth I (1533–1603) took her country from domestic turmoil into an age of empire that saw it rise to prominence as a world power. Elizabeth's mother, Anne Boleyn, was herself a formidable woman, but it was Elizabeth who emerged from the conflict of Henry VIII's reign, her brother Edward VI's short and turbulent stint as king and the religious fervour of her sister Mary's brief occupation of the crown, to become queen in 1558.

And she faced many problems. The religious differences between Protestants and Catholics domestically and across Europe, issues of succession and marriage, internal politics and division within the English court, attempts on her life by Mary Queen of Scots and sedition from foreign powers all threatened her reign.

In terms of religious tensions, Elizabeth favoured a cautious brief. To appease Catholics, she imprisoned Mary Queen of Scots, but kept her alive for many years. She established the Church of England that, although principally Protestant, had the veneer of a blend of both Catholic and Protestant practices. In this way she acted with apparent tolerance towards all religious groups, minimising conflict. However, Pope Pius V was not appeased and had Elizabeth excommunicated in 1570. Mary, although in prison, was encouraged by European allies to continue to plot against Elizabeth and in 1587 Elizabeth's patience's expired and she had Mary tried and executed for treason. Religious tensions in Europe remained high and the execution of the Scottish queen, raids by English privateers, often with royal approval, together with Elizabeth's support for Protestant rebels in the Spanish Netherlands prompted Philip II of Spain to attempt an invasion of England.

Warned of the imminent invasion, the English fleet waited in the Channel for the Spanish Armada. Elizabeth, with her army at Tilbury, addressed the men with these famous words:

> I am come amongst you … in the midst and heat of the battle, to live or die amongst you all; to lay down, for my God, and for my kingdom, and for my people, my honour and my blood, even the dust. I know I have but the body of a weak and feeble woman; but I have the heart of a king, and of a king of England, too.

The Spanish never landed, as history records that the valour of English sailors and the ferocity of the Channel weather scattered the Spanish fleet and cemented the glory of English seamanship.

Elizabeth faced many other enemies, but throughout her 45-year reign she demonstrated great personal courage, cunning, religious tolerance and intelligent leadership, so that she was able to retain almost absolute control of her throne, bringing England to a 'Golden Age'. She was often under pressure to marry and produce a child, but she claimed shrewdly that she was wedded to her kingdom and that she could not give her love or obedience to any one man. Known as 'Gloriana' throughout her reign, Elizabeth I smoothed England's transition to a modern seafaring nation, supported and oversaw the growth of an artistic awakening, and held the nation together in the face of a powerful and determined foreign power. As far as female leaders go, Elizabeth I proved to be a dominant force in national and domestic politics and she can rightly be credited with setting England on a course to becoming a world power.

Challenge: Reflect on how Elizabeth was able to adapt her leadership style to hold the nation of England together through turbulent and troubling times, and how she helped establish a 'Golden Age'. How important are flexibility and adaptability to a leader? There is a saying, 'When it comes to fashion, bend like the wind, when it comes to principles, stand like a stone.' If it is important to know when to bend, it is also important to know when to stand firm. The trick might be in knowing when to do which. How do you know? Might it relate to your values, what you believe and what is important to you? Does it relate to the type of leadership theory you subscribe to?

Summary

- Leadership can be understood and defined in a number of different ways and from a number of different perspectives.
- Leadership can be defined by considering the leader's personality, by the leader's relationship to power, authority or influence over a group, as an instrument of goal achievement or viewed from the perspective of directing or setting a group's values.
- Leadership is considered to be an important instrument in effecting change.
- Leadership can also be said to involve unifying people around values and then constructing the social world for others around those values and helping people get through change.
- There are a number of leadership theories. These include the great man theory, big bang theory, trait theory, style theory, situational or contingency theory, transformational leadership, transactional leadership, authentic leadership, breakthrough leadership and servant leadership.
- There are many different styles of leadership, including autocratic, democratic, paternalistic and laissez-faire.
- Many of the theories and definitions overlap or focus on the individual leader or the context within which the leadership takes place, or both.
- There is a wide range of views, beliefs and ideas about what leadership means, what types of leadership there are and how the types of leadership might be employed to build relationships, establish and communicate a vision, and promote, challenge and bring about change to unify people around values and organisational culture.

Mind Press-ups

Exercise 2.1

Having considered these theories of leadership, do any of them feel as if they ‘fit’ the clinical environment you work within, in terms of explaining what you understand leadership to be about? Why or why not?

Exercise 2.2

Using a general internet search engine, look for “leadership styles”. See what comes up. Identify any styles that you feel will help you and note down the positive and negative aspects of each, or any characteristics that will help you use these when describing or applying leadership styles in practice.

Exercise 2.3

Look at the ten principles of servant leadership (Box 2.3). How do these principles fit within your approach to work? Do you employ any of them in your day-to-day activities?

Exercise 2.4

Transformational leadership is associated with leaders who lead change as a definitive aspect of their role. Think about the characteristics of a transformational leader. Can you reflect on times when you could have employed a transformational leadership approach? Why would this have been appropriate?

Exercise 2.5

Think about great leaders from history, politics, the arts, education, sports or any field of endeavour. List two people for each category you choose and try to describe what it was that made them stand out as a great leader for you.

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3

Followership

David Stanley

We don't need any more leadership training; we need some followership training.
Maureen Carroll, in Lewis 2001, p. 358

Introduction: From Behind They Lead

According to Hersey, Blanchard and Johnson (1996), 'followership' is the flip side of leadership. Followers, they feel, are vital because they accept or reject the leader and determine the leader's personal power. Marion and Uhl-Bien (2001), Kellerman (2012), Raffo (2013), Malakyan (2014), and Uhl-Bien et al. (2014) agree, adding that the interaction between followers and leaders occurs on a multitude of levels, and that followers should be considered when trying to define or understand leadership. Uhl-Bien et al. (2014) suggest that the outcomes that leaders achieve are very much dependent on the attributes of their followers, with Grint commenting that followers make the leader and that 'it only requires the good follower to do nothing for leadership to fail' (2000, p. 133). As such, understanding followership can be vital if leaders are to understand the perspectives of followers.

Leaders cannot function without followers, who act as their eyes and ears and moral compass (in the business world this may even involve customers, and in the health arena it must include clients and patients). Leaders also cannot achieve much without the 'permission' of followers. Indeed, as any culture is based on the people within it, it is often because of their followers that leaders achieve their goals (Malakyan 2014). Leaders frequently get the praise for the work that followers do, and leaders should be aware that much of the credit that rests on their shoulders was first carried on those of their followers. This chapter considers what it means to be a follower and addresses the responsibilities and characteristics of followers.

Defining Followership

As Crossman and Crossman (2011) point out, definitions of followership have been intrinsically linked to definitions of leadership, particularly in terms of links to words such as 'subordinate'. More recently authors have used terms such as 'collaborators', 'partners', 'participants' and even 'constituents' to describe the changing relationship of followers to leaders (Uhl-Bien 2006). Definitions commonly

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focus on a dependent follower–leader relationship or a process in which 'subordinates' recognise their responsibilities to those who are in authority or have recognised leadership roles. Most definitions focus on a hierarchical relationship, although a few focus on the interactive nature of the follower–leader relationship (Howell & Costley 2006), with followers seen as enthusiastic, cooperative, active and engaged, as partners in the relationship rather than passive 'subordinates' waiting to be told what to do. Carsten et al., in support of these later views, define followership this way:

> Followership is a relational role in which followers have the ability to influence leaders and contribute to the improvement and attainment of group and organisational objectives. It is primarily a hierarchically upward influence. (2010, p. 559)

Followers' Responsibilities

It will be instructive to begin by considering followers' responsibilities, as, like leaders, they have many. Followers' responsibilities are no less important than those of leaders, as it is followers who enable good leadership to flourish. To be effective, followers need to recognise that they have responsibilities. These include:

- developing a high degree of literacy about the institution/organisation
- taking responsibility for achieving their personal and organisational goals
- taking ownership of their work
- being active rather than passive (Raffo 2013)
- connecting themselves to the organisation in meaningful ways
- becoming loyal to the organisation's values
- recognising and being aware of their own personal and professional values
- making a personal commitment and being open to change
- asking a great deal of the leader
- demonstrating respect
- not blaming a manager or employer for unpopular decisions or policies
- if they have an opportunity to express an opinion or view, doing so honestly; 'yes men' are poor followers (Wedderburn-Tate 1999)

Offermann (2005) suggests that leaders are vulnerable to the actions of followers; Kellerman (2012) and Malakyan (2014) go further, proposing that in recent years the balance of power has shifted in favour of followers. Leadership studies and leadership training have commonly neglected the role and place of followers in supporting leadership (Kellerman 2012; Raffo 2013; Malakyan 2014). Even good leaders can be led into making poor decisions and into ineffective leadership patterns by the actions of empowered and strong followers. Potentially worse, and more often, leaders may be hoodwinked by followers who fool them with flattery or hinder them with false realities. The case of General Sir Ian Hamilton is offered as an example of the impact of poor followership (Box 3.1).

To guard against the influence of ineffective or disruptive followers, leaders need support people who can relay bad news and who can communicate and act on a solid set of values. Leaders also need to encourage open debate and discourse so that they are not protected or insulated from those they lead (Offermann 2005).

To be effective, followers must have the confidence and courage to offer unwelcome advice or information, if necessary, because leaders require the best and most relevant information if they are

Box 3.1 A historical example of a good leader with poor followers: General Sir Ian Hamilton

General Sir Ian Hamilton was appointed commander of the Allied forces responsible for the assault on the Gallipoli peninsula in 1915. According to Rhodes-James (1965), Hamilton possessed almost every conceivable qualification for a great culmination of an exceptional career. He was an elderly professional soldier with vast experience of combat, leadership and warfare (Carlyon 2010). He also had immense physical and mental courage and resilience, and showed imagination and daring. Yet for all this, his leadership of the Gallipoli landings and subsequent assault on the peninsula failed utterly.

There were many contributing factors to the failure. Hamilton became ill with dysentery for some months, which left him incapacitated for years after the landings. He had difficult and independent-minded subordinate commanders. The effort of launching an assault more than a thousand miles from home and with a large percentage of untried and semi-trained soldiers against well-prepared and well-defended positions compounded his difficulties. Moreover, he was initially stationed offshore on the ship HMS *Queen Elizabeth* while many of his staff were on other transports. This led to significant communication problems.

As the campaign continued, Hamilton moved his headquarters to the island of Imbros and became increasingly removed from the commanders operating across the Aegean on the Gallipoli peninsula. Here he was further isolated by the actions of his administrative staff, in particular an officer called Braithwaite, who tended to protect Hamilton too enthusiastically from what he regarded as unimportant or inappropriate juniors; thus the general was kept in the dark about the reality of the situation on the peninsula (Rhodes-James 1965; Carlyon 2010).

Hamilton made considerable mistakes in his leadership of the Gallipoli campaign. He was out of touch with his front-line commanders for far too long, and he failed to intervene personally in the conduct of the battles or to respond speedily to requests for support or direction. However, he was also poorly served by his administrative staff, in particular Braithwaite, who painted an overly optimistic view of the developing battles and who went as far as keeping vital information from Hamilton at crucial times.

In many respects, Hamilton's failure was the result of his isolation and shelter from the realities of the campaign by his distance from the front line and by interfering administrative staff. Sir Ian Hamilton was an elderly veteran of the British Army and his staff's respect and care actually failed to serve him with accurate and realistic information on which he could base his decisions. In this example, Hamilton's followers had a negative impact on his capacity to flourish as a leader.

to make clear and accurate decisions. Being a follower is not about trailing, sheep-like, in the wake of a leader because they have authority or because they have been appointed to lead, nor is it about abdicating responsibility and waiting passively for the problems around you to be solved. Followers should be deeply involved in the fabric of an organisation/ward or team and participate by actively engaging with the tasks and duties, decisions and direction under consideration. Effective followership prepares people to be effective leaders (Raffo 2013; Malakyan 2014). Followers should seriously consider questions about their responsibilities to the organisation and the leader, and be willing to honestly question their capacity to follow effectively before undertaking a followership role. Followers should think about these issues:

- How good are their followership skills?
- Are they ready to be engaged as followers?

- Are they courageous enough to offer honest and potentially unwelcome information?
- Are they ready to change or adapt along the lines the leader is heading?
- Are they perceived by their leader as a good follower?
- What style of follower do they represent?

In an article about followership in 2002, Paul Di Carlo suggests that there are five types of follower. He describes them in what he calls the 5-P follower model:

- **Participant**: followers who are actively involved and contribute to moving forward
- **Pessimist**: followers who think that change means 'we're doomed' and need to share this with everyone
- **Passenger**: followers who are only here in body, the mind is elsewhere
- **Pig**: followers who are only here for the food
- **Prisoner**: followers who are here, but not by choice

Reflection Point
Look around your organisation, ward or healthcare team. What type of follower are you? What about your fellow followers, what sort of followers are they? Where might they fit on Di Carlo's 5-P follower model?

Di Carlo's 5-P follower model is not the only way to consider the type of follower you might be. Kelley (1988) suggests that followers can be identified by five levels of activity and critical thinking: sheep; yes people; alienated followers; survivors; and effective followers. Douglas (1992) proposes that followers display a range of followership styles from 'very democratic' to 'very autocratic', and he developed a short questionnaire to explore the preferred style. The intention is that followers read a range of 16 statements about the type of employer they would prefer to be in a followership role to. Five options from 'strongly agree' to 'strongly disagree' are offered for each statement, and the score total gives an insight into the follower's preferred style. Box 3.2 is an adaptation of Douglas's Followership Style Questionnaire.

The questionnaire contains 16 statements about the type of employer/leader you prefer. Imagine yourself in a subordinate (follower) position of some kind and use your responses to indicate the preferred way in which your employer/leader might interact with or relate to you. The responses are marked on a five-point scale with ratings SA = strongly agree, A = agree, MF = mixed feelings, D = disagree and SD = strongly disagree.

Followership is not easy and can often be inhibited by a number of factors. These include:

- Leaders who are not trustworthy
- Leaders who are poor communicators
- Leaders whom the followers find they cannot respect
- Leaders who think followers should read minds (poor communication again)
- Followers who feel as if they are not 'needed' in an organisation or who are under-valued
- Poor change processes that exclude followers or neglect their needs or concerns
- Leaders who make poor attempts at getting followers to participate
- Poor attention to rewards (which go far beyond monetary issues)
- Leaders who employ inequality, bias, nepotism and unfairness
- Leaders who are cynical, destructive or hard to approach

Box 3.2 Followership Style Questionnaire

	Statements	SA	A	MF	D	SD
1	I expect my job to be very explicitly outlined for me.	1	2	3	4	5
2	When the boss says to do something, I do it. After all, he/she is the boss.	1	2	3	4	5
3	Rigid rules and regulations usually cause me to become frustrated and inefficient.	5	4	3	2	1
4	I am utterly responsible for and capable of self-discipline based on my contacts with the people around me.	5	4	3	2	1
5	My job should be made as short in duration as possible so that I can achieve efficiency through repetition.	1	2	3	4	5
6	Within reasonable limits I will try to accommodate requests from persons who are not my boss because these requests are typically in the best interests of the company anyway.	5	4	3	2	1
7	When the boss tells me to do something that is the wrong thing to do, it is their fault, not mine, when I do it.	1	2	3	4	5
8	It is up to my leader to provide a set of rules by which I can measure my performance.	1	2	3	4	5
9	The boss is the boss. And the fact of the promotion suggests that they are on the ball.	1	2	3	4	5
10	I accept orders only from my boss.	1	2	3	4	5
11	I would prefer my boss to give me general objectives and guidelines and then allow me to do the job my way.	5	4	3	2	1
12	If I do something that is not right, it is my own fault, even if my supervisor told me to do it.	5	4	3	2	1
13	I prefer jobs that are not repetitious, the kind of task that is new and different each time.	5	4	3	2	1
14	My supervisor is in no way superior to me by virtue of position. They do a different kind of job, one that includes a lot of managing and coordinating.	5	4	3	2	1
15	I expect my leader to give me disciplinary guidelines.	1	2	3	4	5
16	I prefer to tell my supervisor what I will or at least should be doing. I am ultimately responsible for my own work.	5	4	3	2	1
	Total =					

Scoring: add all the numerical values together (e.g. the total might be 70). Now divide this by 16 (the total number of questions, e.g. 70 divided by 16 = 4.37, a score in the 'very democratic' range). See the ranges below to determine your followership style.

Score	Description	Followership style
Less than 1.9	Very autocratic	Cannot function well without programmes and procedures, needs feedback
2.0–2.4	Moderately autocratic	Needs solid structures and feedback, but can also carry on independently
2.5–3.4	Mixed	Mixture of above and below
3.5–4.0	Moderately participative	Independent worker, does not need close supervision, just a bit of feedback
Greater than 4.1	Very democratic	Self-starter, likes to challenge new things by themselves

Source: Douglas, L. M. (1992) *The Effective Nurse Leader and Manager*, 4th edn, St Louis, MO: Mosby, pp. 25–8.

The Good Follower

Good followers do not withhold or avoid difficult options. Good followers need to be courageous. They search for other points of view. They seek out the 'why' in each situation. They keep the leader honest, give opinions and offer the organisation a chance at greatness. Good followers increase both the leader's chance of getting the job done and the relationships made. Good followers are the keys to leadership success and change. Understanding the needs and concerns of followers is vital for leaders if they are to engage them in supporting and working effectively together.

Reflection Point

When you picked up this book I am sure you considered your role as a leader, but have you ever thought about your role as a follower? Malakyan (2014) is clear that leaders and followers are almost symbiotic in their relationship, each being dependent on the other. What impact might the position of the follower have on the leader's capacity to lead or follow through with their change agenda and innovations? What if the characteristics of the followers determined the type of leader that emerged? Kelley (1992), for example, suggests that without his armies (followers), Napoleon was just a man with grandiose ambitions. What impact do your followers' behaviours have on your success or ability to be a leader?

Looking at the leadership–follower dyad (a group of two) from a postmodern perspective, it might be suggested that it is situational, context driven or jointly constructed. To provide some structure at this point, here are three ways in which the leadership–follower dyad has been construed:

- Leadership can be explained in terms of a leader–member exchange relationship, where leaders provide direction and support, and followers achieve agreed outcomes (Avolio & Bass 1988). Such approaches define follower characteristics as **dependent variables**, influenced by a leader (Dvir & Shamir 2003).
- Situational leadership theories describe follower characteristics as **moderator variables** (Vroom & Yetton 1973); that is, the characteristics of *followers* act to influence the relationship between the leader and the follower, and/or the leader and their actions.
- In general, very little effort has been expended in examining follower characteristics (as opposed to behaviours) that act as **independent variables**; that is, follower characteristics that have a direct effect on leader behaviours.

Three examples of studies that have explored follower characteristics as independent variables are those by Bass (1990), Ehrhart and Klein (2001) and Dvir and Shamir (2003). Bass (1990) focused more on a review of follower behaviour in relation to the success of the transformational leader. Ehrhart and Klein (2001) and Dvir and Shamir (2003) studied follower characteristics and noted that successful transformational leadership is not just inherent within the leader's role, but is significantly influenced by the leader–follower relationship. Raffo (2013) identified the characteristics of postindustrial followers and suggested that these included self-management, team spirit, a positive attitude, being a contributor, competence and being ethical.

Malakyan (2014) is of the view that leaders and followers can even trade places and that this forms the basis of their co-dependence. Leadership traits are not superior to followership traits and therefore leadership and followership need to be seen as non-static and dynamic, and leaders and followers need to approach their co-dependence willingly.

In relation to congruent leadership, followers have much of the power, because if they do not align themselves with the values and beliefs of the leader, they will not follow that leader. The leader will be isolated and even if they are not aware of their lack of followers, the leader's actions will not generate motivation among followers or identification with the leader's values and beliefs. The important message to take away from these suggestions is that you do not have to assume that following a leader renders the follower powerless and passive.

Effective leadership is an active process that is affected by the characteristics of, and interaction between, the leader, the follower and the context. As such, these variables can be used both to understand these relationships and to engage more effectively as a leader and as a follower. Regardless of the theoretical model involved, this is a discussion about a relationship; that is, it would be reasonable to surmise that a leader–follower dyad works, or does not work, depending on the quality or type of relationship bonds (and values-based links) developed between a follower and a leader.

The Not-So-Good Follower

Not all seemingly compliant followers are 'good' or useful. Wedderburn-Tate (1999, p. 130) suggests that 'just say yes' followers support the concept of wanting to please the leader by doing or saying what the leader wants. However, she claims that this can lead to the creation of an unhealthy relationship where the yes-sayer and the leader 'mis-serve' each other. The leader is given positive responses by the follower, who may misrepresent reality for fear of offending or appearing disloyal; while the leader – seeking more relevant information or new yes-sayers – sees the follower as superfluous. Yes-sayers are almost sycophantic in their approach to loyalty and rarely offer genuine service to the leader or the organisation.

Wedderburn-Tate (1999) proposes a list of symptoms of leaders with a tendency to prefer yes-sayers:

- They perceived followers who were not yes-sayers as troublemakers
- They perceived followers who were not yes-sayers as not team players

- They did not like people who disagreed with them
- They saw disagreement as a sign of disloyalty
- They believed that disagreement always causes conflict
- They may tell lies to protect followers from harm (real or perceived)
- They are keen to please those in positions of power

The story of General Hamilton is an example of the negative impact on a leader of being served by followers who tried to please and protect him from reality. A leader can recognise this and should be on guard against it. Yes-saying followers tend to be:

- dismissive of comments or feedback by other followers who want to offer realistic information to the leader
- dissenting or even bullying of other followers who want to offer realistic feedback to the leader
- keen to monopolise the leader's time
- keen to offer their views and opinions without being sought
- over-protective of the leader, their vision or values, and staunchly active (almost fanatical) in defence of the leader if criticised
- 'close' to the leader, in personal terms or in proximity, standing by them or usually sitting by them in meetings or at social gatherings

Reflection Point

General William T. Sherman (famous during the American Civil War) said, 'We have good corporals and good sergeants and some good lieutenants and captains, and those are far more important than good generals.' If this is the case, does it apply to healthcare organisations? If so, how? Are middle- and lower-level leaders more significant in determining the success and progress of an organisation? Does Sherman's statement apply in your ward, clinical area or clinical domain? If so, what does that mean for issues like leadership/followership training or career progression?

Followership and leadership are uniquely and inextricably linked in a symbiotic relationship (Wedderburn-Tate 1999). Dynamic leadership is dependent on and influenced by the style that followers employ and by their capacity to take followership responsibilities seriously. In the same way that effective leaders need to understand and foster their understanding of followership, followers need to recognise that they have a responsibility to the leader to be 'good' followers. Good followers increase the leader's chance of getting the task or job done, as well as offering the organisation a chance at greatness. In many ways, followers are the key to an organisation's and a leader's success.

Case Study 3.1

Dorothea Dix was a leader who lost her followers and was soon lost to history (for a while). Read about Dorothea and consider the challenge that follows.

Female Leaders: Dorothea Lynde Dix

Known as the American Florence Nightingale, Dorothea Dix did much as a social activist and health reformer before and after the American Civil War. She was born in 1802 in Maine, grew up in Worcester, Massachusetts and then lived with her wealthy grandmother in Boston. Her father was an alcoholic and

Dorothea, though supported by her grandmother, struggled initially in traditional female occupations: governess, teacher and writer. She refused a proposal of marriage, choosing instead to focus on her teaching career; however, unhappy with her life, in her mid-30s she suffered a debilitating breakdown. Hoping for a cure, she travelled to England. There she was fortunate to meet with a family of Quakers and notable social reformers, who suggested that the government should better support an active role in social welfare. She was exposed to the British lunacy reform movement and on finding a more useful purpose for herself, returned to America in 1840–41.

Following on from what she had observed in England, Dorothea undertook an investigation into how the insane poor were cared for in Massachusetts. Her report painted a bleak picture. She described people caged, kept in stalls and pens, in chains, sometimes naked and even beaten. The outcome was a Bill to expand the state's mental health hospitals and provide better care for the insane.

She travelled with great energy to a number of other states across the north of America, producing similar evaluations and engaging with legislators to draft reform Bills in other states. In 1854 she initiated a Bill in Congress, whereby federal land would be sold to support further facilities for the insane, but President Franklin Pierce vetoed this, arguing that the federal government should not be involved in state-related medical responsibilities. Disappointed by this setback, Dorothea left again for Europe. She took part in an evaluation of Scottish insane asylums and participated in the development of the Scottish Lunacy Commission.

On her return to America, she once more turned to social reform activities, but these were interrupted by the outbreak of the Civil War in 1861. Dorothea was soon appointed Superintendent of (Female) Union Army Nurses and she set about recruiting nurses for the cause. She drew up a list of requirements for applicants that included (Ward, Burns & Burns 1992, p. 149):

- a certificate from two physicians
- a certificate from two clergymen
- being at least 30 years old
- being of good health
- being of good moral character
- being unattractive and modest of dress

More than 3000 women volunteers applied (many were nuns) and they served with the Union (Northern) army throughout the war. Dorothea and her nurses provided what comfort and care they could, often faced with staggering numbers of wounded from both armies. They did not differentiate between them; as one of the Dix nurses stated, 'though enemies, they were nevertheless helpless, suffering human beings'. The Southern army had minimal medical services and Dorothea is fondly remembered in the Southern states for her bipartisan care of their troops during the war. Sadly, the skills she employed as a social crusader (independence, single-mindedness, passion, energy) were less useful when managing large numbers of female nurses. Although a superb organiser, she often clashed with Army doctors (who referred to her as 'Dragon Dix'), to the point where she felt she had no real authority. Dorothea's duties involved organising training facilities for nurses, purchasing supplies, recruiting nurses and setting up field hospitals. She was ill prepared for dealing with the military establishment and was often in conflict with doctors over their drinking habits and neglect of sanitation. Her nurses too commonly found her aloof and although soldiers saw her as an 'angel of mercy', she often felt alone in her efforts to deal with the female nursing service. She recalled her contribution during the Civil War years as the greatest failure of her life.

(Continued)

Case Study 3.1 (Continued)

After the war Dorothea worked to help trace missing soldiers and to assist soldiers in securing their pensions, before returning to social reform activities. In 1881 she moved to New Jersey and lived at the state hospital, where she was awarded a private suite for her use, for 'as long as she lived'. Increasingly an invalid, she maintained a vital correspondence with nurses around the world until her death in 1887.

As a social reformer (she was never trained as a nurse), Dorothea Dix made significant personal contributions to the welfare of mentally ill people in both Europe and America. Her views on the treatment of the mentally ill were radical for the time and very humane, influenced by her unhappy upbringing, social advantages, education and personal passion to make legislative and social improvements for their welfare.

Challenge: Dorothea remembered her greatest contribution as her greatest failure. What might you say to someone you know who has lost sight of the great work and contribution they make in healthcare? Dorothea was unsupported by the medical men and to some extent by the Northern Army in general. What role do followers have in supporting the work of the leader? Would Dorothea's assessment of her efforts have been more sympathetic if she had been given more relevant feedback by those she led in the nursing service and in the Northern Army administration?

Summary

- Followership is the flip side of leadership.
- Understanding followership is vital for leaders to understand the perspectives of followers.
- Followers have responsibilities that are at least as important as the leader's responsibilities.
- Followers often display a preferred style. This can be determined to assess their capacity to follow or hinder a leader's course.
- Good followership can be inhibited by poor leadership.
- Followers are not powerless and good followers have the power to make good leaders great.

Mind Press-ups

Exercise 3.1

Reflect on the relationships you have had with a past or present 'leader'. Think about the kind of working relationship you have had with them and what thought (if any) you have put into your responsibilities as a follower.

Exercise 3.2

Undertake the Followership Style Questionnaire in this chapter. What are your thoughts about the result?

Exercise 3.3

Does your organisation encourage the participation of followers? Do you feel that you have 'power' as a follower? If not, how could you use some of the change models offered in Chapter 7 to increase your influence as a follower?

Exercise 3.4

Who would you identify as the most effective followers in your ward/clinic/team or clinical area? Are these the same people you might identify as leaders or potential leaders?

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4

Congruent Leadership

David Stanley

We are what we think,
All that we are arises with our thoughts.
With our thoughts we make the world.
Speak or act with a pure mind
and happiness will follow you as your shadow, unshakable

The Dhammapad

Introduction: A New Theory

This chapter outlines a new leadership theory called congruent leadership. The theory grew from the results of a substantial research project and has been supported in subsequent studies that were developed specifically to explore the concept of clinical leadership in the health service (Stanley 2006a, b, 2008, 2010, 2011, 2012; Stanley & Sherratt 2010; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015). Congruent leadership is proposed as a framework to support an understanding of clinical leadership and offers the new hypothesis that clinical leaders are more appropriately seen and recognised because of a match between their values and beliefs, and their actions (Stanley 2008, 2011, 2012).

The first part of the chapter outlines how the theory of congruent leadership was developed (or discovered). Then the chapter will elaborate on the theory, what it means, how it is defined and what constitutes congruent leadership. Examples of congruent leadership from practice are offered and it is suggested that clinically focused leaders who display their values and beliefs may be able to effectively foster support, lead clinically and drive change, even if they are not initially aware that this is possible or that they are even being followed. The chapter also highlights how congruent leadership is related to power, quality processes, innovation and change and why it offers a solid foundation for clinical professionals to develop and gain leadership potential. The strengths and limitations of congruent leadership are also explored.

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Congruent Leadership: A Beginning

The theory of congruent leadership developed from the results of my doctoral research and a series of subsequent studies that explored clinical leadership from the perspective of a number of health professional disciplines. The initial research was undertaken with nurses at a large acute hospital in the UK between 2001 and 2004. This was followed up with four further research projects that explored the phenomenon of clinical leadership from the perspective of paramedics (in 2008), senior registered nurses and managers in the aged care arena (in 2012), ambulance volunteers (in 2013) and allied health professionals, mainly dietetists, occupational therapists, physiotherapists, social workers, podiatrists and speech therapists (between 2014 and 2015), all in Australia. It was soon clear that none of the previously established leadership theories described or supported the results that began to emerge from the research. As such, a new leadership theory was needed.

Congruent leadership is proposed as a new theory to frame and understand leadership in the health service (although it is highly likely that the theory can be extrapolated to other domains). It better explains and understands leadership predominantly located in the clinical area, at the bedside, in the clinic, for the paramedic at the roadside and across all healthcare-related disciplines. Beyond this, congruent leadership can be used to explain leadership in education, at the chalkboard or whiteboard; in industry and business, at the coalface or in the office; and in the military, on the battlefield. This introduction sets out to explain what congruent leadership is and how it came into being.

It all Started with Clinical Leadership

At the time that I started to explore clinical leadership, the dominant theory supporting clinical and healthcare leadership was transformational leadership (Freshwater, Graham & Esterhuizen 2009; Marriner-Tomey, 2009; Weberg 2010; Marshall 2011; Jones & Bennett 2012; Tinkham 2013; Ross et al. 2014). However, transformational leadership theory is based on the leader's vision, and how their vision is communicated to those who see them as leaders (or are told they are their leaders, e.g. managers). In the course of the leadership research I have undertaken, having a vision or being visionary was seldom identified by respondents as being relevant or significant. Instead, clinically focused leaders were rarely described as having or requiring the attribute of being visionary. This led to a conclusion that established leadership theories, which rested on 'vision' as their basis, were unable to describe the type of leadership displayed by clinically focused leaders.

There were other theories to consider too. Australian authors Bhindi and Duignan (1997) described what they called 'authentic leadership', where in order to lead, leaders were required to be true to themselves, with this approach to leadership based on the leader's personal credibility and integrity. This was followed by George (2003), who also described 'authentic leadership' in which leaders served others through their leadership and by focusing on their values. These views run parallel to Pondy's (1978) description of leadership where leaders were encouraged to explore their values and lead from recognition of what was identified as important; a view further supported by Scully (2015), who asserted the importance of positive values in leadership.

In the research studies described shortly, time and time again, what stood out as important were values in action, and respondents made comments that supported or pointed to the idea that clinically focused leaders or those who were described as clinical leaders were rarely seen to be driven by or

heard to be articulating a vision. Respondents commonly said something like 'That one' (as they pointed from the interview room when a particular nurse passed the door), 'that one, she is a clinical leader … if my mother becomes sick, she's the one I'd want to look after her.' Or as one allied health professional said, 'a clinical leader is an expert in their field … approachable, effective communicators and empowered, are able to act as a role model, motivating others by matching their values and beliefs about care to their practice.'

It was evident that it was the leaders' actions that drew people to identify them as clinical leaders, and it was the synergy of values between the person identifying the leader and the leaders' actions that prompted these leaders to be seen as such.

Five research studies were undertaken by this author and colleagues that led to and support the development of congruent leadership theory. They are offered in outline in Boxes 4.1 to 4.5.

Box 4.1 Clinical Leadership Study 1

Study title
In Command of Care: Clinical Nurse Leadership (Doctoral thesis)

Aim
To identify who the clinical leaders are in a large NHS Trust in the English Midlands and to explore and critically analyse the experience of being a clinical nurse leader.

Location
Worcestershire Acute NHS Trust in the English Midlands

Dates
Feb 2001–Dec 2004

Methodology
Qualitative – grounded theory

Methods
Questionnaire and interviews

Target group
Registered/qualified Nurses (D–H Grade) on 36 clinical areas (in three hospitals) across one NHS Acute Trust

Analysis
Interviews = NVivo 0.6 and manual data configuration
Questionnaire = SPSS

Sample
Interviews n = 50 (42 RNs/8 clinical leaders)
Questionnaires 850 sent out, 188 returned (22.6%)

Gender mix
Questionnaire
Female = 95%
Male = 5%
Interviews
Female = 100%

Ethics
West Midlands South Strategic Health Authority: Hereford and Worcester Local Research Ethics Committee; LREC 02/43 and permission from Worcester Royal Hospital DON

Results
Clinical leaders were recognised because they were approachable, clinically competent, visible in practice, made effective decisions and communicated well. They were seen to be empowered and positive clinical role models who, most importantly, displayed their values and beliefs and held fast to their guiding principles about care and nursing. The results indicated that the attribute least likely to be associated with clinical leadership was 'controlling' (78%). The data pointed to another leadership theory that supported clinically focused leadership. This was called congruent leadership. This grew from both the questionnaire and interview results, which suggested that clinical leaders were followed because their colleagues and peers saw the leader's actions as a translation of their values and beliefs into practice.

(Continued)

Box 4.1 (Continued)

Clinical leaders were evident in large numbers and represented a wide range of levels of staff, but most commonly it was the most senior clinically focused nurses and rarely the ward managers who were selected or identified as clinical leaders. In addition, the clinical leaders seemed to be more commonly identified in specialist areas of practice, such as accident and emergency and intensive care areas.

Clinical leaders were often unaware that they had followers and commonly clinical leaders were not 'tagged' to a titled or senior position. The common theme was that clinical leaders had their values on show and these were based on a foundation of care. Moreover, many of the clinical leaders identified suggested that they faced issues of role conflict and struggled to maintain their 'clinical focus' in the face of 'management demands'.

Related publications

Bishop, V. (ed.) (2009) *Leadership in Nursing and Allied Health Care Professions*, Buckingham: Open University Press.
Chapter 2: Leadership and management: A new mutiny?
Chapter 7: Clinical leadership and the theory of congruent leadership
Lawrence, J., Perrin, C. & Kierman, E. (2015) *Building Professional Nursing Communication*, Cambridge: Cambridge University Press.
Part of Chapter 8: Professional skills for nurses and other health professionals: Context and capability of practice
Stanley, D. (2004) 'Clinical leadership: A pilot study explored', *Paediatric Nursing*, vol. 16, no. 3, pp. 39–42.
Stanley, D. (2006a) 'Part 1: In command of care: Clinical nurse leadership explored', *Journal of Research in Nursing*, vol. 2, no. 1, pp. 20–39.
Stanley, D. (2006b) 'Part 2: In command of care: Towards the theory of congruent leadership', *Journal of Research in Nursing*, vol. 2, no. 2, pp. 132–44.
Stanley, D. (2006c) 'Role conflict: Leaders and managers', *Nursing Management*, vol. 13, no. 5, pp. 31–7.
Stanley, D. (2006d) 'Recognising and defining clinical nurse leaders', *British Journal of Nursing*, vol. 15, no. 2, pp. 108–11.
Stanley, D. (2007) 'Lights in the shadows', *Contemporary Nurse*, vol. 24, no. 1, pp. 45–51.
Stanley, D. (2008) 'Congruent leadership: Values in action', *Journal of Nursing Management*, vol. 64, pp. 84–95.
Stanley, D. (2009) 'Leadership: Behind the mask', *ACORN*, vol. 22, no. 1, pp. 14–20.
Stanley, D. (2010) 'Clinical leadership and innovation', *Connections*, vol. 13, no. 4, pp. 27–8.
Stanley, D. (2011) *Clinical Leadership: Innovation into Action*, Melbourne: Palgrave Macmillan.
Stanley, D. (2012) 'Clinical leadership and innovation', *Journal of Nursing Education and Practice*, May, pp. 119–26.
Stanley, D. (2014) 'Clinical leadership characteristics confirmed', *Journal of Research in Nursing*, vol. 19, no. 2, pp. 118–28.
Stanley, D. & Sherratt, A. (2010) 'Lamp light on leadership: Clinical leadership and Florence Nightingale', *Journal of Nursing Management*, vol. 18, pp. 115–21.

Box 4.2 Clinical Leadership Study 2

Study title

Perceptions of Clinical Leadership in the St John Ambulance Service in Western Australia

Aim

To identify how clinical leadership is perceived by paramedics and ambulance personnel in the course of their everyday work and the effectiveness and consequences of the application of clinical leadership in pre-hospital care delivery.

Location

Western Australia (metropolitan, rural and remote areas of practice)

Dates

Feb–Nov 2010

Methodology

Qualitative – phenomenology

Methods

Questionnaire

Target group

250 paramedic (non-volunteer) and ambulance officers who attended in-service education between February and November 2010 in Perth, Western Australia

Analysis

Questionnaire = SPSS and spreadsheet

Sample

250 questionnaires distributed, 104 returned = 41.6% return rate

Gender mix

Questionnaires
Female = 36%
Male = 64%

Ethics

Ethical approval was sought and secured through the Curtin University Human Research Ethics Committee (Nu: SON&M 1-2010)

Results

In relation to the characteristics of a clinical leader, most respondents suggested that clinical leaders needed to be clinically competent (96%), a role model for others (93%), an effective communicator (89%), inspire confidence (85%), be approachable (96%) have integrity (93%), be supportive (91%), be a decision maker (87%), be visible in practice (86%) and set direction (87%). Just over 84% indicated (in keeping with Study 1) that 'controlling' was the attribute least associated with clinical leadership.

Under half (42%) saw themselves as clinical leaders, although over one-third (35%) felt that they could not engage in leadership activities for a range of reasons, including a lack of encouragement, lack of training opportunities, work pressures and a lack of opportunity to be leaders. Almost 60% indicated that they faced barriers to becoming or deploying clinical leadership, with many indicating that they faced resistance from colleagues, no opportunities, the current management culture and a lack of experience.

Of the 104 respondents, their average length of service with the St John Ambulance Service was just under 7 years (6.9 years), with the longest service of any respondent being 30 years. In terms of formal leadership training, only 40.6% indicated that they had had some sort of formal leadership training (although it was not clear what constituted this). In terms of formal management training, 26% indicated that they had had some sort of management training. The gender make-up of the respondents was in keeping with the wider ambulance service, with 64% men. The age distribution showed that the majority (68%) were under the age of 41. A large number of respondents were from metropolitan centres, with only 7.4% of respondents indicating that they were based in rural or regional areas.

(Continued)

Box 4.2 (Continued)

Most respondents did not care where their experience was from or what sort of experience it was as long as they had valid roadside experience. Most did not value research insights or qualifications. What mattered was that the values of the clinical leaders were matched by their actions and abilities.

Many did not see themselves as clinical leaders and few thought that they could influence organisational issues. Most respondents thought that they should have an influence on clinical care and valued team working. Clinical leaders (in keeping with Study 1) were seen to be visible role models, leaders in clinical practice, skilled, experienced, clinically focused, approachable, knowledgeable, driven by their desire to provide high-quality care, of high moral character and practised in change. They were seen to be team members who made decisions, often under pressure.

Related publications

Stanley, D. (2011) *Clinical Leadership: Innovation into Action*, Melbourne: Palgrave Macmillan.

Stanley, D., Cuthbertson, J. & Latimer, K. (2012) 'Perceptions of clinical leadership in the St. John Ambulance Service in WA. Paramedics Australasia', *Response*, vol. 39, no. 1, pp. 31–7.

Stanley, D. (2013) 'Perceptions of clinical leadership in the St. John Ambulance Service in WA: A research report', http://www.sph.uwa.edu.au/__data/assets/pdf_file/0003/2272647/Report-Perceptions-of-clinical-leadership-in-the-St.pdf (accessed 1 July 2016).

Box 4.3 Clinical Leadership Study 3

Study title

Leadership at Home: Perceptions of Clinical Leadership at Swan Care Group Bentley Park

Aim

To investigate perceptions of leadership and approaches to leadership development of senior nurses and care home managers in an aged care residential facility in Western Australia.

Location

Swan Care residential facility in Bentley Park, Perth, Western Australia

Dates

Mar–Sept 2012

Methodology

Qualitative – phenomenology

Methods

Questionnaire and interviews

Target group

Senior clinical nurses and residential care home managers in a residential care home in Western Australia

Analysis

Interviews = NVivo 0.6 and manual data configuration
Questionnaire = SPSS

Sample

20 staff were sent questionnaires: 10 with a return rate of 50%
Eight senior nurses or care home staff were interviewed (some had also completed the questionnaire)

Gender mix

Questionnaires
Female = 100%
Male = 0%
Interviews
Female = 100%
Male = 0%

Ethics

Ethical approval was sought and secured with the University of Western Australia Human Research Ethics Office (RA/4/1/5084) and the study had the consent of the management of Swan Care Bentley Park

Results

Results of the study indicated that the attributes and characteristics of clinical leaders identified by the senior nurses and care home managers who participated in the study were consistent with the results of the two previous studies. The vast majority of respondents suggested that clinical leaders were identified because they were approachable (100%), had sound clinical skills and knowledge (100%), were honest, had integrity (100%), supported others (100%) and were visible in the clinical area (100%).

It was also noted that participants saw a distinction between leadership and management and that their more clinically focused roles led them towards a leadership-centred approach. However, few had any leadership instruction beyond clinical 'experience' and almost all saw barriers that hindered their development or application of leadership in the care home environment. In order to play a more effective part in service improvement and care provision and have a positive impact on resident care and staff support, it was considered essential that senior nursing and care home managers be better supported to recognise the significance of developing clinical leadership attributes and applying them in the care home environment.

As with the two previous studies, few participants saw themselves as clinical leaders, although they recognised that clinical leaders were evident at all levels in the care home, and again, the 'manager' was less likely to be seen as a clinical leader than the more senior clinically focused nursing staff. As with the previous studies, the attribute least likely to be associated with clinical leadership was 'controlling' (80%). Again, leaders seemed to be recognised because they had their values on show, rather than because of any affinity with their vision.

Related publications

Stanley, D. (2013) 'Leadership at home: Perceptions of clinical leadership at Swan Care Group, Bentley Park: A pilot study report', http://www.sph.uwa.edu.au/__data/assets/pdf_file/0004/2272639/Leadership-At-Home-Swan-Care-Group-report.pdf (accessed 1 July 2016).

Stanley, D., Latimer, K. & Atkinson, J. (2014) 'Perceptions of clinical leadership in an aged care residential facility in Perth, *Western Australia', Health Care Current Reviews*, vol. 2, pp. 122. doi:10.4172/hccr.1000122

Box 4.4 Clinical Leadership Study 4

Study title

Volunteer Ambulance Officers' Perceptions of Clinical Leadership in St John Ambulance Services Western Australia Incorporated

Aim

To identify how clinical leadership skills were perceived by volunteer ambulance officers in the course of their everyday work and the effectiveness and consequences of such skills in pre-hospital care delivery

Location

Western Australia (metropolitan, rural and remote areas of practice)

Dates

Sept 2012–Apr 2013

Methodology

Qualitative – phenomenology

Methods

Online and paper-based questionnaires

Target group

Volunteer ambulance officers (VAO) in Western Australia

Analysis

Questionnaire (paper-based and online) with SPSS

Sample

Approximately 500 VAO were sent questionnaires (although there were estimated to be 2,787 VAO in the service in WA at the time of the study) and 61 were returned, a return rate of only 12.2%

Gender mix

Questionnaire
Female = 49%
Male = 51%

Ethics

Ethical approval was sought and secured with the University of Western Australia Human Research Ethics Office (RA/4/1/5451) and had the consent of the management of the St John Ambulance Service WA Inc.

(Continued)

Box 4.4 (Continued)

Results

Respondents' average length of service with the St John Ambulance Service was just under 10 years (9.9 years), with the longest service of any respondent being over 40 years. In terms of formal leadership training, only 32.7% indicated that they had some sort of formal leadership training (although it was not clear what constituted this). A further 60.7% indicated that they had not had any formal leadership training and 6.6% were not sure. In terms of formal management training, a similar 31.2% indicated that they had had some sort of management training, while 65.5% indicated that they had not, and 3.3% were unsure.

The gender make-up of the respondents was interesting, in that there was almost a 50:50 split, men making up 50.8% of the sample. The age distribution showed that the majority (73.1%) were over the age of 41. A large number of respondents were from regional centres, with only 8.2% of respondents indicating that they were based in metropolitan areas. In relation to the characteristics of a clinical leader, most suggested that clinical leaders needed to be clinically competent (90%), a role model for others (89%), an effective communicator (87%), to inspire confidence (85%), be approachable (84%), have integrity (79%), be flexible (77%) and set direction (75%). Almost 84% indicated (in keeping with all the studies) that 'controlling' was the attribute least associated with clinical leadership. Most did not care where their experience was from or what sort of experience it was as long as they had valid roadside experience. Most did not value research insights or qualifications. What mattered was that the values of the clinical leaders were matched by their actions and abilities.

Many respondents did not see themselves as clinical leaders and few thought that they could influence organisational issues. Most thought that they should have an influence on clinical care and valued team working. Clinical leaders were seen to be visible role models, leaders in clinical practice, skilled, experienced, clinically focused, approachable, knowledgeable, driven by their desire to provide high-quality care, have high moral character and practised in change. They were seen to be team members who made decisions, often under pressure.

Related publications

Stanley, D., Metcalfe, H., Gallagher, O. & Cuthbertson, J. (2013) 'Volunteer ambulance officers' perceptions of clinical leadership in the St. John Ambulance Service in WA: A research report', http://www.sph.uwa.edu.au/__data/assets/pdf_file/0003/2272647/Report-Perceptions-of-clinical-leadership-in-the-St.pdf (accessed 1 July 2016).

Box 4.5 Clinical Leadership Study 5

Study title

Western Australian Allied Health Professionals' Perceptions of Clinical Leadership

Aim

To identify how the concept and application of clinical leadership are perceived by allied health professionals (AHPs) and the implications for service improvement, the adoption of quality initiatives and innovations for change.

Location		**Dates**
Western Australia (metropolitan, rural and remote areas of practice)		Nov–Dec 2014
Methodology		**Methods**
Mixed methods with quantitative data dominating the mix		Online SurveyMonkey questionnaire
Target group		**Analysis**
AHPs employed within the Western Australian Department of Health Main professional disciplines included dietetics, occupational therapy, physiotherapy, podiatry, social work and speech pathology		Questionnaire = SPSS (version 21) with qualitative data analysed by spreadsheet and Word documents
Sample size	**Gender mix**	**Ethics**
311 online questionnaires were returned, with 307 offering relevant data	Female = 86.5% Male = 13.5%	Ethical approval was sought and secured through the Government of Western Australian Department of Health South Metropolitan Health Service Human Research Ethics Committee (No: HREC 14/45 Code: EC00265)

Results

Participants in this study represented only 6.1% of the total AHP workforce of the WA Department of Health. The data indicated that the respondents had been AHPs for an average of 14.6 years. The vast majority of respondents came from the six targeted allied health professions groups of dietetics (11.2%), occupational therapy (17.8%), physiotherapy (19.7%), podiatry (3.0%), social work (18.4%) and speech pathology (15.5%). The majority of respondents were at Health Service Union Award (HSU) Level P1 (base-grade clinician) or P2 (senior clinician) (68.1%), with only about 15% of respondents at Level P4 or beyond. The majority of respondents (86.5%) were female and the median respondent age was 38.9 years, with the majority of AHP respondents being between 21 and 40 years (54.3%). Moreover, the majority of respondents worked in acute hospital environments (59.9%) and in a metropolitan location (73.7%).

In terms of the respondents' perceptions of clinical leadership, the majority of respondents (79.2%) saw themselves, and thought they were seen by others (76.2%), as clinical leaders. The main attributes identified as being attributed to clinical leaders were effective communicator, sets direction, is clinically competent, has integrity and is honest, is approachable, acts as a role model for others, copes well with change, is supportive, is a mentor and is a motivator. The main attribute identified as being least associated with a clinical leader was 'is controlling' (83.7%). In support of this, when asked if a clinical leader needed to be in a management position to be effective, only 22.2% agreed that they did. However, when asked if having a clinical focus was important for an effective clinical leader, 85.3% suggested that it was. Other attributes seen as central to effective clinical leadership was to have the skills and resources to perform tasks effectively, possess team working skills, be visible in the clinical environment, express appreciation to colleagues, be an initiator, have a high moral character, communicate well or be an 'excellent communicator' and be flexible.

(Continued)

Box 4.5 (Continued)

Clinical leaders were also perceived as having an impact on how clinical care is delivered, supporting staff, being innovative, leading change and service improvement, participating in professional development and (although to a lesser extent) influencing organisational policy.

A large number of respondents (81.4%) indicated that there were barriers hindering their effectiveness as a clinical leader. The barriers included a lack of time and a high clinical demand on their time, having to deal with bureaucracy, a lack of opportunities to be a clinical leader, limited funding and resources, a lack of mentorship, working part time and problems with the whole health system.

Related publications

Stanley, D., Hutton, M. & McDonald, A. (2015) *Western Australian Allied Health Professionals' Perceptions of Clinical Leadership: A Research Report*, http://www.ochpo.health.wa.gov.au/docs/WA_Allied_Health_Prof_Perceptions_of_Clinical_Leadership_Research_Report.pdf (accessed 1 July 2016).

The results from the studies outlined have led to the development of a new leadership theory: **congruent leadership**. This theory suggests that leaders demonstrate a match (congruence) between the leader's values and beliefs, and their actions.

The research results indicated that clinically focused nurses and a range of health professionals who have moved decisively and clearly in the direction of their values and beliefs can be seen expressing congruent leadership. They may have simply stood by their values, working not because they wanted to change the world, but because they knew that what they were doing was the right thing and that their actions were making a difference.

When acting out or role modelling their values and beliefs (even subconsciously), something was happening in their relationships with their clients, patients or colleagues that gave a clear signal about what they believed or what their values were. This linked congruent leadership with the expression of emotional intelligence and values-based relationship building.

The research studies indicated that others responding to the expression of the leaders' values and beliefs in action saw these leaders as such because they were approachable, clinically knowledgeable and competent. They were visible in practice, were role models for the behaviour they espoused and communicated well. They were able to make effective decisions, were empowered, could motivate others and, because their actions were evident or matched their values and beliefs, they were seen as passionate and committed leaders. This was rarely because they were visionaries, in powerful positions or wielded great authority.

The studies were undertaken with a range of different health professionals, used a range of methodologies and were conducted in different countries, with different genders and over a wide span of years. The study results have been presented in a number of countries (Thailand, Singapore, Tanzania, Canada, the UK, Australia and Ireland), all with resounding endorsements of the principles of congruent leadership theory. In addition, three replica studies are underway in the UK, Australia and South Africa.

Each of the five studies focused on capturing data about clinically focused leaders. The results point to a new way of understanding leadership that suggests that leaders are followed not for their vision, for being visionary, for being creative or for being transformational, but because there is a match between their values and beliefs, and their actions.

The various research studies indicated that followers were attracted to or followed congruent leaders because of the principles they stood by. The leaders carried these like a standard or banner

that they may not intentionally show or be conscious that others saw. However, it was their values and their application through their actions that followers recognised and rallied to. The congruent leader's metaphorical banner or standard was usually a statement of what they believed was important to them. It might say 'I care for patients like they were my family', 'I teach these children as if they were my own', 'I'll be here at the bedside with you', 'I know what it's like, I'm on your side' or 'Together we can do it'. Whatever it was, it was the demonstration of the leaders' values and beliefs that prompted others to see them as leaders and follow them, even if the leader was not aware of this.

These clinically focused leaders capture what it means to be a congruent leader: standing by their values in the execution and drive of their actions, putting their hands where their heart is, walking their talk and acting out and following through with what they believe to be right. These leaders are not selling a vision or communicating a path for others to follow, they are living their vision and walking the path themselves, role modelling with commitment, conviction and determination what they believe is the right thing to do. They are congruent leaders.

Reflection Point

Look around your organisation, ward or healthcare team. Think about the results from the studies outlined in Boxes 4.1–4.5. Who are the clinical leaders where you work and do they fit the results from the studies?

Should the results of these studies matter? Why might they be relevant or not?

Congruent Leadership Theory Explored

Congruent leaders are skilled and experienced nurses and other health professionals. Congruent leaders may have a vision and idea about where they want to go, but this is not why they are followed – it is because they are driven by their values and beliefs about care and high-quality nursing or health practice. Congruent leadership is based on the leader's values, beliefs and principles and is about where the leader stands, not where they are going. This approach to leadership is paralleled by Kouzes and Posner's description of leadership, which suggests that 'values drive commitment' and that 'people want to know what you stand for and believe in' (2010, p. xxii). Congruent leaders are motivational, inspirational, organised, effective communicators and they build relationships. They commonly have no formal, structured or hierarchical position in an organisation and even if they do, it is not their position that motivates the follower, but their values and beliefs as evidenced by their actions.

Congruent leaders appear to be guided by passion, compassion, commitment, courage and respect for others. They build enduring relationships, stand the test of their principles and they are more concerned with supporting the empowerment of others than with power or their own prestige. Kouzes and Posner support this view, suggesting that 'if you are ever to become a leader whom others willingly follow, you must be known as someone who stands by his or her principles' (2010, p. 34).

In contrast to congruent leaders, transformational leaders are commonly found in positions called leadership or management, have hierarchical or titled positions or fulfil a leadership role as an expectation of their job description (see Table 4.1).

Table 4.1 Comparison of the features of transformational and congruent leadership.

Transformational leadership features	Congruent leadership features
Driven by establishing direction and aligning people	Driven by acting on values and beliefs
Motivating and inspiring Produces change, often dramatic About where you are going (vision) Effective communicators Creative/initiative Recognised leadership/management, hierarchical or titled positions	Motivating and inspiring Approachable/open Actions based on values and beliefs About where you stand (principles) Effective communicators Visible Empowered Any level, not necessary to have a title or hierarchical position Guided by passion, compassion Build enduring relationships

Note: Although there are some similarities, the key differences relate to what motivates or drives the leaders: vision or values and principles.

Not all leadership is about changing or challenging people's vision of the future. Some leaders in the research interviews were seen as leaders because they demonstrated where their values lay and were followed because others identified with these values and stood with them. One research participant said:

> I think you've got to have respect for that person because of the way they nurse, you identify with them, identify with the way they nurse and agree with that.

Another commented:

> I am not only able to empathise with patients and their relatives, but with staff as well … trying to think 'what would they be going through?' … it makes my ability to communicate with them much better.

Another added:

> I think people know that I am quite passionate about what I do and I also like to support others … to achieve the best they can achieve and very strongly centred on patient care and good standards of care.

Congruent leadership explains why and how nurses and other health professionals and non-titled leaders at all levels can function and be effective without formal influence in the clinical area and without formal deference to the organisation's vision. As such, the qualities of a congruent leader include honesty, loyalty and integrity.

Leadership comes from having respect for another person's 'way they nurse', 'approach to care', 'therapeutic skills' or 'clinical knowledge'. Other health professionals identify with these values and beliefs and with the clinician's capacity to empathise with colleagues and clients.

A Solid Foundation

If nursing and other clinically focused health disciplines are to develop effective leaders, they need to do so without losing the core values and principles that guide their professional, client-focused core (Scully 2015). Congruent leadership establishes a foundation from which all good or effective clinically focused leaders can start, because it grounds the leader's principles within the core values of their profession's principles and values. This will ensure that the dominant cultural narrative of these professional disciplines is one of patient-centred or person-centred care, therapy or treatment. In this way, the profession's core values and care-centred attributes are placed ahead of those associated with previously dominant values, which commonly stem from groups that may sometimes be in conflict with professional values (e.g. financial or economic or even managerial goals and directives). In an effort to achieve their vision, transformational leaders may at times move from positions of influence and power to positions of control. As such, they run the risk of potential exploitation (Rafferty 1993) and may seek to secure more control in an effort to achieve their goals. Unwittingly, in doing so, they run the risk of losing their connection to the professional discipline's core values and guiding principles, or at best they become embroiled in a state of conflict as their managerial (controlling) demands conflict with their professional and often personal desire to remain focused on patient care, therapy and treatment (Gentile 2010).

In the UK, the whole National Health Service (NHS) has embraced the 6Cs established by the UK Chief Nurse in 2013. These are care, compassion, communication, courage, commitment and competence (Taylor & Bradbury-Jones 2014; Stephenson 2014) and represent the collective understanding (values) of what the NHS sees as central to the ethos and culture that is being developed. However, words and slogans are not enough. In April 2014, a blog on nursingtimes.net, which followed an article announcing the roll-out of the 6Cs, prompted an online discussion on the *Nursing Times* website. The article suggested that porters, caterers, doctors and Trust chief executives were to be asked to embrace the 6Cs in an effort to extend the core values to all staff working in the NHS. One anonymous blogger noted:

> I am involved in a complaint we have made to a Mental Health Trust. Our family has been treated appallingly by the Chief Executive during the process of the complaint, causing immense upset and stress. That same Chief Executive, a nurse, blogs and twitters about compassion and being open and honest. Words and silly slogans mean nothing unless they practice what they preach.

Clearly, this chief executive was not regarded as a congruent leader by the anonymous blogger who made the complaint. It also reminds us that talking about our values and putting them into action are two very different things. Have nurses and the NHS lost sight of the values that matter? Had these remained in clear focus, might the issues discussed in the Francis Report (Francis 2013) have occurred?

The recognition and application of congruent leadership may offer clinically focused health professionals an opportunity to develop greater influence in the leadership stakes. However, until nurses, physiotherapists, ambulance officers and other clinically focused health professionals can themselves influence and initiate this and, importantly, recognise themselves as congruent leaders, others may continue to see clinical nursing and other clinically focused health professionals as secondary, subsidiary or of low status (Antrobus & Kitson 1999).

This said, a healthy 80% of allied health professionals in our studies did indicate that they saw their potential to be clinical leaders. This was less well demonstrated by the other health professionals, with only 40% of ambulance officers, 47.5% of volunteer ambulance officers and 30% of senior nursing home staff able to recognise themselves as clinical leaders.

In the nursing literature, nurses have in the past been described as 'invisible' and 'dirty' (Roberts 1983; Robinson 1991; Davies 1995; Wilkinson & Miers 1999) and, while the references are somewhat dated, it is possible that the remnants of these views persist. In *From Silence to Voice*, Buresh and Gordon (2013) indicate that nurses remain at risk if they are not able to find their voice and offer clear communication about their profession. These views further support the notion that some clinically focused health professionals continue to hold the view that they have only a limited stake in leadership or being seen as leaders.

Also associated with the recognition of congruent leadership is the realisation that values, as well as standards, need to become the focus of development in the health service in general (Scully 2015). Government documents and other literature released over recent years (Curtis, de Vries & Sheerin 2011; NHS Leadership Academy 2013; DoH UK 2015a, 2015b; DoH WA 2015; Rafferty et al. 2015) may have focused more on what is important (values) than in the past. While considerable consultation has taken place, directives and directions are not always in keeping with the values and guiding principles of the nursing profession, ideal nursing practice or the professional practices of other health disciplines. Indeed, consultation with nursing groups is not always clearly demonstrated.

This has led to the clash of values that O'Reilly and Pfeffer (2000) found likely to disrupt the development, success and performance of companies in the business world. Clinically focused health professionals, it should be remembered, make up a huge percentage of the body of any health service. Nurses constitute the largest single group in the health services of America, Australia and the UK (Grosios, Gahan & Burbridge 2010; Australian Institute of Health and Welfare 2014; American Association of Colleges of Nursing 2016) and allied health professionals are a significant proportion of other health professions, with 6% in the UK (Oliver 2015) and approximately 17% in Australia (Australian Institute of Health and Welfare 2014). If clinically focused health professionals are unable to express their core values and beliefs, or are inhibited from doing so, the negative impact on leadership for the health service is likely to be considerable. Nurses and other health professionals contribute too much to patient care and the health service to remain unrecognised (and unheard), because their contribution, values and leadership are sorely needed.

Congruent leadership in action can be seen in a number of examples from practice (Box 4.6).

Box 4.6 Examples from practice

Example 1: Roadside warrior

During a break in a training session, a paramedic expressed his disappointment with the ambulance service management he was working for. It seemed that while the service had initiated a role called 'clinical leader', the job description saw the personnel positioned not on the road, with their fellow clinically and client-focused colleagues, but in offices to develop policies and processes. While the policies and processes would be used to influence and guide practice and were therefore not insignificant, the paramedic lamented the potential loss of clinical leaders from where he saw them as being of more value. His view was that the clinical leaders would be better employed as roadside experts, where they could support, guide and role model excellent paramedic practice, and where junior paramedics and volunteer ambulance officers could see and be helped directly by their clinically focused paramedic skills, decision-making abilities and real-world paramedic insights.

This paramedic felt that the office-based role would soon erode the senior paramedic's skills and make them less relevant to roadside practice. He also considered that their many years of experience and well-honed clinical skills could be better employed by these leaders being seen (visible) and followed because they were there, doing the things that paramedics aspired to.

I knew that I was talking with a senior paramedic and our conversation had started with me asking if he was considering taking up one of the clinical leader roles. He was clear that he valued what he could do 'on the roadside' more than the 'office job'. It was not just that he would rather be on the road and not in an office, and after all 'the pay was better in the office job'. This paramedic believed that he had more to offer his colleagues and the public by being seen performing what he believed were the key and clinically appropriate actions of a senior paramedic. He thought he could do more by being visible, approachable and by role modelling excellent paramedic practice. I realised soon after this conversation that I had heard the thoughts of a congruent leader.

Example 2: A change for visiting time

One of the research interviews in the initial research study relates to an account of a junior registered nurse (RN) who was faced with an anxious husband whose wife had that day undergone emergency surgery. The husband wanted to visit his wife and be at her side, but he needed to work when the ward had visiting times. The ward enforced strict visiting times (14:00–16:00 and 18:00–20:00) for all relatives and other visitors and although the ward was 'open' for a number of hours, this particular man was unable to attend at these times due to working evening and afternoon shifts. The junior RN, knowing she was acting against the specific instructions of the ward manager and senior RN, allowed the man onto the ward at 10:30 to visit his wife. The junior RN undertook to do this because she believed that had this been her husband or had she been the wife, this was the action she would have wanted the nurse to follow.

The nurse knew that she could have incurred disapproval or a reprimand from the ward manager and senior RN, but she undertook to support the husband and defended her stance against the more senior nursing staff. The incident caused some discomfort for the more junior nurse and the fall-out from her action was that she was indeed reprimanded. This initiated debate at the regular ward meeting that ultimately resulted in many of her colleagues agreeing that they would have liked to have done the same and this, in time, led to a revision in the ward's visiting processes and procedures.

The junior RN employed no long-term strategy in admitting the husband outside of the permitted visiting times and had not set out to disrupt the ward visiting-time procedures. However, by following her beliefs about respecting the needs of patients and in this case their relatives too, the nurse initiated what developed into a slow revolution that resulted in significant change and an improvement in relatives' access to their ill, worried and isolated friends and family. Clinical leaders who display congruent leadership match their values and beliefs to their actions and in this example the junior RN took a risk in following her beliefs. Nevertheless, her colleagues recognised this action as part of the qualities and characteristics associated with a clinical leader. As the junior RN was visible and present in the clinical area and through her commitment and passion for the core values of nursing, she was (even unintentionally) able to motivate and inspire others to follow. The more senior nurses who had developed the visiting policy were not as present on the ward, did not deal as regularly with dissatisfied or upset relatives and friends, and were not as commonly in the position of having their nursing and caring values and beliefs challenged.

Example 3: Physiotherapy challenge

At a workshop exploring clinical leadership in Western Australia, two physiotherapists offered some feedback. Two months earlier, at the first part of the workshop, the participants had been given the task of identifying areas in their practice where they might be able to bring about some measure of change. The physiotherapists outlined the change they had initiated on return to their clinical area, a medical rehabilitation ward in a busy city hospital. They had for some years been following a practice by which cardiac patients, prior to discharge, had to demonstrate that they could climb a set of stairs. This had become a pre-discharge prerequisite and no cardiac patient could be discharged until success in this

(Continued)

Box 4.6 (Continued)

task had been demonstrated and recorded. The issue the physiotherapists identified was that often this meant that a patient's discharge was delayed until a physiotherapist could undertake the activity. They set out to identify where the practice had originated and what clinical evidence sat behind it. They met with all the cardiac medical officers in the hospital and consulted a wide range of literature. The literature proved of limited value and the medical staff even less so, as none of them suggested that it was their idea to have the test undertaken prior to discharge.

Faced with a practice that seemed to have no basis in clinical evidence or medical practice, the two physiotherapists suggested that it served no sound clinical purpose and that it should be stopped. While such a changed clearly offered a number of benefits to the hospital, in terms of reducing the length of stay and speeding up the discharge process, the hospital and ward managers were at first not keen to change the practice. They were not sure that a change like this, initiated as it was by two physiotherapists, was worthy of consideration. They were concerned that not all medical practitioners were in favour of the change and they were less convinced of the lack of literature to support this practice, given that 'it had been going on for so long'.

The physiotherapists persisted and recruited key medical staff to argue their position. They knew that the change to a less specific cardiac assessment was a better outcome for the patients, the assessment process and the discharge issues, and because of these factors they were resolute and determined.

These physiotherapists were also congruent leaders. They had been motivated to look for change issues through their participation in the workshop, but it was their values and beliefs that a better outcome could be had by changing the cardiac patient assessment process that kept them focused on their values and determined in their belief that the practice should change. They used excellent communication skills and were seen as collaborative and collegial by their medical partners. The eventual outcome was a better, more flexible and appropriate assessment strategy that allowed many more patients access to a speedier and safe discharge.

Reflection Point

Consider the three examples in Box 4.6. Do they demonstrate the attributes of clinical leaders or actions that display congruent leadership? If not, why not? If so, then why? Relate one of the stories to a clinical colleague and ask them if they feel that the actions discussed refer to a congruent leader. Does this even matter?

Why might these stories be relevant or not when considering the theory of congruent leadership?

The Strengths of Congruent Leadership

There are a number of strengths afforded by an understanding and application of congruent leadership, outlined in what follows.

Grassroots Leaders

One of the main strengths of congruent leadership is that it supports the promotion of 'grassroots' (Roberts 1983, p. 29) leaders. If, as Roberts and others have suggested, nurses (and possibly other health professionals) are an oppressed group, then finding ways to liberate leaders within the core

group of health professionals without plucking them out or removing them from the rank and file will ensure that leaders can develop who remain focused on the core issues, values and beliefs that are relevant in a patient-focused environment. The congruent leader's credibility is recognised and established when their actions match their values and beliefs. It is their ability to demonstrate or display their actions and not their position, title or role that facilitates their ability to lead.

Historically, Mary Seacole (see Case study 4.1) offers an example of a congruent leader. Mary felt so strongly about nursing and her need to help others that she travelled independently, as an 'unofficial nurse' (Bostridge 2004, p.19), to the Crimean War to provide care and treatment to British soldiers, where at great personal and financial risk she stood by her principles with definitive action (Bostridge 2008).

Another example in support of congruent leadership is offered in the research studies, where an identified clinical leader, when discussing a change in the type of clients for whom her ward would cater, indicated:

> I had to take a long hard look at my values and beliefs and look at the values and beliefs of the team and … I decided that although I wanted to champion the cause of older people I didn't necessarily think that putting them all together in one place did that and I think it didn't put over the picture of what normal society is about and we realised that we could still fight things like ageism or whatever in … a general ward.

Congruent leadership, therefore, helps grassroots leaders, clinical leaders and clinical staff who lead on an everyday basis. Giving clinical leaders a name for their leadership approach with which they can identify can only lead to an increase in grassroots leaders or clinical leaders *actually* seeing themselves as leaders. Many of the research interviewees described what they saw as the qualities and characteristics of clinical leaders, but failed to recognise these qualities or attributes in themselves, even when others could. Current leadership theories that emphasise 'vision' as the key attribute of leadership or that link leadership and management responsibilities close down avenues of expression or understanding for leaders who lead without formal authority, recognised power or titles that encompass leadership (Welford 2002; Thyer 2003; Goertz Koerner 2010; Man 2010; Weberg 2010; Casida & Parker 2011; Marshall 2011; Swanwick & McKimm 2011; Hutchinson & Jackson 2012; Jones & Bennett 2012; Tinkham 2013; Ross et al. 2014; Weng et al. 2015).

Foundation for Other Theories

Another strength of congruent leadership is that it offers a foundation on which other theories can be constructed (Figure 4.1). From this foundation, clinical leaders, nurses and grassroots leaders can build an understanding of and connection with the core values and beliefs about healthcare. From a foundation that recognises and values the contribution that clinically focused health professionals make, clinical work is identifiable and named.

No longer invisible, clinical work is recognised and clinical leaders who are approachable, knowledgeable, clinically competent, effective communicators, visible, positive role models, empowered, decision makers and who stand and hold fast to their guiding principles can have a positive impact on healthcare and lead clinical care forward by holding to the principles central to each profession.

Strong Link between Values and Actions

A significant strength of congruent leadership is that it builds a strong link between values and beliefs and actions. In this regard it is not static, but dynamic. Like congruent leadership, authentic leadership (Bhindi & Duignan 1997; George 2003) describes leaders who have a genuine 'desire to serve others

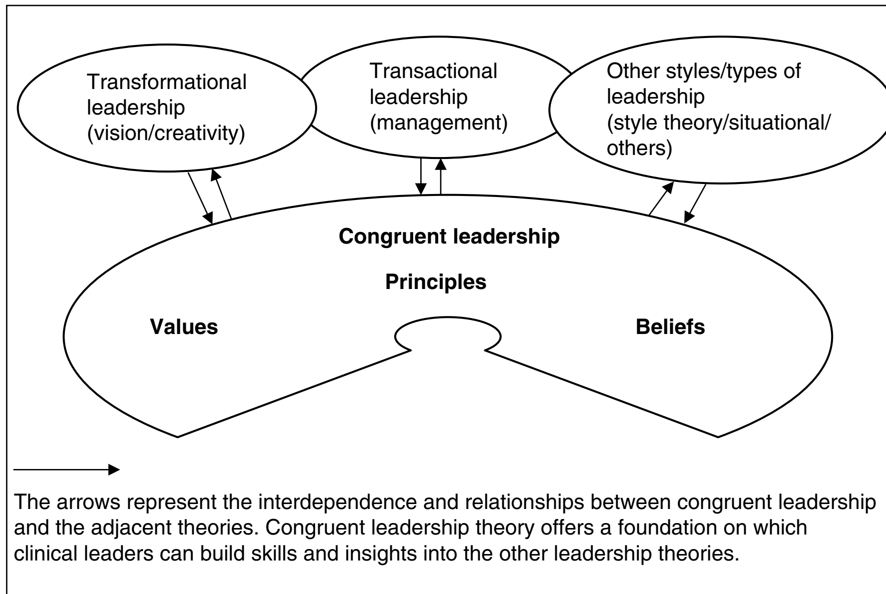


Figure 4.1 The relationship of congruent leadership to other leadership theories/models.

through their leadership' (George 2003, p. 12) and many of the attributes for both types of leadership are similar. However, congruent leadership makes explicit the link between purpose, meaning and values and the leader's commitment to acting on them and in accordance with them. Congruence is a statement of agreement, of consistency, and using this word to describe this type of leadership helps promote the link between values, beliefs, meaning and action. In effect, having beliefs and recognising your own values and knowing where you stand are of little merit if they are not employed when you are faced with challenges, or if they are not displayed and congruent with your actions. Authors in support of authentic leadership (Bhindi & Duignan 1997; George 2003; Wong & Cummings 2009) recognise this to some extent, with George indicating that authentic leadership is about 'being yourself; being the person you were created to be' (George 2003, p. 11).

Nevertheless, congruent leadership is more than just being. It is about acting, displaying, demonstrating and living the leader's values and beliefs. Although similar to authentic leadership, congruent leadership emphasises the translation of values and beliefs into action, for it is in the action that leadership is evident and effective. Clinical leaders employing a congruent leadership approach are recognised and feel valued for the contribution they make to care and for the value they add to nursing's therapeutic benefit for patients (Freshwater 2002). Clinical leaders are also recognised because the actions and activities they employ are based on and guided by the values and beliefs they hold passionately, not only for the vision, creativity and clinical expertise they may bring to clinical practice.

Supports Further Understanding of Clinical Leadership

One of the main benefits of congruent leadership is in advancing an understanding of clinical leadership. Indeed, in any environment where leaders are not invested with authority or a title to lead, where leaders function in the trenches, at the front line, at the coalface or in direct proximity

to the patient, client, child or service user, understanding, promoting and developing congruent leadership may be of benefit.

One of the common themes from the research that supports this book was the conflict that clinically focused health professionals felt when trying to reconcile leadership and management tensions (Stanley 2006d). When health professionals gave voice to their values (Gentile 2010) or lived them in their actions (Stanley 2006a, b, 2008, 2011), they commonly ran the risk of coming into conflict with organisational or management goals or objectives. Therefore, congruent leadership facilitates and supports an approach to leadership focused on clinically based values.

Anyone can be a Congruent Leader

Congruent leaders are found in a range of positions and across the spectrum of an organisation. The application of congruent leadership is not limited to people in leadership, titled or senior positions. Anyone can apply or demonstrate congruent leadership, if they are encouraged and supported to see the significance of their values and beliefs.

Reflection Point
Can anyone be a congruent leader? The study results indicate that clinical leaders who display congruent leadership attributes can be found in large numbers right across the health service. What do you think? Are you a clinical leader? And if so, does the theory of congruent leadership resonate with you?

The Limitations of Congruent Leadership

There are limitations to congruent leadership theory, to which the discussion now turns.

New Theory

Congruent leadership is a new theory that was confirmed as a valid theory to support clinical leadership. Although the research undertaken to support the concept stands alone and has to be acknowledged as resting on a narrow platform, I have exposed the theory to a large number of qualified nurses at conferences and before a raft of students studying a range of courses, in different countries and contexts. The resounding conclusion is that it resonates with their experience of leading in practice and fits with and supports their understanding of clinical leadership.

Similar to Authentic Leadership and Breakthrough Leadership

Authentic leadership, breakthrough leadership and congruent leadership all focus on values as the driving force for which the leader is recognised. Nevertheless, similar is not the same, and it may be because congruent leadership has grown from a health professional focus that it rests on a firmer base to help support an understanding of clinical leadership.

Not Driven by a Focus on Change

Significantly from a health service perspective, congruent leadership is not obvious in its focus on the promotion of leaders who are directed to 'change' practice and lead change. This does not mean that congruent leaders do not engage in innovation and change, just that they are not driven by this

focus. It is noted that health reform across the globe is focused on better leadership for the improvement of patient care and leadership that can support and help promote change and stimulate innovation. The NHS Leadership Centre was specifically directed at promoting leadership that focused very firmly on 'change' rather than 'values'-centred leadership (NHS Leadership Centre 2002), and the development of clinical leaders who can influence people and lead change is a significant focus of much of nurse education and health service training.

However, as congruent leadership is focused on translating values and meaning into action, it can be assumed with confidence that many of the leaders' actions will result in change and innovation, as clinical leaders seek to influence and improve the quality of care provision. I acknowledge that organisations specifically seeking to promote leaders who drive and foster change may find congruent leadership too obscure for their purposes. I would assert, though, that focusing on people's values and beliefs and clarifying these remains a crucial first step in any change process.

Not Suitable for Leaders with 'Control' as an Objective

Leaders who are required to exercise control over others (managers), or who are not visible or engaged in the process of doing the 'work' of the people or groups they lead, will struggle to employ a congruent leadership approach. Congruent leaders do not talk through their values or beliefs or order others to adopt them, they display them. They stand by them and make them evident to others, sometimes unconsciously. If clinical leaders are in a position where they are unable to engage in the 'work' of their colleagues, or if they are required to exercise control over (manage) their colleagues – or those they lead – congruent leadership may not be evident and will be of limited value. In the research results 'controlling' was specifically seen as a characteristic not associated with clinical leadership and, as such, a leader functioning in a position of control, if it results in a clash of values, will find the application of congruent leadership difficult or inappropriate.

Congruent Leadership, Change and Innovation

Mahatma Gandhi, the Hindu religious and political leader and social reformer, once said, 'We must be the change we wish to see in the world.' In many ways this sits at the core of what congruent leadership means. In the study used to expose congruent leadership, no assumptions were made about who the clinical leaders were or what their characteristics might be. Instead, these matters were rigorously explored.

As indicated in the Gallup Report (2010) on nursing leadership, clinical leaders make a significant contribution to the quality of patient care. This is confirmed by Stanton, Lemer and Mountford (2010), who add that the clinical leader's time has come. This is driven by a need to engage clinicians in policy developments, as the emphasis on quality increases, as the need for front-line clinical staff to engage in change and innovation grows and, finally, as clinicians are recognising themselves as stakeholders in the health industry. However, clinical leaders can do so much more if they are recognised (by themselves and others) as leaders and encouraged to see that leadership does indeed exist at many levels. If clinical leaders are shown to display congruent leadership, their passion is for participation in hands-on patient care and they are driven to improve and deliver a high-quality service, then the pool from which nursing and the health service can draw future leaders is greatly enhanced.

As well as allowing others to see these aspects, they need to recognise them themselves. If change and innovation are to be supported and promoted from the clinical environment, it will be the nurse or health professional who intervenes, who takes action, or who responds to challenges because they stand by what they believe, who will make a significant contribution. Indeed, they are as valuable, as important and as effective as the leader with a grand plan.

Recognising the significance of values and beliefs and their impact on actions is vital, but in terms of influencing innovation and change it is also essential that clinically focused health professional leaders understand the tools that can be used to facilitate change. Nurses and other health professionals in countries all over the world can be heard sitting in tearooms or at the lunch table discussing what is wrong with the health service, or how 'the recent changes in care delivery will have this or that impact' and 'if only they could do this or the other' or 'if only someone would listen to my view'. Complaining, suggesting, theorising and proposing – these ideas and opinions often go no further than the tearoom or lunch table.

It could be that whingeing is the natural state of the hard-pressed health professional, but I don't believe it. Sometimes change or innovation is slow or resisted because health professionals have not learnt to listen to their 'true' or inner voice (Buresh & Gordon 2013) or simply because they have not learnt the skills associated with effectively managing or driving change and innovation or the liberation of empowerment. The ideas and suggestions are there – just listen in to any tearoom or lunch-table conversation. It may also be that health professionals are not clear about what leadership means, who leaders can be, or who are recognised as leaders in clinical practice.

While managers might have the authority to support change, they may not have the practice focus or clinical insights to see what change is needed in practice (Stanley 2006d). Thus it is clinically focused health professional leaders who are in an ideal position to see the change that is needed, and the value and impact that change and innovation can have for patient or client care. However, they may feel that they lack the authority to take their ideas and suggestions further.

Change and innovation can be effected by the congruent leader, but first the clinically focused health professional leader needs to understand the significance of their own values and beliefs. Second, they need to recognise that they have followers, because these followers have realised the match between the clinically focused leader's values and beliefs and their actions. People look to clinically focused health professional leaders for leadership even if the leader is not aware of it. The third point is that change can occur even without power or formal authority. Therefore, clinically focused health professional leaders need to understand that, used effectively, reflection and change management techniques, creativity, evidence-based approaches, networks and delegation can be powerful tools to support, motivate and inspire others and to minimise conflict.

Congruent leaders in clinically focused positions can exercise considerable influence over clinical change and support substantial innovation, if they only recognise that leadership is not tied to positions of power, titles, badges, big offices and authority. Leaders in clinically focused practice-related positions do not need to have the 'big picture' or exercise 'vision', or be in powerful and authoritarian positions, or hold budgetary control. Clinically focused leaders are the front-line, coalface, roadside, bedside decision makers (Stanton, Lemer & Mountford, 2010) and when they employ (or can learn to employ) collaborative strategies to limit conflict, develop the motivation and influence of others and implement change management techniques, they can be the force that will help deliver high-quality, more effective care and shape a better tomorrow for the health service.

Congruent Leadership and Power

Congruent leadership is not power neutral. The power of congruent leadership comes from unifying groups and individuals around common values and beliefs. This is not a strategy as such, but the results from my research demonstrate that nurses and other health professionals seek out or follow leaders who are more inclined to display or hold values and beliefs that they themselves hold. Manley found that when she displayed her values and beliefs, others began to share them and the clinical area united as colleagues began to identify with the common purpose of 'providing patient-centred care' (Manley,

2000b, p. 38). One of the statements made by a participant in Manley's research supports this by saying, 'sometimes I feel like an evangelist trying to spread [the] word to other people in other areas' (2000b, p. 37). A clinically focused leader, operating within the core professional principles, or by a set of standards or guiding principles of a professional body or registration authority – for instance, the Australian Nursing and Midwifery Council's 2002 Code of Professional Conduct or 2006 Standards for Professional Practice and The Code for Nurses and Midwives (Nursing and Midwifery Council 2015) – is more likely to be recognised for their consideration of patients' rights and needs and their caring attitude than a nurse or health professional who functions outside of these guiding principles or who is not engaged in direct patient care. Therefore, a nurse or health professional seeking to lead in the clinical environment will find greater success if their values and beliefs are consistent with the dominant values and beliefs of their colleagues, or if they are able to bring their colleagues to a point where their values and beliefs about care, therapy and professional behaviour coincide. Conflict (Stanley 2006c; Gentile 2010) can result if the principles and values of one group or individual are at odds with others, and power and influence in terms of leading often fall to the dominant group or leader.

A congruent leader's power and influence derive from being able to articulate and display their values, beliefs and principles, as the examples in Box 4.6 and Manley's (2000a, b) research was able to illustrate. Followers recognised or aligned themselves with these same values or beliefs and, by supporting and promoting them, increased the leader's credibility and worth. By promoting the significance of this leader's values and beliefs over any others, the leader would be able to influence or change practice or generate innovation. Change, while often not the intention (although it was for Manley), results when values and beliefs are displayed, promoted and then adopted by followers.

Berwick (1994), a US medical practitioner, and Schneider (1999), writing from a pharmacological viewpoint, indicate that clinical expertise sits at the core of clinical leadership potential. Although being clinically competent and knowledgeable are included in the characteristics identified in my studies, being a 'clinical expert' was not a central characteristic of clinical leadership. This may add support to the argument that clinically focused leaders employ congruent leadership that is based on their values and beliefs rather than on their clinical skills, clinical knowledge and technical abilities. Pendleton and King feel that medical practice and healthcare are suffused with values, although they tend to be expressed as standards. Both are similar, they say, and both act as guiding principles, although 'values state what is important … and tend not to vary', while 'standards state what is good or acceptable … and may well vary' (2002, p. 1353).

In the business world too, O'Reilly and Pfeffer (2000) and Gentile (2010) see values as crucial. In comparing the performance of a number of companies with superior results in their area of specialism, the more successful companies had an approach to leadership that was based on values. Values came first and acted as guiding principles that helped these companies to make crucial and difficult decisions. O'Reilly and Pfeffer (2000) also noted that the values these successful companies held were not prioritised as such, but that the companies operated in such a way as to aim to function so that their values were shown and they worked hard to resolve clashes of values. Focusing on values meant that the businesses were able to build trust, motivation and commitment (O'Reilly & Pfeffer 2000). Hall (2005) supports this view, suggesting that companies who addressed and followed sound ethical practices were much more likely to be profitable and successful, by a considerable margin. Kouzes and Posner (2010) offered similar research where they demonstrated that employees who were clear about the organisation's values and also had a high degree of clarity about their own personal values had a greater commitment to the organisation. Significantly, it was a correlation between a person's personal values and their match to the organisation's values that drew the strongest commitment. Their conclusion was that people cannot commit fully to anything unless it fits with their own beliefs or values (Kouzes & Posner 2010). This is a powerful concept for the health service to grasp, as many

health professionals enter their profession because they value 'making a difference' (Stanley et al. 2014) or want to work with people and help make a difference for people.

Successful clinically focused leadership is therefore proposed to rest on a model of congruent leadership that, as with the business view of O'Reilly and Pfeffer (2000), Kouzes and Posner (2010), Gentile (2010) and Hall (2005) and the healthcare view of Pendleton and King (2002), is based on leaders who respond to challenges and critical problems with actions and activities in accordance with (congruent with) their values and beliefs.

Congruent Leadership and Quality

Clinical leaders are able to make a significant contribution to the quality of patient care and initiate innovation and quality in front-line clinical services. This can be enhanced if clinical leaders are encouraged to recognise that leadership occurs and needs to be evident at many levels in an organisation.

If health professionals focus on the values that are central to their professions' core and on patient-centred care, they will also be drawn towards focusing on improving patient outcomes, client care, therapeutic improvements and quality processes. It is clear that safety and quality issues are paramount to governments, public policy and decision makers at health department and senior health organisation levels, to the media and, most importantly, to consumers of healthcare (Francis 2013). It is proposed here that the key to having the most effective impact on safety and quality processes is to focus on the development of leadership skills at all levels, but specifically on clinically focused leaders who function at the 'coalface' in the clinical area and in close proximity to clients and patients (Mahoney 2001; Rich 2008; Murphy, Quillinan & Carolan 2009).

It is clinically focused leaders who operate in daily contact with clients and patients, and who are more likely to recognise and be able to respond to deficits in patient care or lapses in quality. If healthcare organisations and institutions are to deliver safe, high-quality healthcare to patients, clients or consumers, then governance systems and processes need to be robust and operate throughout the organisation. For this to be the case, communication systems and leadership systems need to be likewise robust and acknowledge the critical place that clinically focused health professionals play in implementing quality processes or reporting faults in those processes.

The UK National Patient Safety Agency (2004) suggests seven steps for ensuring patient safety, with 'lead and support' for staff as the second step. However, this can be most effectively implemented if it is clinically focused health professionals who are visible and engaged in the clinical area, implying that clinically focused leaders are best placed to ensure patient safety.

The Australian Victorian Quality Council (2005) has also suggested that clinically focused leaders play a significant role in quality processes by participating in establishing strategic safety objectives and in setting, and taking responsibility for implementing, the safety agenda. They also suggest that clinical leaders should foster the allocation of resources to support best practice; that they should act as 'champions' for service improvement; and that they should raise the status of safety and quality activities, contribute to clinical practice improvement initiatives and educate their fellow clinicians. Mahoney (2001) and Rich (2008) support these suggestions and add that clinically focused health professional leaders should act as role models for quality, provide expert evidence-based care, collaborate with others to facilitate best practice, take responsibility for quality initiatives and advocate for changes that will benefit clients and patients. If these aspirations are central to how clinical leaders practise, then congruent leadership will be evident.

Cook (2001), Baker, Norton & Flintoff (2004), Sirola-Karvinen and Hyrkas (2006), Alleyne and Jumaa (2007), Wong and Cummings (2007) and Murphy, Quillinan and Carolan (2009) all agree with

Box 4.7 Top ten health professional values

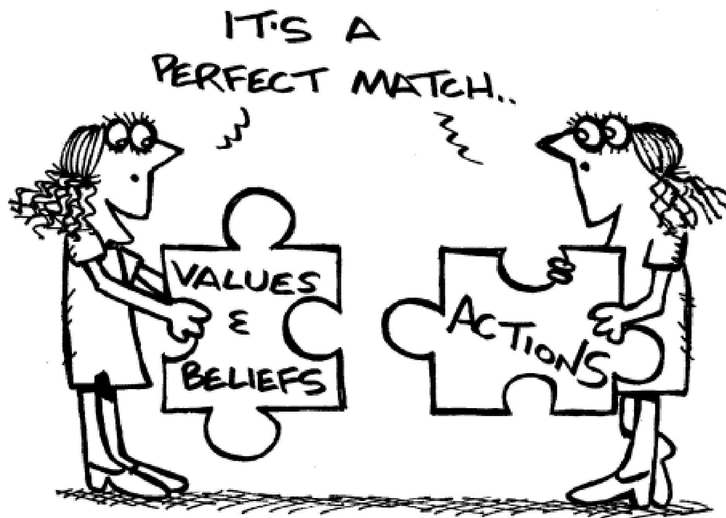
Honesty/truthfulness/fairness	Clear interpersonal skills/listening skills
Integrity	Organised
Trustworthiness	Professionalism
Compassion/care	Clinical knowledge
Respect	*Others mentioned, but not as constantly cited, are*
Reliability	*creativity, self-control and humility*

the proposition that clinically focused leaders are recognised as vital for the provision of good patient care, the promotion of creative and productive work environments and the development of excellent nursing practice. Murphy, Quillinan and Carolan (2009) also suggest that clinical leadership offers a cost-effective way of improving patient care outcomes in times of financial contraction.

The characteristics identified as being consistent with congruent health professional leaders (clinically competent, clinically knowledgeable, effective communicators, decision makers, empowered motivators, open and approachable, role models and visible in practice) underpin the role that clinically focused leaders can play in promoting quality improvement initiatives and the implementation of evidence-based practice. Indeed, it is arguable that it is because clinically focused leaders are driven by their values and beliefs that these leaders, displaying congruent leadership, are ideally placed to have positive impacts on safety and quality processes.

Debate and further research may be needed to establish or even rediscover what the core values of the nursing profession or other health professions may be (examples are given in Box 4.7). However, the Gallup Report (2010) on nursing leadership suggests that the US public rated nurses as having the highest standards of honesty and ethical practice (at 83%) of any professional group.

Understanding professional values may not be as simple as proposing a list of characteristics or attributes. The Australian Nursing and Midwifery Council's (2002) Code of Professional Conduct and National Competency Standards (2006) offer further insights into what are thought to be minimum standards (a type of expression of professional values) for nursing professionals. These offer significantly more detail about the issues of both values and ethically based professional practice and behaviour.



To conclude, clinical nurse leadership is commonly demonstrated in the ward or unit by a clinical leader who is directly involved in providing healthcare. Clinical leaders are visible to their colleagues and considered to be knowledgeable, competent clinicians (although not necessarily experts), who motivate and inspire others because their values, beliefs and guiding principles are on show and are recognised as such. These principles and values motivate and guide the clinical leader to act in ways that support patients' rights and address issues of confidentiality, dignity, privacy and advocacy. When they deal with critical problems, face challenges and direct or provide care, it is the clinical leader's employment of a congruent leadership approach, based on values, beliefs and principles, that is evident. Leaders who 'control' and manage from within offices, or who fail to display values and beliefs in congruence with their actions, are rarely seen as clinical leaders.

Case Study 4.1

Mary Seacole's story is offered as an example of how a clinically focused health professional was able to exercise power, bring about change and innovation and have an impact on quality healthcare in the 19th century. If Mary could do it, then how much more likely are congruent leaders now to be able to support health professional innovation and change? Read the outline of Mary's achievements and consider the challenge that follows.

Female Leaders: Mary Seacole – 'Mother Seacole'

Mary Seacole was born Mary Jane Grant in Kingston, Jamaica in 1805. She had a mixed-race (free Creole) mother and a Scottish-born officer for a father. Her mother ran a boarding house for sick and injured soldiers and sailors and it was here that Mary began to learn her nursing skills. Mary's mother was a noted 'doctress' who used traditional Caribbean and African herbal remedies to heal and tend the sick in her care. As a Creole, Mary saw herself as lucky, almost privileged, compared to the fortunes of the slave community that dominated the island.

Mary was educated and supported by an elderly woman whom she referred to as 'her kind patroness'. In 1821 she travelled to London for the first time. In this era about a third of all Britain's trade was with Caribbean islands and travel across the Atlantic was relatively common. When Mary returned to Jamaica she nursed her 'old indulgent patroness' before returning to their family home. Mary continued to learn much from her mother and also travelled about the Caribbean and parts of Central America, where she ran a series of taverns and boarding houses, all the while learning more about medicine and caring for ill people.

In 1836 she married Edwin Horatio Hamilton Seacole (rumoured to be an illegitimate son of Horatio Nelson and Emma, Lady Hamilton), but he died in 1844 after a series of financial and domestic disasters overcame them. Following a time of deep grief, Mary turned a 'bold front to fortune' and assumed the management of her mother's hotel. She threw herself into her work, declining many offers of marriage. In 1850 she treated patients suffering from a cholera epidemic that killed an estimated 32,000 Jamaicans. With great insight into the transmission of disease, she recognised that the outbreak of the epidemic was likely to be attributed to a steamship that had arrived from New Orleans, Louisiana. Her experience in dealing with cholera was to prove vital later in her life.

In 1851 she travelled to visit her half-brother in Panama, Central America and arrived in time to treat the first victim of a cholera outbreak there. The patient survived and Mary's reputation as a healer was cemented. Other patients came to her for care and while the rich paid, she treated the poor for free. Mary remained in Panama for a time, becoming ill herself, but she made a speedy recovery and went on

(Continued)

Case Study 4.1 (Continued)

to open a hotel and tavern and continued to care for the ill and injured. In 1853 she returned to Jamaica and was immediately recruited by medical authorities to help deal with an outbreak of yellow fever. Mary's response was to recruit a number of other Afro-Caribbean woman and to set up a hospital outside Kingston where they cared for victims of the disease. After the outbreak subsided, Mary travelled back to Panama to finalise her business dealings and it was here that she learnt about the escalating conflict in the Crimea. She decided to volunteer and set off to enlist as a nurse in London.

Mary travelled with letters of recommendation from various doctors in Jamaica and Panama, but she was unable to convince the British medical or military authorities to use her. Even though the Nightingale nurses who travelled to the Crimean were under-staffed, due to her skin colour Mary was refused an interview and the opportunity to go with the Nightingale nurses. Not put off, Mary applied to the publicly subscribed Crimean Fund to travel independently, but was again refused. Once more undaunted, she raised her own funds with the help of a doctor from Panama and set off for the Crimea on a Dutch ship, the SS *Hollander*.

On the way she stopped at Malta and a doctor returning from the Crimea wrote a letter of recommendation and introduction to Florence Nightingale for Mary to use on her arrival. In Constantinople, Mary arranged to travel to Scutari and meet with Florence, but she was again rejected.

Having come this far, Mary transferred her supplies to another ship and set off for the seat of the fighting on the Crimean Peninsula, arriving at Balaclava early in 1855. Here she built a 'hotel' at a place she called Spring Hill. The 'hotel' was built from driftwood, packing cases, iron sheets and house parts scavenged from the nearby town of Kamara. She used local labour and opened the newly christened 'British Hotel' in March 1855. The 'hospital' provided provisions and food for French and British soldiers. It was little more than a collection of huts, one of which served as a small hospital ward. Mary provided tea and coffee and dealt with common medical complaints in the mornings and then set off to visit casualties around the battle area in the afternoons.

Florence Nightingale made a number of references to Mary Seacole in various correspondence, referring to her as 'a woman of bad character' whom she accused of running a 'bad house' or brothel. Yet there is no evidence to support this and Nightingale is also recorded as saying that Mary Seacole 'had done a great deal of good for the poor soldiers'. Mary made a point of visiting the battlefields and treating wounded and ill men, often under fire. A *Times* newspaper special correspondent said of Mary that she was a 'warm and successful physician, who doctors and cures all manner of men with extraordinary success. She is always in attendance near the battle-field to aid the wounded and has earned many a poor fellow's blessing.' A soldier said of her, 'she had the secret of a recipe for cholera and dysentery, and liberally dispensed the specific, alike to those who could pay and those who could not. It was bestowed with an amount of personal kindness which, though not an item of the original prescription, she deemed essential to the cure.'

So closely involved in the front-line care of soldiers was Seacole that she was the first woman into Sevastopol after the siege was lifted. The war's conclusion brought ruin, though, as the trade at the British Hotel diminished and she returned to England poorer than she had left. Soon she was declared bankrupt and a fund was set up (the Seacole Testimonial Fund) to offer support. In July 1857 the Seacole Fund Grand Military Festival was held to contribute to her Testimonial Fund. The event was supported by many military men and over 1000 artists performed, including 11 military bands, and the attendance was over 40,000. Mary also produced an autobiography, *The Wonderful Adventures of Mrs. Seacole in Many Lands*, the first book written by a black woman in Britain. Gradually she regained her financial footing and when she died in 1881, in London, she was financially independent again.

Her many achievements in the Crimean War were somewhat overshadowed by Florence Nightingale's fame and while well known in her lifetime, Mary has since faded from the pages of history. She remains

well known in the Caribbean and there has been a resurgence of interest in her contribution to nursing in recent years. In 2004, Mary Seacole was voted into first place in an online poll of 100 Great Black Britons and her contribution to nursing and medical care in Central America, the Caribbean and the Crimea solidifies her place as a supreme clinically focused and congruent leader. In 2016 a statue of Mary was unveiled opposite St Thomas's Hospital in London.

Challenge: Mary lived an extraordinary life, yet it was based on simple principles. Like any other congruent leader, when she was needed she stood tall. Her contribution to the health and welfare of the French and British fighting men in the Crimea was no less personal, and often more so, than the care offered by Florence Nightingale, yet like so many people in the health service it has gone unnoticed and unrecognised in the shadow of other forces and issues. Think about what you have achieved in the past week or month. How many lives have you touched in the course of your work? These achievements may not have got into the papers or been seen on the evening news, but they matter very much to the people whose lives you have touched. Reflect on when you have stood tall, stood out or advocated for the people in your care. How have your actions affected the personal life or influenced the history of a patient, client or their family? What might have occurred if you had not spoken up or acted on their behalf? When were you last a congruent leader?

Summary

- Congruent leadership developed from the results of research specifically exploring healthcare-related clinical leadership.
- Congruent leadership is based on a number of research studies undertaken within a range of different health professional disciplines, using a range of methodologies, in different countries, with different genders and over a wide span of years.
- Congruent leaders match their values and beliefs to their actions.
- Congruent leaders are not consciously selling a vision or communicating a path for others to follow. Instead they are recognised because they are living their values and walking their path with conviction, commitment and determination.
- Congruent leadership is proposed as a framework to support an understanding of clinically focused leadership.
- A new hypothesis is offered that suggests that clinical leaders may be more appropriately seen and recognised by the match between their values and beliefs and their actions.
- Congruent leadership offers a solid foundation on which clinical professionals can develop and gain leadership potential.
- Congruent leadership is not power neutral. The power of congruent leadership comes from unifying groups and individuals around common values and beliefs.
- If health professionals focus on the values that are central to their professions' core, they will also be drawn towards focusing on improving patient outcomes, client care and quality processes.
- The strengths of congruent leadership are that it supports a focus on grassroots leadership, it offers a foundation on which other theories can be built, it builds a strong link between values and beliefs and it supports the advancement of the clinical leader's place in health service development.
- The limitations of congruent leadership are that it is a new theory, that it is similar to other 'values'-based leadership theories, that it is not suitable for leaders where 'controlling' is a key function of their role and that it does not have 'change' as its primary focus.
- Congruent leaders are focused on quality, innovation and change by acting out their values and beliefs.

- Clinical leaders are found in great numbers and across the spectrum of the health service.
- Clinical leaders are practitioners who have gone to the edge and flown, stepped boldly in the direction of their values and beliefs or confidently stood by them and demonstrate congruent leadership.

Mind Press-ups

Exercise 4.1

Think about your personal values and take some time to make a list them. Are the things you listed similar to the values offered in Box 4.7?

Exercise 4.2

Discuss your values list with a professional colleague. Find out if they have similar values, what their values are or how they might express them.

Exercise 4.3

Congruent leadership describes a leader who is recognised because their actions match their values and beliefs. Can you think of healthcare practitioners whom you would identify as congruent leaders?

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5

Leadership and Management

David Stanley

The only safe ship in a storm is leadership.

Faye Wattleton, feminist activist and author, b.1943

Introduction: Necessary and Essential

This chapter looks at the difference between leadership and management. It is acknowledged that while some leaders make great managers and some managers make great leaders, the proposition that supports the concept of clinical leadership is that leaders and managers are different … in many ways (Anderson 2012; Jones & Bennett 2012; Scully 2015). It is suggested within this text that role ambiguity exists for many health professionals who undertake clinical roles but have parallel management functions (Stanley 2006c; Cutcliffe & Cleary 2015). To some extent this is the premise of Richard Branson's book *Business Stripped Bare* (2009). For Branson, the entrepreneur or business leader is often unable successfully to manage the company he has established and his skill set may be more effectively used in creative activities related to expanding the industry or branching out to other ventures. It is clear that managers are necessary for any chaotic or large organisation to function, and that leaders are essential if innovation and change are to be supported, or if values-based leadership is to resonate with those in the organisation.

The literature and research-based evidence suggest that conflict exists when clinicians assume management roles without appropriate training, support or instruction, and that in terms of leadership, leaders find that their goals may be compromised or limited by overarching management or organisational aspirations or targets (Stanley 2006c; Kerridge 2013; McLellan 2015; Orvik et al. 2015; Scully 2015). This chapter considers literature that outlines the differences between management and leadership. It also suggests that if clinicians are able to recognise the differences between leadership and management, nurses and other healthcare professionals will be able to support a more appropriate approach to clinical area management, clinical leadership and the care of patients and clients.

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Misunderstood

Often clinicians are required to make the transition to manager and, in some cases, retain a clinical function; however, many health professionals recognise that even the best clinical staff may not make the best or most appropriate managers (Anderson 2012; Scully 2015). Research related to clinical leadership with a range of health professionals showed that most were poorly trained in leadership (paramedics 40.6%, allied health professionals 43.4%) and even fewer were instructed in formal management skills (paramedics 26%, allied health professionals 31.9%; Stanley, Cuthbertson & Latimer 2012; Stanley, Hutton & McDonald 2015). Even so, managing a clinical case load or a clinical team of staff is not the same as managing a ward, department or division. Sadly, clinical leaders are seldom offered or able to access management or leadership instruction prior to these 'promotions', leading to potential conflict and possible role ambiguity (Kerridge 2013).

Leadership and management courses have developed in the health services across the globe in order to better support clinical leaders and neophyte managers. Yet will these courses offer an ideal solution? Employers may hope that by allowing managers to retain a small part of their original occupational role this will offset any discomfort caused by having to adapt to new or alien roles of management and control. There has been a proliferation of 'leadership' training or courses to support the managerial development of clinical staff into management positions, but this may offer a flawed solution, because if leadership and management are different, then the requirement is for courses that support the specific roles undertaken; that is, leadership courses that address genuine leadership issues and management courses for people whose focus is on management. To some extent this is being addressed in the UK with the development of the NHS Leadership Academy and the establishment of the Leadership Framework (NHS Leadership Academy 2013a). The drive across the global health industry is to have more clinicians in key leadership roles (NHS Leadership Academy 2013a; DoH WA 2015; McLellan 2015; Rose 2015; West et al. 2015; NHS Leadership Academy 2016). While this may seem ideal, it is hampered by a perpetual misunderstanding about the difference between leadership and management (Murphy, Quillinan & Carolan 2009; Anderson 2012; Kerridge 2013; Cutcliffe & Cleary 2015). The situation is changing, however, with more and more courses being focused on clinical leadership and the emphasis of the content shifting from vision and strategic planning to values-focused leadership instruction (NHS Leadership Academy 2013b; DoH WA, 2015). The results of failing to recognise and address this leadership/management dichotomy have been conflict, confusion, a challenge to the clinician's values and beliefs, disassociation from the clinician's core clinical values, ineffective leadership, ineffective management and potentially dysfunctional clinical areas. All of these are detrimental to quality care (Stanley 2006a, 2006b, 2006c; Kerridge 2013; Cutcliffe & Cleary 2015).

Reflection Point

Are leadership and management different? Speak with a colleague and see if they have a view about this. Also, do job titles matter? Think about this. Why do we have the job titles we do? What does it mean to be a registered nurse, therapy team leader, ward/department or clinical team manager, clinical nurse, senior physiotherapist or nurse consultant? What do the badges we wear say about our roles? Do they say anything about us personally?

A House Divided Cannot Stand

Abraham Lincoln said in 1858, 'A house divided against itself cannot stand.' He was referring to the US Congress, where many of the states approved of slavery and many did not. I believe that this is also true when applied to clinical staff whose focus is divided between clinical and professional values, and their management role and its associated responsibilities. Long (2011) supports this view when suggesting that what is needed is a reconciliatory approach to the leadership/management divide, adding that leadership and management are complementary activities that support an effective health service. Management should not be viewed negatively (Scully 2015) or as less valuable than leadership; however, they are different and need to be recognised and understood from the perspective of these differences. Many health professionals appear to be disillusioned when the values of their employing organisation are at odds with their core professional values and beliefs (Bishop 2009; Kerridge 2013; Cutcliffe & Cleary 2015). Naughton and Nolan (1998) anticipated this when considering nursing's future role, indicating that the drive to offer more (managerial) power to nurses could create a number of tensions, especially between professional aspirations and the demands of a new managerial culture. They felt that 'many nurses have found themselves torn between the push towards the ideal of individualised holistic care and the reality of resource constrained environments' (Naughton & Nolan 1998, p. 983).

Forbes (1993) posited that traditional management tasks (i.e. staffing, staff evaluation, budgeting etc.) were best left to administrators because these duties would just cloud the clinical focus of senior clinical nurses; a conclusion supported by Doyal (1998, p. 9), who found that nurses appointed to managerial roles suffered from a 'confusion of identity' that often led to 'anxiety and isolation for the post holders'. Doyal (1998) also indicated that ward managers and senior nurses felt uncertain about where to position themselves, particularly in the areas of relationships with colleagues, professional identity and managerial responsibilities. Cutcliffe and Cleary (2015) indicate, with an example from Canada, that this sort of role confusion has indeed come to fruition and that nursing leadership is seen as aligned with administration and management positions, leading to a replacement of nursing leadership positions with non-nurse supervisors. These feelings of conflict were also evident in the comments that allied health professionals made when describing the barriers they saw in trying to establish a clinical leadership role. Almost 30% indicated that there was some conflict between their clinical role and the frustrations of 'juggling multiple responsibilities' (Stanley, Hutton & McDonald, 2015).

Firth (2002) further supported these findings following interviews with a sample of ward managers. 'Role ambiguity' was identified as a main theme of her research and participants were found to be unclear about their role, even angry about how the role had evolved. The majority of managers interviewed indicated that if they could delegate the administrative side of their job to someone else, their role would be improved, causing Firth (2002) to conclude that ward managers experience conflict between the management and clinical dimensions of their role. These findings are not new and certainly concur with those of a similar study undertaken in 1999 (Stanley 2000). This explored the role of ward sisters or senior registered nurses (RNs) in general ward areas of a number of hospitals in the English Midlands. One participant in the study, when asked to discuss her role as a senior nurse, replied:

> I think it is a role that is diminishing slightly. Ward sister, ward leader, ward manager, team leader, there are 101 names for it and I don't think it is respected very much in the NHS because it is a very difficult role straddling clinical and management. You never know quite where your boundaries are.

The study concluded that senior RNs struggled with little support, limited resources and staff shortages. Participants were commonly ill prepared for their role, particularly in relation to leadership and quality issues, and increasingly expressed feelings of conflict in their work. This was due to their preconceived, traditional idea of what their role and responsibilities should be, set against the realities of a changing health service (Stanley 2000). This change, or blurring of professional boundaries, was noted by Reed and Kent (1997), who attributed it to a loss of clear nursing leadership. Kerridge (2013) and Cutcliffe and Cleary (2015) remain aware that there is confusion and vagueness about the role and function of health professional managers, characterised by complexity and a loss of clarity over their role and responsibility. Further evidence of this role conflict is offered by Willmot (1998), whose evaluation of the changing role of the charge nurse indicated that 72% of charge nurses felt unable to find a balance between the two roles, while a similar number also expressed feelings of isolation from their peers and teams. Long (2011) suggests that issues of role balance remain, draining clinical confidence and undermining health services. Allied health professionals described similar issues when some suggested that clinical leadership was not even perceived to be a role that they could (or should) fulfil. A number suggested that there were many misconceptions about what a clinical leader's role was, as well as a negative attitude towards allied health professionals who aspired to be clinical leaders, and that they were often told that clinical leadership should be a management function (Stanley, Hutton & McDonald 2015).

Kippist and Fitzgerald (2009) reported on a study of 14 senior members of a cancer therapy unit in New South Wales, Australia, where the tensions between 'hybrid clinician' managers' professional values and the healthcare organisation's objectives were measured. Their results indicated that organisational effectiveness was lacking when the clinical and managerial roles were combined and that the combination of clinical and managerial functions caused conflict, which affected other organisational members and had negative implications for the efficiency of the healthcare organisation.

Malcolm et al. (2003, p. 654), and more recently McLellan (2015), support the notion of a gap between the clinical culture and a governance or managerial culture, suggesting that clinical leaders should remain focused on professional issues, quality and care and not 'cross over to the other side' (i.e. management). In the UK, nurse consultants have been developed to occupy a clinical, quality and care development role. However, when Guest et al. (2001) investigated the nurse consultant role, they found that as well as being able to identify many positive areas within their work, nurse consultants also encountered problems of role ambiguity, role overload, role conflict, role overlap and role boundary management issues.

These views support criticisms from Kerridge (2013), who suggested that any nursing strategy needs to think more critically about the training needs of clinical ward nurses. It could be argued that there has been some impact as a result of considerable investment in training by the UK government through the NHS Modernisation Agency and the NHS Leadership Academy, and in Australia by each state Health Department. However, a focus on skills related to leadership and management may not address the core issue affecting front-line health professionals, who commonly experience conflict from having to balance the managerial and clinical demands of their post (Forbes 1993; Doyal 1998; Stanley 2000, 2006a, b, 2011; Firth 2002; Kippist & Fitzgerald 2009; Long 2011; Kerridge 2013; Cutcliffe & Cleary 2015; Rose 2015; West et al. 2015). The regularity with which the issue of role conflict and blurred role boundaries appears in the literature (it also became evident in the numerous research studies that support this author's view on clinical leadership) points perhaps to a fault in the structure of ward/unit/health service management. Clearly, the perception that many nurses and allied health professionals have that the best

clinical professional may not be the best ward/unit/clinic manager rings true and needs further consideration (Cutcliffe & Cleary 2015). If there is role conflict, confusion and disassociation from clinicians and their core clinical values, could it be because leadership and management are two different things and need to be considered independently to gain the most complementary fit?

Leadership and Management: Apples and Pears?

The fact that some managers lead and some leaders manage does not mean that leadership and management are the same. There is much more to both leadership and management than a title. For example, I would argue that although I can run for a bus, this does not make me an athlete.

While Long (2011, p. 4) suggests that the separation of management from leadership could be 'harmful', Zaleznik (1977, p. 61) proposes that 'managers and leaders are two very different types of people'. He adds that the conditions favourable to the growth of one may even be detrimental to the other. Zaleznik (1977) claims that managers and leaders have different attitudes towards their goals, careers, relations with others and themselves. He considers that managers' goals arise out of necessity rather than desire, and that managers excel at diffusing conflict between individuals or departments, placating all sides while ensuring that an organisation's day-to-day business gets done. His view of leaders, on the other hand, is that their goals arise from a personal or passionate desire to infuse meaning into the world. Leaders, he maintains, are about people and meaning, while managers like to work with people, tend to maintain a low level of 'emotional' involvement and may withdraw from the meaning of events. Managers, he indicates, are seen as fairly passive people, intent on keeping the show on the road. However, leaders seem to be more solitary, proactive, intuitive, emphatic and attracted to situations of high risk. Leaders ask the 'why not' question and 'do the right thing', while managers 'do things right' (Bennis & Nanus 1985).

Kotter (1990) supports these assertions, considering leadership and management to be different, each having its own function and its own characteristic activities. In his view, management is about controlling and putting appropriate structures and systems in place. He describes managers as being involved with planning and budgeting, setting goals and targets, organising and staffing, problem solving and coping with complexity. Management is indeed co-dependent with complexity, and modern management has evolved because without good management large organisations and complex enterprises tend to become chaotic. Good managers bring order and consistency to key dimensions like quality and profitability.

Leadership differs in that it is about coping with change, responding to chaos or even to some extent creating chaos. This can involve the creation of challenges that shift the status quo or push people out of their comfort zones. Clinical leaders are the key to initiating innovation. Part of the reason that leadership has become such an issue – particularly in relation to current health industry needs – is that more innovation and change always demands more leadership (Kotter 1990). Few people would argue that change has not been a constant feature of the recent health industry landscape. However, leadership has more to do with aligning people, setting direction, motivating, inspiring, employing credibility, adopting a visionary position, anticipating change and coping with change (Jones & Bennett 2012; Scully 2015). While acknowledging that both management and leadership are necessary for the functioning of complex organisations, Kotter (1990) emphasises their differences, suggesting that leadership seems to be rooted in the maxim that the more change there is, the more leadership is required. While supportive of Kotter's views, Warren (2005) is more specific, indicating

that 'vision' is the main difference between leadership and management. Management, he states, consists primarily of three things:

- analysis
- problem solving
- planning

Warren (2005) considers that a leader is essentially able to clarify the purpose of an activity, stating that leadership consists of:

- vision
- values
- communication of vision and values

From this perspective, leaders could be described as the 'heart of an organisation', with the essence of leadership being to inspire a group to come together for a common goal. Leaders motivate, console and work with people to ensure that they are bonded and eager to move forward. This means innovating, setting direction, communicating to everyone and keeping people on track when times get tough.

Leadership and Management: Snakes and Ladders?

Research related to clinical leadership between 2001 and 2015 (Stanley 2006a, b, c, 2009; Stanley, Cuthbertson & Latimer, 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015) also brought to light key themes that addressed the differences between management and leadership. The research involved specific questions that sought to explore the participants' understanding of and insights into these differences and the impact they had on their role. The consensus drawn from these studies was that managers tended to depend on their position, title and hierarchical status (a point supported by Curtis, de Vries & Sheerin 2011 and Kerridge 2013), while leaders depended on their ability to inspire people, relying instead on their knowledge and experience.

The majority of research respondents saw managers as having 'more authority than a leader' and leadership was seen as 'not necessarily grade (position) related … it is a quality that some people have … the ability to inspire colleagues'; a notion with which Grossman and Valiga (2012) and Scully (2015) would concur. Another participant said that the difference was that 'the manager has got the title, and therefore they manage because of the title, but there are other people that lead by virtue of their opinion'. These views or variations of them were surprisingly consistent across the nursing, paramedic and allied health professions.

Some participants emphasised the interpersonal relationship aspect of leadership, describing leaders in terms of 'dealing with people, while management was more about dealing with systems and processes'. Supporting this perspective, another participant indicated:

> Leadership involves everybody … leadership is more about guiding people, it's about talking to people, being on their wavelength, seeing how they feel, seeing what they are capable of doing. Management to me is more office-based, managing the people that are working for you. Managing budgetary constraints and things like that.

Others said that 'management was about being controlled' or that 'managers found it difficult to get properly involved'. Describing the difference between management and leadership, many offered

views about the diminished clinical input of managers. One commented, 'managers are … no longer clinical. They do clinical shifts, but they are so bogged down with everything else that's going on … and all the paperwork that's involved with it'. Another nurse said of her manager:

> Sometimes perhaps she is not very approachable. You feel that you know she's obviously busy doing the managerial stuff and actually running the ward … doing the day-to-day things rather than being able to support the staff clinically … she doesn't carry much of a clinical workload[,] she is more administrative.

When asked if there were issues around being a leader or a manager, one participant said, 'management and leadership are totally separate entities … there are barriers, especially the higher up the ladder you get, you get focused on the clerical side and the patient care can suffer'. Another respondent maintained, 'I think you can perhaps get somebody that knows nothing about nursing and you can put them in a management position, you know they probably could do the job', a view echoed by another: 'they could pick someone off the street and make them into a decent manager, but leadership comes from within … it's different'.

Other participants described managers as distant from the clinical areas, 'more interested in the finance and things', 'more office-based', 'hidebound' or having 'more authority than a leader'. This view of the manager was repeated from another participant who said, 'they are basically … you know 80 per cent of the time they are sat in the office doing something … it's like a supervisory role'.

Another respondent suggested that 'management could diminish your impact as a leader'. The negative side of being promoted or seeking promotion in the health service was that there is a greater tendency to come off the 'shop floor', which can reduce your impact as a leader. Recognising that leaders were found at all levels and in a range of different areas, a number of participants described a leader as 'someone who doesn't have to be in a management position', 'someone inspirational', 'someone who comes with knowledge and experience'. Leadership and management were clearly seen as different, although a relationship existed between them. Long (2011) describes leadership and management as having a complementary relationship, with each being important for organisations to function safely and effectively. However, the research respondents and participants outlined a clear tension in the leadership/management relationship. Managers are commonly cited as being removed from care, climbing the managerial career ladder, but at the same time sliding down the professional snake in terms of clinical credibility, effectiveness or their capacity to lead clinically. This situation was also identified by McLellan (2015) when describing the 'crisis in NHS leadership' and supported by Cutcliffe and Cleary (2015) when discussing the conflict between leadership and management. Clinically focused leaders were seen in the author's research as coming from any level, advancing clinical care because they were approachable, inspirational, visible, clinically skilled, experienced and, most importantly, driven by their core caring values.

In the original clinical leadership research undertaken with nurses in the UK, clinical leaders identified two issues in relation to differences between management and leadership – 'juggling everything' and 'conflict' – with a major preoccupation being balancing their clinical and managerial responsibilities. One interviewee said:

> I see myself as having two priorities. One is the patients obviously, that's what we're here for, and my second is my staff … if there is a conflict between staff requirements and patient requirements, the patient requirements come first.

This issue was also identified by Long (2011) as a concern common in complex health organisations. Another research respondent supported this view, adding:

> It would be wonderful … without a doubt … I mean I'd rather not be dealing with people's salaries … annual leave request … monitoring sickness … because I would be far more valuable out on the ward working alongside junior colleagues.

These perspectives were echoed by allied health professionals 10 years later in another study in Australia (Stanley, Hutton & McDonald 2015). In terms of clinical leadership, they suggested that they faced the same issues of having to do more with less and conflict between demands on the clinical role and a requirement to be management focused. One respondent suggested that there were 'competing clinical demands – client work is always prioritised within the service and this can be a challenge in creating enough time and space to give to other roles'. Another added:

> I am concerned that the focus on business philosophy can overshadow the fact that we are not in a business environment, but a therapeutic environment, and that a 'business framework' can only go so far. Having said that, an understanding of business/human resources etc. is essential.

Clinical leaders in all the research studies described themselves as being driven by their beliefs about client/patient care. They spoke of their desire to apply and display high-quality care and provide excellent roadside care or effective therapies. Conflict arose when management responsibilities were seen to diminish their effectiveness as clinical leaders. This was summed up by one participant who said:

> The more management responsibility you've got, the less you are visible in the clinical area. There is only so much you can do[,] which is one of the reasons why I don't want to go any further [with her career].

Not only were leadership and management different, the clinical leaders in all the studies clearly indicated that taking on management responsibilities was likely to be detrimental to the fulfilment of a clinician's clinical leadership capacity.

Leadership and Management: Heart and Head?

Long (2011), Anderson (2012), Jones and Bennett (2012), Rigoloski (2013) and Scully (2015) see managers as the brains of an organisation. Managers establish systems, create rules and operating procedures and put in place incentive programmes and the like. Management, however, is about the business, not about the people (Robbins 2002; Anderson 2012). Therefore the people are important only as a way of getting the job done. Managers have subordinates and they emphasise rationality and control focused on goals, resources, organisational structures or people management. Leaders have followers, are imaginative, passionate, innovative, non-conforming, risk takers, and work from the perspective of their vision or values (Anderson 2012; Jones & Bennett 2012).

For some time, concepts and descriptions of management and leadership have been used interchangeably. Anderson (2012), however, describes leadership as being about taking action and communicating values in the context of a relationship. It is not about reinforcing the status quo and a reliance on hierarchy. As such, Anderson (2012) and Cutcliffe and Cleary (2015) suggest that it is time to lay to rest the false confusion about leadership definitions and accept that leadership is

different from management, that leadership applies to all kinds of people at all levels in organisations, and that leadership is about relationships and the leader's behaviour (Jones & Bennett 2012). Field Marshal Sir William Slim said of managers that they 'are necessary, but leaders are essential. Leadership is of the spirit, compounded of personality and vision … management is of the mind, more a matter of accurate calculation, statistics, methods, timetables and routine' (Slim 1957).

Management and leadership can therefore be described as two different concepts (see Table 5.1). Management is a function that must be exercised in any organisation; leadership is a relationship between the leader and the led that can energise an organisation. It is astute, as this chapter concludes, to recall that you cannot manage people into battle.

Table 5.1 Summary of the difference between factors attributable to leadership and management.

Factors	Leadership	Management
Aims	Change/innovation	Stability/status quo
Objectives	Communication of vision Expression of values	Achievement of organisational aims or objectives
Theoretical approach	Transformational or congruent	Transactional
Relationship with conflict	Uses conflict constructively	Avoids or manages conflict
Relationship to power	Personal charisma/ personality/values	Formal authority/hierarchical position
Blame/responsibility	Takes the blame	Tends to blame others/processes
Core energy	Passion	Control
Relationship to the led/ managed	Followers	Subordinates
Creativity	Explores new roads/innovation	Travels on existing paths
Main focus	Leading people/establishing new ways	Managing work/tasks/people
Planning	Sets direction	Plans detail
Motivation from	Heart/spirit	Head/mind
Response pattern	Proactive	Reactive
Persuasion style	Sell	Tell
Personal motivation	Excitement for work/ unification of values	Money or other tangible reward/ getting job done
Relationship to rules	Breaks or explores the boundary of rules	Makes or keeps rules
Approach to risk	Takes risks	Minimises risk
Approach to the future	Creates new opportunities/ innovation	Establish systems/processes
Who within an organisation	Anyone/everyone	Those with specific senior hierarchical positions
Relationship to the organisation	Essential	Necessary

Source: Stanley (2011). Reproduced with permission of Palgrave Macmillan.

Reflection Point
Take a sheet of paper. On the right-hand side, make a list of the characteristics and qualities you would seek in a good/effective manager. On the left, make a list of the characteristics and qualities you would seek in a good/effective leader. Compare the lists. Are they the same? Where are they different? Look at the list in Table 5.1. How does this list compare with yours?

Going into a battle in war, or entering into the conflicts and issues of an organisation or clinical arena, requires leaders, not managers. Accepting this means recognising the differences between leadership and management, and applying the correct, most appropriate activity at the right time, in the right way. Bennis and Nanus (1985), famous for their study of leadership and management, remind us too that most organisations are managed – not led.

A Culture Shift

So this chapter offers the view that leadership and management are different. It also provides evidence that management and leadership functions embodied in the same person, or within the same post, lead to values breach, confusion, conflict and diminished clinical and management effectiveness (Kippist & Fitzgerald 2009; Kerridge 2013; McLellan 2015; Cutcliffe & Cleary 2015).

Addressing this issue must surely be considered central to improving the efficiency of clinical areas and to developing sustainable improvements in the quality of patient/client care. A house divided cannot stand, and it may be time to recognise the divisions that the current approach to ward/unit/clinic or department management effects. The shift in culture to achieve this would be tremendous and has implications for the provision of appropriate continuing professional development and, indeed, maybe even a political shift in healthcare policy. However, the potential benefits in terms of improvements to patient care and staff retention could be tremendous too.

Zaleznik (1977), Kotter (1990), Robbins (2002), Stanley (2006c, 2011), Warren (2005), Kippist and Fitzgerald (2009), Curtis, de Vries and Sheerin (2011), Jones and Bennett (2012), Kerridge (2013) and McLellan (2015) all point to differences between leadership and management. The health industry is constantly dealing with change, and organisations need both leaders and managers (Swanwick & McKimm 2011; Kerridge 2013). Sometimes it is the manager who fulfils a leadership role, while at other times others within the organisation lead. Indeed, one of the key criticisms of the Francis Inquiry (Francis 2013) was that confusion existed because a care culture had developed where management was separated from ward-level leadership, and where further confusion existed over who should be responsible for care. To suggest that only managers can lead would be a mistake. Maintaining the status quo requires considerable energy, and working as a manager in any health industry organisation demands resilience, commitment and dedication as well as recognition that leadership occurs on many levels. Managers therefore fulfil a vital role. However, they may not be best placed to be effective clinical leaders. Managers are about stability, running the organisation and keeping things on an even keel. Some managers are able to lead and engage in both stable management tasks and creative risk-taking leadership – but only rarely (Anderson, 2012).

Appointing and training people who are asked to function as managers, but with expectations that they will offer dynamic and risk-taking leadership, sets them up to fail or leads them to feel insecure in their role; a point identified by Long (2011) in relation to medical practitioners' reluctance to take on 'senior managerial' roles in the NHS. Across all professional disciplines these practices are almost

epidemic in proportion. No one wins and the health industry and patients suffer, as the Mid Staffordshire inquiry shows (Francis 2013). Clinical leaders with significant management responsibilities are potentially placed in positions of diminished clinical effectiveness (Christian & Norman 1998; Kerridge 2013). Ward managers, senior RNs and a host of other senior clinical staff with managerial responsibilities find themselves climbing the managerial ladder, only to slide down the clinical snake. Advancing themselves or their organisation's objectives is too often at the cost of effective clinical leadership, often depriving some (neophyte nurses, other professionals and unskilled or semi-trained carers at the bedside) of their guidance and clinical leadership that could really improve patient/client care.

For a genuine opportunity to develop more efficient ward/unit management and clearer, more effective clinical leadership, it may be time to accept that having leadership and management functions reside in one person or post is inefficient and counter-productive, both to the individual concerned and to the health service's future development and success.

Recognising the difference between leadership and management will also allow professional development to embrace education focused on leadership development that is based on clinical practice, and not simply management principles overlaid on clinical functions.

Case Study 5.1

Joan of Arc is one of France's national heroes. Born in 1412, she was a simple peasant girl who, at the age of 12 or 14, heard the 'voices of the saints', Michael, Catherine and Margaret, calling her to save France from the English. With this divine inspiration she rose to become a soldier, leader, martyr and finally a saint herself. She was convinced that God had called her to free France and she showed remarkable moral courage and significant military leadership to inspire the demoralised, humiliated and discredited French army to fight on during the Hundred Years' War. Read this brief account of her life and consider the challenge that follows.

Female Leaders: Joan of Arc

Joan defied convention and the obstructions of statesmen, churchmen and generals to follow her divine beliefs. She travelled across war-torn France to seek an audience with the Dauphin Charles, the uncrowned son of the previous king, Charles VI. Her quiet determination and religious devotion led to her gaining access to the Dauphin and she persuaded him to allow her to lead his army to lift the siege of Orleans. Clad in white armour and wielding a battleaxe, Joan led the army to a stunning victory in only nine days and became known as the 'Maid of Orleans'. There is some debate about the contribution she made in actually planning or fighting during the battle, as her testimony during her later trial implied that she preferred the standard to the sword. She may have been more influential on a motivational level, but she clearly had a dramatic impact on the reversal of the French army's fortunes. The English reviled her as a witch who must have had some sort of supernatural power. Other victories followed and she witnessed the crowning of Charles VII at Rheims, before convincing the new king to continue his offensive and liberate other parts of France.

In an attempt to lift the siege of Compiègne, Joan was captured by the Burgundians, sold to the English and tried as a heretic. She was so convinced of her divine mission that interrogators decided it would be useless to torture her, but when the church threatened to hand Joan over to the secular courts, she confessed to heresy and agreed to put on women's clothes again. She was sentenced to life in prison, but her 'voices' returned and she recanted. As a result, she was handed over to the secular

(Continued)

Case Study 5.1 (Continued)

authorities and at the age of 19 she was burnt at the stake as a witch. Charles VII, wishing to maintain the truce with Burgundy and not wanting to be seen to be associated with a witch, failed to intervene.

Joan's devotion and belief were unwavering and as she died a priest shouted above the flames that she was assured of eternal salvation. The English were so concerned that no relic of her should remain that they burnt her body three times and scattered the dust from her ashes in the river Seine.

Twenty years later Charles VII, now with a safe hold on the French throne, supported an inquiry into Joan's trial. Her conviction was overturned and 500 years later, in 1920, the Roman Catholic Church made her a saint. Joan of Arc has remained a significant figure in western culture, and in French politics the memory of Joan's devotion to the salvation of her country is often evoked.

As with the varied and vexing definitions of leadership, the story of Joan of Arc offers a contrary insight into leadership, when in an age of war and male dominance, a simple peasant girl rose to lead an army and conquer the English and their assumptions about strength and determination.

Challenge: Joan was able to lead the French Army into battle and stir the men to follow her and believe in her, in spite of their previous string of defeats. Was this leadership or management? To what extent are clinical leaders in positions of leading without managerial authority? How is it that leaders can motivate followers when they have little direct managerial authority or sometimes little awareness that they are even seen as leaders? When your values or beliefs are challenged, how strongly do you feel that you can hold on to them? Few female health professionals are threatened with being burnt alive; although this was not always the case, as Ehrenreich and English (1973) attest. To what extent does gender play a role in people's assessment of leadership potential today? (See Chapter 17 for more on this issue.)

Summary

- Leadership and management are different, but remain complementary.
- Misunderstanding the differences can lead to values conflict, confusion, a challenge to the clinician's values and beliefs, disassociation from the clinician's core clinical values, and ineffective leadership and management.
- There is considerable evidence that management and leadership functions, when embodied in the same person or within the same post, lead to confusion, conflict and diminished clinical and management effectiveness.
- Nurse managers and a host of other senior clinical nurses with managerial responsibilities find themselves climbing the managerial ladder at the expense of their clinical career, advancing themselves, or the employer's objectives, at the cost of effective clinical leadership.
- There may be other, more effective, productive and satisfying models for the facilitation of management and leadership approaches in clinical areas.

Mind Press-ups

Exercise 5.1

Think about your formative healthcare education. What did you learn about management? Was this adequate? Do you think that there are other matters or topics that health professionals should learn

about to ensure that they are skilled managers (e.g. financial management, human resources management)? Did your formative healthcare education prepare you to function as an effective manager?

Exercise 5.2

Think about a leader (from your work, from history, politics, or any walk of life) whom you admire, look up to or have been inspired by. Write a short summary about what it is or was about them that you admire, respect or identify with. Look at the qualities and characteristics of leadership and management you have described. How do they match?

Now do the same, but this time think about a manager whom you admire, look up to or have been inspired by. Repeat the process. Again, how do the qualities and characteristics of leadership and management match?

Exercise 5.3

Are clinical leadership, management and nursing leadership different? Think for a moment about these three concepts and how they relate to your professional position. Is there something happening in the health service (wherever you work) that implies a shift in the way things are being done? Are we seeing the rise of leadership? If so, how is this manifest at the coalface? What do your colleagues think?

Exercise 5.4

In researching the difference between leadership and management in the health service, trying to undertake both roles (leadership and management in the one position) was found often to lead to considerable conflict. Have you ever experienced the types of values-based conflict suggested here?

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Part II

Clinical Leadership Tools: How to Influence Quality, Innovation and Change

Man is a tool-using animal. Without tools he is nothing, with tools he is all.
Thomas Carlyle, Scottish philosopher, 1795–1881, from *Sartor Resartus*, 1834

The second part of this book deals with how clinical leaders who act in concert with their values can initiate change, enhance quality care, lead innovation and support their own development. Primarily, each chapter offers practical information about a range of 'tools' or topics that clinically focused health professional leaders can use to support a focus on values-based care and compassion-driven practice, as well as to lead innovation, quality initiatives and change practice through the employment of a congruent leadership style.

Chapter 6 discusses the relationship of organisational culture to congruent leadership and clinical leadership. Recognising that values are the primary driver for organisational culture change is central to this chapter's position.

Chapter 7 offers a range of models for managing change. If the clinically focused leader's values are to be translated into action, a clear understanding is required of how to bring about innovation and change. Therefore, clinically focused health professionals need to understand models and processes that can be used to support the effective implementation of change. A range of models are offered in this chapter, including SWOT analysis, stakeholder analysis, Pettigrew's context/content/process model, the change management iceberg, the PEST model, Kotter's eight-stage change process model, the nominal group technique, process re-engineering and force-field analysis. Other approaches are mentioned and there is also a discussion of why health professionals may be resistant to change.

Chapter 8 considers how clinical leaders make decisions and the relevance of that decision making. The core part of the chapter outlines potential strategies and refers to models that foster effective clinical decision making. Theories that support decision making are also outlined, along with a discussion of why decisions may go wrong, group decision making and the significance of decision making for clinical leaders.

Chapter 9 explores the issue of creativity and why it is an important concept for clinical leaders seeking to initiate change, promote innovation and stand by their values. The chapter defines creativity, explores how creative capacity can be built and considers what the barriers to creativity may be. It also elaborates on the significance of understanding creativity from a clinical leader's perspective.

For clinical leaders to be effective they need a reasonable understanding of how teams function, why teams may sometimes fail to deliver and how they themselves can support the creation of powerful teams. Chapter 10 offers this information, as well as a discussion of the value of team working

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and the role of team members. The chapter also considers self-led teams and the impact of leadership on a team's ability to deliver.

Chapter 11 focuses on networking and delegation, two essential skills for clinical leaders to acquire or hone. Networking is first explored in terms of the skills needed and strategies that can be used to enhance it. Then the skills of delegation are described so that clinical leaders can develop successful delegation attributes and strategies.

Conflict is recognised as a feature of most work environments and is central to the professional dichotomy between values-led care and other drivers for clinical practice. Chapter 12 offers information about how conflict is recognised, the different styles of dealing with it and how clinical leaders can more effectively manage conflict. Non-productive behaviour types are also outlined and approaches such as active listening, self-talk and i-messages are elaborated as strategies for coping with conflict.

Chapter 13 offers information about motivation and inspiration, vital aspects of clinical leadership. The chapter considers approaches to motivating others and how people are inspired to follow and engage, with steps to improve patient care and the health service.

In effecting change and initiating innovation, clinical leaders will benefit from an understanding of evidence-based practice. Chapter 14 provides an introduction to strategies to creating a spirit of enquiry and developing evidence-based practice habits. The barriers to using evidence in practice, approaches to applying evidence-based practice and strategies for addressing the practice, research and education nexus are also discussed.

Chapter 15 is about reflection and emotional intelligence. This chapter outlines what reflection is and how it can be used as a tool to support clinical leaders' development. It also describes what emotional intelligence is and how it can be applied in the clinical context. Moreover, the chapter considers how clinical leaders can employ emotional intelligence to focus on their own values and beliefs and use them in a productive and care-enhancing way.

Finally, Chapter 16 explores the central place of quality initiatives and project management in helping clinical leaders express their values meaningfully and constructively. Learning where clinical leaders can direct their energies to greatest effect is central to magnifying the power of their values in the clinical domain.

6

Organisational Culture, Clinical Leadership and Congruent Leadership

David Stanley and Sally Carvalho

> *Values aren't buses … they're not supposed to get you anywhere.*
> *They're supposed to define who you are.*
> Jennifer Crusie, b.1949, author of *Maybe This Time* and many other novels

Introduction: Values First

This chapter addresses the relationship of organisational culture and leadership, and specifically the vital place that congruent leadership can play in helping leaders shape or influence an organisation's culture. In the introduction to the *Culture of Care Barometer* (Rafferty et al. 2015, p. 6) it is made clear 'that quality and culture are not uniform within, let alone across organisations'. And as a result, the 'lack of consistency in care culture impedes the spread of good practice across organisations' (Rafferty et al. 2015, p. 6). The introduction goes on to suggest that in the main, 'failures are not usually brought to light by the systems … such as incidence reporting, mortality and morbidity reviews, inspections, accreditations clinical profiling and risk and claim management' (Rafferty et al. 2015, p. 6). This is because these approaches fail to capture the reality for most patients or clients and for health professional staff. Instead, it is only by understanding and influencing the 'culture of care' that genuine change and improvement can be made, with culture being seen as everybody's business and central to the way things are done within each organisation.

What is Organisational Culture?

Organisational culture is not an easy concept to pin down and it is vague and slippery at best, with many organisations unsure of what it is and how to change or guide it (Hall 2005). Schein defines culture as

> a pattern of shared basic assumptions that the group learned as it solved its problems of external adaption and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (Schein 2010, p 17)

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Hall (2005) aids in our understanding of organisational culture by suggesting that every organisation, regardless of its size, age or industry, has a culture. Hall adds that what separates leading organisations from each other is their ability to shape or direct the culture to bolster their business or support the organisation to better achieve its goals. In addition, organisations also find that they engage the 'hearts and minds' of their employees or create an environment where people are inspired to achieve extraordinary results (Hall 2005, p. 1).

Davies, Nutley and Mannion (2000) suggest that there are two ways to conceptualise organisational culture. First, organisational culture can be seen as something that an organisation 'is'. Seen in this way, the social interaction of people within the culture make the organisation and become the organisation. The second view of organisational culture is that an organisation has a culture of which it is part, but which is separate from the organisation and is described as one of its attributes (Davies, Nutley & Mannion 2000; Scott et al. 2003). From this second perspective, it is possible to conceptualise organisational culture as something that can be modified, created or even managed (Davies, Nutley & Mannion 2000).

The analogy of an iceberg is often used to represent the 'seen' and 'unseen' elements within an organisational culture. The 'seen' elements are described as the surface manifestations of the culture (rites and rituals) that are commonly thought to be more readily manipulated and open to change. The 'unseen' elements represent the deeper beliefs, feelings and values that are often below the surface, out of view and far more difficult to recognise or change. It is these deeper elements that are described as a reflection of the values of the organisation and point to its approach to key issues such as safety, quality and, in healthcare, compassion, patient care and a client-focused perspective (West et al. 2014).

However, there is far more to organisational culture than the definitions would suggest. An organisation's culture (in fact any culture) is deeply embedded, grown from shared emotional experiences, which are often unconscious and made up of mutual basic assumptions and beliefs that guide how people relate to each other. From this initial outline it can be seen that there are clear links between congruent leadership theory and shaping and developing an organisation's culture.

Culture also describes how things 'are done around here' (Fowke 1999, p. 1) and offers a source of stability, helping employees, customers, students or patients and clients recognise where their place is in the complex structures and systems of a large organisation. Culture is based on often unquestioned assumptions about values and beliefs, with each member of the organisation's culture commonly fitting in, or getting on, even if they do not realise that they are working towards shared basic assumptions and core beliefs. This may go some way to explaining why some congruent leaders do not recognise that it is their shared values and beliefs that mark them out as leaders.

Cultures are built from pivotal events (stories, myths and ceremonies) that form the bedrock of shared beliefs and values. As such, it is values and beliefs that are used to build an organisation's culture; again, this is why an appreciation of congruent leadership is so vital.

That said, an organisational culture can be built or made by design (or default), implying that if a culture is not consciously constructed or structured with intent, it will be grown from the power and influence of members of the organisation, or subcultures within a larger organisation, and become embedded of its own accord.

An organisational culture has a social energy built over time and it is something that can also change, over time. In fact organisational cultures are always changing, as new staff, new employees, new managers, new circumstances and new politics or policies come into play on the goals, values, direction and actions of the organisation. Indeed, any organisation that does not embrace change will not survive (Handy 1999; Hall 2005). The message is to be the master of the direction that the organisational culture takes so that the people with an investment in it can feel, at least in part, in charge of that direction.

Box 6.1 Why did the *Titanic* hit an iceberg?

The story of how passenger liner RMS *Titanic* hit an iceberg in 1912 is well known and celebrated in film and literature. But why did it happen?

The answer is not a dark night, a still sea, minimal lookouts or the ship's swift passage through the sea, although they all played a part. The real reason is more central to organisational culture than you might think.

The captain, Edward Smith, knew about the presence of icebergs in the Atlantic Ocean, as the crew had been warned by at least one other vessel. He knew that speed put the ship at greater risk and he knew that the best course of action was to go slower. However, safety was not the driving value of the White Star Line, the company that owned the *Titanic*. What was of value to this organisation was speed and getting the record for crossing the Atlantic. The owner of the company, Joseph Ismay, was on board that night. He instructed the captain to ignore the iceberg warnings and to go as fast as possible.

Had the organisational culture valued safety, the ship would have gone more slowly, been designed with more lifeboats and put more value on the lives of the people on board than on the possibility of a record speed. The company's reputation and profits were based on speed and not safety, so it was this that drove the crew to ignore the warnings and go as fast as they could on the cold, still, dark night. Until they hit the iceberg.

Therefore, organisational culture is something that is constantly evolving and reacting to changes in the surrounding environment. As such, it remains a matter of choice. It can be accepted, rejected or redesigned. However, even if it is not attended to, it is still there, invisible and all pervasive unless there is a move to try to change it.

An organisation's vision may assist in setting its direction and goals and it may be these that help it see its way to the future. However, it is the organisation's culture that helps it get though day-to-day activities and thrive, survive or dive (see Box 6.1). It is the extent to which the managers and organisational 'brains trust' realise that culture is the key that enables an organisation to make it home, or hit an iceberg.

Reflection Point

Talk to people in the area in which you work about what they think makes up or influences the organisational culture. How do their views link with or counter those in this chapter? And does it matter whether they do?

A Culture of Care and Compassion

It is clear that an organisation's culture is influenced by economic, political, legal and technological elements, and by the context within which the organisation operates (Rytterstrom et al. 2013). In addition, the culture is influenced by the dominant cultural views and behaviours of the majority of the organisation's members. These factors combined create the principal values, beliefs, norms and meanings that individuals infuse into the work they do.

Therefore, the creation of an organisational culture of care and compassion is based on reinforcing the significance of care and compassion as key attributes, beliefs and values that build meaning and life into the organisation's culture. The central aspect of creating and maintaining a culture based on care and compassion relates to reinforcing and rewarding employees and members of the organisation who act on these values and beliefs and deliver performance consistent with the desired culture (Rytterstrom et al. 2013). Such a culture is known as 'supportive' (Luthans et al. 2008) and it is built on the practice of energising and fostering the activity of the organisation's members (in all positions) to value and behave in caring and supportive ways.

In 2015, the UK's Department of Health released a document entitled *Culture Change in the NHS: Applying the Lessons of the Francis Inquiry* (DoH 2015). In it there is a recognition that while a culture change has begun, sustaining cultural change will only be possible if doctors, nurses and front-line staff feel free to speak out when they have concerns. This has led to a deliberate drive to ensure that the NHS is the 'most open and transparent (health) system in the world on key measures of patient safety and patient experiences' (DoH 2015, p. 7). To achieve this, a number of positive measures have been introduced, including the first national guardian for freedom to speak up in the NHS (Middleton 2016). This is in response to the new legal duty known as the duty of candour (DoH 2015), which places a responsibility on all NHS organisations to ensure that if anything does go wrong, patients and their relatives are informed immediately. It also makes clear that front-line clinicians, closest to patient care and the implications of poor judgements, need to have a voice in addressing problems with the healthcare culture (Middleton 2016). Another initiative is the introduction of a 'name above the bed' system, which will allow relatives and patients to know who is in charge of their care and who is accountable and responsible for their welfare. These few examples are evidence that change is taking place and, while only the beginning, that a series of initiatives aimed at making the NHS more open and transparent are being fostered. In addition, an unprecedented and bold effort has been made to capture feedback from patients, clients and their relatives using online and paper-based surveys, such as the Friends and Family Test (introduced in April 2013) to ask patients whether they would recommend their hospital to their friends and family (DoH 2015). Such is the value placed on NHS service users' and stakeholders' opinions that the Care Quality Commission (CQC 2015) conducted a national survey of patients who had received care in 154 acute and specialist NHS Trusts. The feedback is being used to bolster and support the positive steps that health professionals are taking to build a culture of care and compassion.

However, the NHS has also recognised that staff need a feedback mechanism too. Thus, in order to promote a positive emphasis on a transparent health service, NHS staff are supported and engaged to be confident about providing feedback on their own employing organisation's culture using the Staff Friends and Family Test (introduced in 2014), with results and case studies readily available on the NHS England website.

These changes and initiatives from the UK Department of Health and NHS Trust managers are essential, because where organisational members see a lack of care and compassion, for their welfare, for their skills or for the contribution they could or do make, or if feedback is used as a stick to beat staff, the message that is reinforced is that the organisation does not care for them, does not value them or their skills, and that employees are simply replaceable resources. This fosters a culture where suspicion, bullying, a lack of care and compassion and mistreatment are dominant (Francis 2013; Rytterstrom et al. 2013).

Where this style of culture develops there are inevitable consequences compromising patients, examples being the Public Inquiry related to children's heart surgery at the Bristol Royal Infirmary (Kennedy 2001) and the 33 patient deaths at Stoke Mandeville during an outbreak of *Clostridium Difficile* infection (Kennedy 2006).

Moreover, all of the organisation's staff need to be trained and educated so that they can articulate their concerns when they do speak up. The training should include guidance and education about the pivotal place of values and beliefs when they are translated into actions (Stanley 2011; DoH 2015). While realising that the key staff of the health service are clinical staff, the Department of Health (2015) also recognises that leaders are central to shaping culture and that it is essential for leaders to be supported and educated to provide effective, culturally appropriate leadership based on an organisation's foundational values. This again points to the place of congruent leadership in helping foster education for leaders at all levels, but most significantly clinically focused leaders.

In the health arena (as in any industry/organisation), the powerful place of culture means that the dominant culture is fostered and infused into the organisation's product. If the product is healthcare, support and compassion, then it will be little surprise to find that quality healthcare, client support and compassion will fail to be consistently delivered if the dominant cultural narrative is negative, non-supportive or non-responsive. As Turkel (2006), Ranheim, Karner and Bertero (2011) and Rytterstrom et al. (2013) indicate, the mistreatment of staff can serve as an example of how poor care practices are influenced by a culture where care and compassion are not valued, as was identified by the Care Quality Commission's investigations related to poor patient care at Winterbourne View Hospital (DoH 2012).

Reflection Point

Access the NHS England website http://www.england.nhs.uk/ourwork/pe/fft/case-studies/ for case study reports where respondents to the 'Staff Friends and Family Test' have influenced cultural change. During your clinical practice experience, have you participated in providing your organisation with feedback about its performance and did you experience any changes to the organisation's culture as a result?

Culture and Leadership

For some time now the health industry has recognised that to improve it has to develop or enact new cultural practices through new values and beliefs to initiate new ways of working (Mannion et al. 2008; Mannion, Konteh & Davies 2009). In the UK, the Department of Health has specifically identified the need for leadership education and training (DoH, 2015, p. 16), because 'the right leaders are critical in shaping culture'. As such, it has recognised that with the right understanding of these leaders' values and the impact they have on how they lead, a greater effect on shaping organisational culture is likely. Reforms in government policy, organisational strategies and strategic documents across the globe have also called for improvements in organisational performance and better clinical care (Francis 2013; DoH 2015), with many focusing on how leaders can better support a value-based organisational culture.

The Francis Report (Francis 2013) offers the clearest example of such a document, with the dominant themes of its 290 recommendations indicating that at the core of the problems in Mid Staffordshire NHS Trust was a failure of organisational culture. This was followed in 2015 by a further report, *Sir Robert Francis' Freedom to Speak Up Review* (Francis 2015), which also highlighted the centrality of a culture of safety and learning becoming part of everyday practice.

What these and other reports and reviews have identified is that for organisations to address failures, they need to deal not with quality processes or quality assurance measures, but with

building or influencing their cultural practices and with how leaders within organisations do this in a positive way.

The key to this link lies in the actions of the organisation towards its employees. As congruent leadership theory indicates, leaders are followed because they put into practice their values and beliefs. These can be positive values as well as negative ones: staff follow the lead of people identified as 'leaders' and if they are treated in negative ways (not listened to, mistreated, bullied, ignored or not valued for their skills or efforts), then it will not be a surprise if they copy these behaviours or see them as central to the organisation. This is especially the case if the leaders they see behaving in this way are promoted, rewarded and even awarded. West et al. (2014) indicate that how staff talk to each other can help shape the organisation's culture, but significantly that these same staff reported that their behaviours were based on observations of how other staff were spoken to.

The role of the senior executive is vital in setting the tone for an organisation's culture. The King's Fund (2012) sought to elaborate the characteristics of an engaged form of leadership in response to research conducted by Storey et al. (2010) identifying the damage caused by over-dominant chief executives. As Hall (2005) and Storey and Holti (2013) indicate, most employees will see leaders at many levels, and in this regard it is the actions and behaviours of mid- or lower-level 'leaders' that are more likely to be dominant in setting an organisation's cultural tone. Rafferty et al. (2015) indicate that in health and clinically focused organisations, it will be clinically focused leaders who act to enrich the environment and deliver the key message about whether staff are valued or supported. Again, congruent leadership theory, which as already outlined has grown from attempts to understand clinical leadership, helps explain why clinical leaders are identified and followed and the significance of this theory in terms of linking leadership, actions, values and beliefs, all of which are central to setting, directing or modifying an organisation's culture.

Reflection Point

Read and reflect on the Winterbourne View hospital inquiry (DoH 2012) at http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213221/4-page-summary.pdf

The organisational culture at Winterbourne View was such that the senior nurse managers were exasperated at their powerlessness to challenge poor care, despite their qualifications and accountability, because they had less power than the front-line staff. This is an example of an organisational culture where the people perceived to have the least power actually had the most. What are some of the pivotal events that have built the culture of the ward, clinic or unit you work on? What does this mean in terms of creating or shaping culture? Can cultures be made or shaped by clinical leaders? If so, how might they go about it?

How Congruent Leaders Shape Culture

It is possible to change an organisation's culture. However, this is not possible unless it is understood that organisations have more than just cultures – they have cultures, structures and systems. Each of these elements is vital and without all of them the organisation would crumble. The structure offers a skeleton for the organisation, helping link responsibilities, roles, frameworks, facilities and equipment. Systems deal with how processes work and how people interact. The culture is about 'people … not cash, equipment, facilities or even product and in a service focused organisation (e.g. the health industry) … culture is *the* critical variable' (Fitz-Enz 1997, p. 50).

Organisational cultures can change when the values and beliefs that constitute them are challenged. This point is supported by the NHS Leadership Academy, which asserts:

> Leaders create a shared purpose for diverse individuals doing work, inspiring them to believe in shared values so that they deliver benefits for patients, their families and the community. (NHS Leadership Academy 2013, p. 5)

Congruent leadership is not directly focused on change, but congruent leaders can influence change by acting in concert with their own values and beliefs, especially if these offer an alternative to the current, dominant or prevailing culture. Indeed, this is evident now in many organisations that are led by leaders who demonstrate their values and beliefs. However, these may be at odds with a culture of support, care and compassion, so that other values are on display and foster less productive, more negative cultures. Working to shape an organisation's culture becomes central to the facilitation of lasting and meaningful change, and therefore congruent leaders become significant agents for change (even if they do not know it). What is more, the change they institute can be very powerful, and can be summed up in terms of vision and values:

- **Vision** is about where an organisation is going and what it is doing.
- **Values** are about how an organisation is doing what it is doing. Values drive decisions and become the foundation of the culture, contributing to the design and function of the operating system and organisational structure.

As such, establishing a values-based culture further underpins the organisation's vision. If the values and beliefs also link to people's emotional and relationship networks, congruent leaders are in a position to influence and build powerful and lasting organisational cultures.

Reflection Point
Access the Care Quality Commission's (2015) report on the nurse-led Cuckoo Lane Surgery in London (http://www.cqc.org.uk/location/1-1264349857). This service has been given an outstanding rating by the CQC for its leadership structure and strong team working, which have resulted in outstanding care for key patient groups. This case study is a good example of an organisational culture change from a failing general practitioner–led service to a successful nurse-led service.

Leaders are therefore required to shape culture by taking responsibility for where they sit within the organisation and recognising that their behaviours and actions will be seen, followed and role modelled. There are a number of ways in which leaders can foster organisational change. Hall (2005) suggested the following activities that I have developed further. Leaders need to do the following:

- Become models of the culture – 'champions of culture'. The research that forms the basis of the theory of congruent leadership identified that being a role model was central to how clinically focused leaders were recognised.
- Remain visible in their 'modelling role'. Being visible was another key attribute of clinical leaders and meant that congruent leaders were recognised as visible, approachable and present.
- Ensure other senior staff support and also model the desired culture (staff at all levels in an organisation see different people as 'senior leaders' depending on where they are placed and who they

interact with). Mid-level and even lower-level leaders/managers are vital and, in the healthcare arena, clinical leaders feature as pivotal leaders in this regard. This is reinforced in the research that underpins congruent leadership theory, with leaders recognised as clinical leaders seen at all levels of the organisation; significantly, they were less likely to be at a senior management level or in positions of control.
- Develop personal ownership and responsibility for their behaviour and how it will influence or be seen by other people. This suggests that leaders cannot just 'talk the talk', they need to be seen to 'live' their values and beliefs and put them into action.
- Employ personal communication approaches (avoid email where possible, speak with people, establish communication approaches that are personal). This supports the attributes of congruent leaders, who use excellent communication skills and lead by their actions rather than just what they say they will do.
- Repeat messages in multiple ways to ensure that the message is received consistently and effectively. This again rests on congruent leaders' ability to use excellent communication skills. The keys to establishing personal and meaningful communication and having others see leaders' values in action are to build respect and trustworthiness and to keep communication clear with open interpersonal skills.

Ask yourself:

- Can people believe what you are saying?
- Do you listen to others' concerns?
- Are your intentions clear?
- Are your actions consistent (congruent) with your values?
- Do you say and do what you mean?

In addition, Garvin and Roberto (2005) suggest that effective change leaders (congruent leaders) provide opportunities for employees to practise the desired behaviours repeatedly, while personally modelling new ways of working and providing coaching and support. In this way, effective congruent leaders explicitly reinforce organisational values on a consistent basis, using actions to back up their words.

In order to establish lasting cultural change, people need to be rewarded for actions that support and promote the new ways of operating. Appropriate rewards will send clear messages about the desired culture. How these behaviours are rewarded is also important, with more effective rewards producing more rapid and lasting change. There are a number of rewards that could be implemented, although Hall (2005) has suggested the following three as very effective:

- Individual team recognition at an organisational meeting or event
- Informal recognition by a manager
- Professional development opportunities

After interviewing a number of staff in the UK, Rafferty et al. (2015) report that NHS staff suggested that their commitment, productivity and engagement were strongly linked to four themes that were essential for them to feel part of a positive work culture. These were:

- The resources to deliver quality care
- The support to do a good job
- A worthwhile job that offers the chance to develop
- The opportunity to improve team working

There is considerable evidence to support the conclusion that monetary rewards or awards do not rate highly if the task calls for even rudimentary cognitive skills. Pink (2009) adds that there are three factors leading people to perform better and increase their personal satisfaction at work: mastery (the urge to get better at things), autonomy (a desire to be self-directed) and purpose (a desire to find meaning in the things we do). Pink (2009) is of the view that if the profit motive becomes unmoored from the purpose motive, bad things happen. This again links motivational forces based on values and beliefs to why leaders who demonstrate congruent leadership may be more effective in leading and changing organisational culture.

Reflection Point
Read the Executive Summary of Rafferty et al.'s (2015) *Culture of Care Barometer*. Does culture matter more than quality assurance measures in terms of gaining an insight into reality and meaning for patients and staff?

The Department of Health (2015) offers a raft of specific information in the report *Culture Change in the NHS* that can be used to guide organisational change. However, this can be distilled to the following broad areas:

- Prevent problems by employing transparency, acknowledging issues and responding to mistakes by recognising that more needs to be done. Report and respond to critical issues by monitoring patient safety and allowing and encouraging staff to speak up and speak freely.
- Detect problems quickly and do something about them. Handle patient complaints appropriately, seek relevant patient feedback and engage (connect) with a wider range of service users in the delivery of and consultation about the service.
- Take action promptly and maintain robust accountability, ensuring that what is meant to happen is happening, with inspections, ratings, clear lines of accountability and measures to ensure that clinical accountabilities are understood and acted on.
- Ensure that staff are trained and motivated. This involves developing leadership skills and practices in keeping with a culture based on values and beliefs. It also means that all members of the organisation need to be aware of the 'right values' and to focus on ensuring that clients and patients have better experiences of the service. Finally, it is incumbent on the organisation to support staff, because as Dixon-Woods et al. (2013) indicate, there is a close relationship between the wellbeing of staff and patient outcomes.

The key to changing culture lies in changing and reinforcing the desired behaviours and positive values. Leaders then need to encourage everyone to play their part in shaping the organisation's culture, and to model these behaviours and values themselves. Then leaders need to invite participation, ownership and commitment from colleagues and team members. It is often said that what people create, they cherish. Therefore, lasting change is based on using appropriate rewards to reinforce desired behaviours and values. From this standpoint, organisations can establish respect, grow trust and communicate more effectively (with staff, employees, students, clients, stakeholders etc.). Then the organisation's vision, strategic plan and way forward can be planned.

If clinical leaders are recognised because their values and beliefs are on display and are acted on, then they are already in a position of being seen as leaders from a cultural perspective. Interestingly,

however, they may not be demonstrating the culture that the organisation is hoping or wishing to promote, especially if the organisation's values clash or are in conflict with the clinical leaders' professional values.

Clinical Leadership, Education and Training

Attempts to introduce clinically focused health professionals to leadership education are not new. For at least the past 15 years, professional bodies and health service providers have recognised that care, service quality and change are more likely to occur if health professionals at all levels are provided with access to appropriate education about leadership. Sadly, some of the clinical leadership education offered has been aimed at the wrong targets (managers), or focused on topics driven by 'management' and focused on 'management', with little on offer to genuinely promote an understanding of what clinical leadership is, or how and why clinical leaders are followed.

Many of the educational programmes are driven by an attachment to 'transformational leadership', even though there is little empirical evidence to support this leadership theory. Again, the organisational and management drivers were to the fore in plans for the the training programmes. Some progress has been made, but I suggest that more could have been achieved if clinical leadership and an appropriate understanding of clinical leadership or leadership theories that support it were employed in leadership education.

Brown, Crookes and Dewing (2016) and others (Scott & Miles 2013; Ailey et al. 2015) have called (appropriately) for clinical leadership education to be infused into undergraduate nursing programmes and suggest that benefits would ensue if 'leadership' was recognised as an expectation of all registered nurses. This is likely to be the case for all clinically focused health professionals and was indeed a recommendation from a 2015 study into clinical leadership among allied health professionals in Western Australia (Stanley, Hutton & McDonald 2015).

This is not the first time this call has been made. Rafferty (1993) also recommended that more attention needed to be paid to leadership training, management development and clinical leadership. The nursing profession, she declared, required more research into nursing leadership and an exploration of the role of research in leadership development. Leaders were required with 'verve and vision' who could support the development and creation of a healthcare system that allowed nurses to express their values and the value of nursing (Rafferty 1993, p. 27). However, she recognised that at the time of her report, nursing leadership development had been neglected and was in 'crisis'. She also saw the complexity, contradiction and confusion associated with leadership issues and recognised that immediate and vital action was needed if the nursing profession was to 'claim legitimacy in the leadership stakes' (Rafferty 1993, p. 26). The health professions have really made inroads into leadership education with a raft of leadership and clinical leadership programmes and other training programmes on offer all across the globe and in all health services. The Mid Staffordshire crisis refocused attention on leadership issues in the UK and ripple effects are being felt around the world. However, I believe that we are still a long way from realising Rafferty's recommendation and there remains much for us to learn about leadership from a clinically focused perspective.

In 1997, Malby indicated that the crisis persisted because there was a belief that nursing was incapable of promoting a leadership culture or consciousness. The 2010 Gallup Report from North America, *Nursing Leadership from Bedside to Boardroom: Opinion Leaders' Perceptions*, seems to suggest that little has changed and that nurses remain unable or poorly positioned to have any impact on health policy reform.

In addition, in spite of Rafferty's (1993) call for more research into leadership, when compared with the academic, political and management domains the uniqueness of clinical leadership has remained

largely unrecognised and under-valued (Lett 2002; Stanley 2008). It is certainly true that more and more research addressing clinical leadership is becoming evident and in the past five years more studies have appeared in the health-related literature. Even so, the realisation that clinically focused health professions can influence, change and improve quality care seems only slowly to be finding resonance with health service managers and educational program planners. Addressing this shortfall has been a powerful motivation behind the direction of my clinical leadership research and the approach taken in this book.

It is my contention, based on the research and literature that supports this book, that a new theory specifically related to clinical leadership would be more appropriate to gain an understanding of how to recognise and support the development of clinical leaders. As such, congruent leadership (Stanley 2006a, b, 2008, 2011, 2014; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015) is proposed as a new theory to support the demonstration of qualities and characteristics attributable to clinical leaders (see Chapter 4).

Case Study 6.1

Cathy Freeman is an Australian woman who overcame many of the barriers faced by indigenous people to represent her culture and country as a sporting icon. Her cultural heritage dominates her life and how others see her achievements. Consider Cathy's story and the challenge that follows.

Female Leaders: Cathy Freeman

Catherine (Cathy) Astrid Salome Freeman was born on 16 February 1973, in Mackay, Queensland, Australia. Her father was Norman Freeman, an ex-rugby player from Woorabinda. He was a loving father, but was prone to excessive drinking and violent outbursts. When Cathy was 5 years old he moved to the Aboriginal Mission three hours west of Mackay, where he lived away from his wife and children for the rest of his life. He was soon diagnosed with diabetes and became further depressed, drinking more frequently. Cathy's mother Cecelia was known to be very strict with her children; always for their own benefit, of course. However, early on Cathy found her mother overbearing and even domineering. This lead to frequent arguments and Cathy sometimes ran off at night to hang out with her cousins. Her mother was nevertheless a constant in her life and Cecelia proved to be a great source of support when Cathy was troubled or upset. She also encouraged the young girl with her running and from an early age Cathy was prompted to write out 'I am the world's greatest athlete' as a positive affirmation on which to build her athletics dreams.

Cecelia married Bruce Barber, a white railway worker, and initially this new relationship upset the children. Eventually, though, Bruce was to become one of Cathy's greatest supporters and even though the family had to move frequently because of his job, it was Bruce who recognised Cathy's potential and became her first coach. He took an interest in positive psychology and counselled or supported Cathy during some niggling injuries and a bout of glandular fever that threatened to stall her early career. It was also Bruce who raised money to allow Cathy and her younger brother Norman to attend various national athletics championships.

Bruce also knew his limitations and once he was sure Cathy would excel in her sporting career with more guidance, he put his energies in 1987 into securing her a place at Fairholme College in Toowoomba where, with the aid of a scholarship and better coaching and facilities, she did indeed improve.

It is for her sporting prowess that Cathy is best known. She won her first gold medal at her school championships when she was 8, although she faced frequent discrimination for being an Aboriginal. Once she had to watch the first-place trophy being given to another girl, even though Cathy had won the race, because it was inconceivable that a black child could win. Her first international race was at the Commonwealth Games in Auckland in 1990. She ran as part of the Australian 4 × 100m relay team. In doing so she became the first female Aboriginal Australian to win a gold medal in any international athletics event.

In 1991 Cathy was named Young Australian of the Year. After more intensive training she took part in the 1992 Olympic Games in Barcelona, Spain, becoming the first Aboriginal to represent Australia at the Olympics. She did not win a medal, but the competition offered vital insights into how to prepare for later competitions.

In 1994 Cathy again excelled at the Commonwealth Games, this time in Victoria, Canada, where she won the 200 m and 400 m Gold medals. In terms of heightened international recognition, she came under more intense scrutiny at the 1996 Olympics in Atlanta, Georgia, USA. Here she ran her personal best of 48.63 seconds to win a Silver medal in the 400 m event. This was followed by a Gold medal in the 400 m at the World Athletics Championships in 1997.

Off the track Cathy was also making waves as a successful Indigenous ambassador, supporting and promoting Aboriginal culture. Much of this off-field work contributed to her being named 1998 Australian of the Year.

Next she competed in the 1999 World Athletics Championships in Seville, Spain and was successful with a Gold medal in the 400 m event. However, her real target was the Gold medal at the Olympics and as the year 2000 rolled around, the world watched with fascination and anticipation as she stormed to victory in the 400 m final. Cathy had also carried the Olympic flame at the opening ceremony, but her highlight in these games was her fantastic victory. She stood out too in a specially designed green and gold running suit, in complete contrast to the ill-fitting and poor running equipment that she had been offered or able to secure as a young athlete.

Her dream of winning Olympic Gold had come true and she had done it in front of her friends and family in Australia. Her only regret was that her father, Norman, had died before her greatest win. Cathy retired from competitive running in 2003 and began to concentrate more on her domestic responsibilities and on the Cathy Freeman Foundation, which focuses on making life better for Indigenous Australians.

Challenge: Cathy Freeman is a great athlete in spite of her cultural heritage not because of it, although her upbringing, her cultural background and the circumstances of her youth clearly affected her athletic development. If culture is people focused and if culture can be changed, how much power do we have to change negative or potentially disruptive influences so that we can be our best selves, be the best clinicians or do the best for our patients or clients?

Summary

- Culture is people focused.
- Culture is about how things are 'done around here'.
- Culture has some seen and unseen elements, making it a difficult issue for organisations to understand or deal with.
- The dominant culture will be infused into the product and atmosphere of an organisation.
- The key to changing culture lies in changing and reinforcing behaviour and values.

- Organisations can make or create their culture, or they can allow it to develop on its own.
- Congruent leadership theory strongly supports the links between culture, values and beliefs and leadership.
- Everyone in an organisation has an impact on the organisational culture, although leaders at all levels can have a dramatic effect on how an organisation develops and delivers its service.
- Clinical leaders may be the key leaders needed to secure solid organisational change that is genuinely focused on client/patient-centred care and compassion.

Mind Press-ups

Exercise 6.1

If culture is people focused, what impact do you think technology is having on our relationships and our organisational culture? Talk to some of your senior colleagues and ask them how much impact changes in technology have had on their workplace culture.

Exercise 6.2

Think about the 6Cs, discussed in Chapter 4. Bradshaw (2016) wrote a very interesting article about the hidden presence of M. Simone Roach's model of caring, which seems to have been the 'unwritten' precursor to the 6Cs. Bradshaw is of the view that the origins of the 6Cs should be acknowledged (I agree), but what do you think? Which matters more, what the 6Cs are based on or whether they are understood and enacted? Why might this matter?

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7

Managing Change

David Stanley

Time is neutral and does not change things. With courage and initiative, leaders change things.
Jesse Jackson, American civil rights leader, Baptist minister and politician, b.1941

Introduction: Tools for Change

In many ways this chapter sits at the heart of what clinical leadership is about – change. If the health service and care practices are to improve, nurses and health professionals need to be able to recognise what is not working well and develop strategies and solutions to change practices, attitudes and processes. This is specifically so because service improvement and developing the health service are based on effective change, and leadership is central to bringing about and facilitating change (Kotter 1996; McPhail 1997; Iles 2011; Hendy 2012; Babine et al. 2016).

Effectively dealing with change implies that clinical leaders require a tool kit of skills and techniques (Iles 2011) and the courage to champion change (Hendy 2012). Clinical leaders are also in the ideal position to initiate innovative change focused on service improvement and quality and on patients/clients/services that has the potential to be ongoing, practice driven and clinically relevant (Essen & Lindblad 2012). This chapter aims to outline why change is a key clinical leadership issue and offers nurses and healthcare professionals the tools to deal with or manage change successfully. It also offers insights into recognising resistance to change and handling it. Michael Leunig (one of my favourite poets and artists) explores the issue of change in his poem 'A Common Prayer' (2003, adapted with permission of HarperCollins Australia):

We struggle, we grow weary, we grow tired.
We are exhausted, we are distressed, we despair.
We give up, we fall down, we let go.
We cry. We are empty, we grow calm, we are ready.
We wait quietly.

A small, shy truth arrives. Arrives from within and without.
Arrives and is born.
Simple, steady, clear. Like a mirror, like a bell, like a flame.
Like rain in summer.

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A precious truth arrives and is born within us.
Within our emptiness.

We accept it, we observe it, we absorb it.
We surrender to our bare truth. We are nourished.
We are changed. We are blessed.
We rise up.

All Change

Many health professionals will recognise the undulations of the change process described in Leunig's poem in their working lives. Change seems to be an almost unrelenting feature of the health service industry (Essen & Lindblad 2012). During my time working in the UK National Health Service, and to a lesser extent in other health services, modifications to the structure of the organisation felt like almost biannual events, where healthcare organisations and hospital divisions were amalgamated or disbanded, rebranded or dissolved, with little real impact on the front-line service offered by clinically based staff. However, the organisation or hospital logo was changed or the chief executive appeared with a new title or was replaced altogether. On the shop floor staff did the same things, although it seemed they often did so with fewer staff or resources. Change came and went and the only real concern was that front-line staff were frequently not consulted or involved, having to deal with or respond to the changes as best they could.

The issue is that organisations, particularly those such as hospitals or others that deal with healthcare concerns, are not like factories. They are communities of people and therefore they behave just like other communities. People are the core resource of the health service and even with the advent and entrenchment of technology, people still are, and will always be, central to the health industry.

This means competition for power and resources; fights over values, goals and opinions; and conflict over aims and where scarce resources should be used. Powerful professional or industrial groups fight to exercise control and the environment of constant change creates uncertainty, disharmony and insecurity. Although nurses are the largest healthcare group in most countries, they have commonly failed to understand how change can be managed and may still fail to recognise that they can direct or influence change, rather than be passive respondents to the forces about them. There are some notable exceptions to this generalisation – one being the mobilisation of the nurse practitioner movement in Australia between 2007 and 2010 – but generally nurses are poorly equipped to influence change.

In nursing and healthcare, as in the wider community, there are those who want to change but do not know how to effect it, those who want to change and think they know what is best and try to impose it on others, and those who do not want to change at all and would willingly settle for a quiet life. There are pressure groups, lobby groups, cliques, rivals, clashes, personality differences, alliances, friendships, contests and apathy. It would be odd if the workplace was not like this and it would be foolish to think that there is some ideal world or parallel universe where differences do not exist.

Indeed, it is these very differences that provide the fuel to drive the organisation or community. Imagine an episode of *Home and Away* or *EastEnders* where there was no conflict, no dispute, no tension and no secrets! It is these very differences that are essential if a community is going to continue to adapt to the world about it, to change—in other words to develop and react to new situations. Change is a necessary condition of survival whether for individuals, communities or organisations. Differences are a necessary ingredient of change and a never-ending search for improvement. Improving quality in healthcare involves changing the way things are done, changing processes and the behaviour of people and teams of people. The challenge for any one of us is to

harness the energy and thrust of differences so that the individual, community or organisation does not disintegrate during the process of change, but develops and grows.

This does not mean that all change is positive, however. Change very often implies a cost, sacrifice or challenge. The issue is who pays the cost and whether this matters. Consider the following questions:

- Building hospitals with multiple single rooms has enhanced privacy, but what impact has it had on patient safety?
- There is ample evidence-based literature that the advent of nurse practitioners has had a positive impact on patient care. However, what impact will the power of the medical lobby have on the development of nurse practitioners to work to the full capacity of their scope of practice?

The answers very much depend on your perspective. The question of whether single rooms are safer is dependent on other factors such as staffing ratios and skill mix, the initiation of 'rounding' and the general attitude of the hospital to safety issues. Are patients happy to sacrifice a little safety for greater privacy? Change always has a trade-off. In relation to the development of nurse practitioners' capacity to contribute to a more flexible health service, clearly from a nursing perspective – and (I would argue) from a patient perspective too – the benefits are both extensive and supported by significant evidence. However, the change affects the medical profession's potential income stream, and in this regard the introduction of more effective and more flexible nursing services are seen as a threat. There are other points that could be made in relation to both examples, but mine is that change – whether we like it or not – does happen.

Without change we would wither and die, and from this perspective change needs to be embraced and managed (Cran 2016). There are ways we can help change come about without destruction, dispute, hostility or division, nevertheless. Industry and business have considered this question for some time and developed the term 'change management' or 'organisational management' in response to dealing with or directing change (Cran 2016). Sadly, that now has a number of negative connotations and is often associated with concepts like 'downsizing', 'layoffs', 'industry redesign' and 'multiskilling'. It could at least be argued that industry and business have been proactive in the face of the realisation that change happens.

There is a positive way to look at the term 'change management' or 'organisational management' and to put a human face on dealing with change (Cran 2016). Consider it as the application of a strategy by which change is made or helped to happen in a controlled or orchestrated way. Taken further, this can mean a strategy in which change is facilitated positively and successfully. Therefore, if we are to change things in this direction we need to understand the principles of change management or organisational management. This is not the end of the process but the beginning, and there is much more to changing something than understanding or following a set of guidelines.

Garside (1998) indicates that in the nursing literature there are few examples of the use of organisational management or change management. She suggests that this is because healthcare managers do not have a lot of time to reflect on their work, and are often so focused on short-term objectives that they have neither the opportunity nor the inclination to reflect on long-term plans for change. Little has changed since the 1990s and indeed even now the health-related literature indicates that matters of project management (Chapter 16) or change management are slim indeed. There are examples where some change management tools have been applied to clinical nursing situations. Laight (1995), for example, used force-field analysis (FFA) to help promote appropriate eye care for critically ill patients; Snyder (1984) also used FFA to facilitate change in a nursing environment. SWOT analysis is more commonly seen but, as Garside (1998) suggests, these examples are rare.

However, Garside (1998) does see a place for the use of change management models taken from industry and business in the health arena. Indeed, if clinical leaders are to have a genuine impact on healthcare practices and positively lead improvements in care and health practices, mastering

approaches to change management is vital. McClelland, McCoy and Burson (2013) and Babine et al. (2016, p. 40) support this view, indicating that it is a key part of the clinical nurse's role to engage in 'systems management' that supports the implementation of sustainable practice change. An engagement in systems management can then have an impact on the delivery of care by other health providers, allowing evidence-based practice and team approaches to enhance collaboration. The next part of this chapter outlines a number of models for facilitating change in a planned and structured way.

Approaches to Change

A variety of tools can be used to support change, and some will be explored in this section. However, before these are explained, a note of caution: just because there are tools for change does not mean that change, at least the planned change, will result. The models will help, but in the end it may depend on the circumstances and attitude with which they are used as much as your skill with the tools. Iles (2011) makes it clear that to be beneficial, change needs to be approached with care, courage and enthusiasm. Iles (2011, p. 22) sees 'conversation' as central to this process and reminds change agents that simple, empathetic, engaging conversations that bring people into the process of change are vital if the outcome is to be positive. The principle here is to remember that people who are involved or kept informed are more likely to support or engage with the change (recall: *people will cherish that which they help create*). Also, workplaces are not machines, they are communities, and as such it may not always be possible to see the impact of even the smallest and simplest of changes.

The models that will be outlined in this chapter are:

- strengths/weaknesses/opportunities/threats (SWOT) analysis
- stakeholder analysis
- Pettigrew's context/content/process model
- change management iceberg
- PEST
- Kotter's eight-stage change process
- nominal group technique
- process re-engineering
- force-field analysis (FFA)

SWOT Analysis

A SWOT analysis can be used as a personal reflection tool or as one for organisational management and change management. By looking at an organisation's strengths, weaknesses, opportunities and threats, you may be able to analyse the current direction of the organisation (ward/clinical area/workplace), formulate future goals and objectives, or analyse specific situations, ideas, groups or activities. Then, once the assessment is made, ask yourself whether you can change or challenge the threats.

Consider how the points relate to each other. Can the threats be changed to opportunities and the weaknesses to strengths?

By looking at these areas you may be able to foresee the obstacles to change. The analysis requires scrupulous honesty and the capacity to be open and look at the threats – or are they weaknesses? The exercise can often be very difficult and it may require uncomfortable realisations and difficult admissions. In some cases, SWOT might be more useful to find reasons *not* to change.

Box 7.1 SWOT

Use the SWOT change model to consider your professional development performance in relation to your future career plans. Identify your own strengths and weaknesses, and consider the opportunities that present themselves and the potential threats.

Strengths	Weaknesses
Opportunities	Threats

The four parts to a SWOT analysis are:

- **Strengths**: what are the strengths of your organisation? In what areas does it function well?
- **Weaknesses**: what are the weak points in your organisation?
- **Opportunities**: are there circumstances present that create openings and the potential for positive change?
- **Threats**: are there other circumstances that could threaten or jeopardise your organisation?

By considering these four areas, you may be able to identify where you need to target resources or energy to bolster the strengths or reduce the weaknesses of a situation or problem. The task also encourages you to reflect on the opportunities evident and what threats there could be. It is a simple approach, but it relies on you having access to significant insight and information to ensure that all the relevant details are taken into account (see Box **7.1**).

Stakeholder Analysis

Stakeholder analysis is used to develop a profile of the people who are related to the change being proposed. They may be central or peripheral to the change; indeed, they can be anyone who has the potential to influence its outcome. If you apply the stakeholder model, do not use people's real names to avoid identifying actual individuals and causing potential offence (and potentially having a negative impact on the change outcome). Consider the characteristics of the individuals whom you see as stakeholders, and assess their capacity to be helpful, ambivalent or obstructive. Think carefully about why you see people in certain ways. The three basic characterisations are:

- lions
- sheep
- donkeys

The idea is that lions are likely to be champions for change and so will be helpful or supportive. They are particularly relevant at the adoption or initial stages of change (Hendy 2012). Sheep are generally unlikely to oppose the change and often 'go with the flow' or follow emerging trends. Many sheep are simply apathetic or ignorant of the impact that the change is likely to have, so really they should not be ignored, but included and educated so that they may become lions. The analysis helps work out who will be helpful and who will be resistant to change. Resisters are termed donkeys. They tend to be sceptical, hostile or even work against the change.

The analysis allows you to consider who has low tolerance to change and who is likely to be adventurous, who looks for a challenge and who are the sceptics, the adaptors and the saboteurs. Working

these out will profit the proposed change greatly, as it may allow agents for change to target known agitators or develop a more collaborative or inclusive strategy for change in order to diminish resistance and share ownership (see Box 7.2).

Box 7.2 Stakeholder analysis grid

Stakeholder	Must support	Must acquiesce	Can be ignored

To use the stakeholder analysis grid:

- Enter in the left-hand column the stakeholder's name or some sort of code for the person if anonymity is an issue (people with an interest in the project).
- Decide how important each person's support for the project is and tick or put a comment in the appropriate box.
- Decide whether the person is a lion, a sheep or a donkey.
- Plan strategies for dealing with or ignoring donkeys, turning sheep into lions and recruiting lions to the planned change.

Pettigrew's Model

Andrew Pettigrew is one of the foremost writers on change in the UK health service and he has formulated a model with which to analyse change. The core of the model emphasises the importance of a broad, contextual approach to change. Pettigrew felt that an analysis of change should not just look at the processes of change, but also at the political features of the organisation, and the history and cultural context in which the change might take place (Pettigrew & Whipp 1998). Pettigrew, Woodman and Cameron (2001) suggest that the model offers a continuous interplay between ideas about the context of change, the process of change and the content of change. You can see these three components in Figure 7.1.

Pettigrew defined the context as the 'why and when' of change. He also differentiated between the inner and outer aspects of the context (outer might be the prevailing economic circumstances and

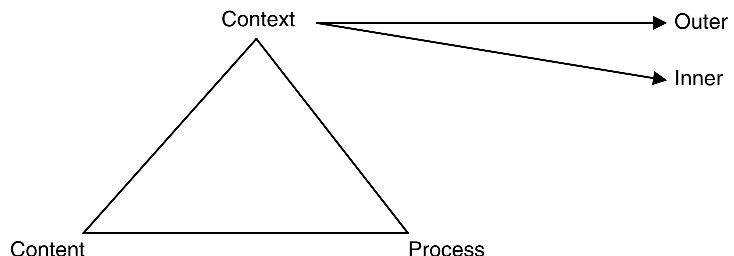

Figure 7.1 Pettigrew's change model.

the social and political climate at the time; inner might refer to the resources, structure, culture and local politics). Content is described as the 'what' of change and is concerned with areas of transformation (what is to be changed). The process covers the 'how' of change and refers to how the change will be made to come about, what actions are needed, who will do what and how things will get done.

The usefulness of this model is that it reminds the change agent that it is important to consider and keep in mind the complexities of the organisation, and that change is commonly influenced by characteristics in the internal and external environment.

The Change Management Iceberg

The change management iceberg was developed by Wilfried Kruger and is based on the concept that dealing with change means dealing with barriers. Kruger's view (Ackerman-Anderson & Anderson 2001) is that many managers or change agents only consider the tip of the iceberg – cost, quality and time – as significant issues. However, a number of other issues are below the surface, waiting to influence the proposed change (Figure 7.2). These are the management of perceptions and beliefs about the proposed change, and issues of power and politics. Such factors imply that more needs to be understood about the proposed change for it to be implemented successfully.

Dealing with the types of barriers that arise and how the change can be implemented is dependent on the kind or type of change and the strategy for change that is followed or applied.

Change may be 'hard' (information systems/processes/policies), which can be difficult enough to implement but only scratch the surface in terms of impact on the iceberg. It can also be 'soft' (e.g. values/mindsets/capabilities), which can result in more profound change, and be more difficult to initiate or suffer from more ingrained barriers.

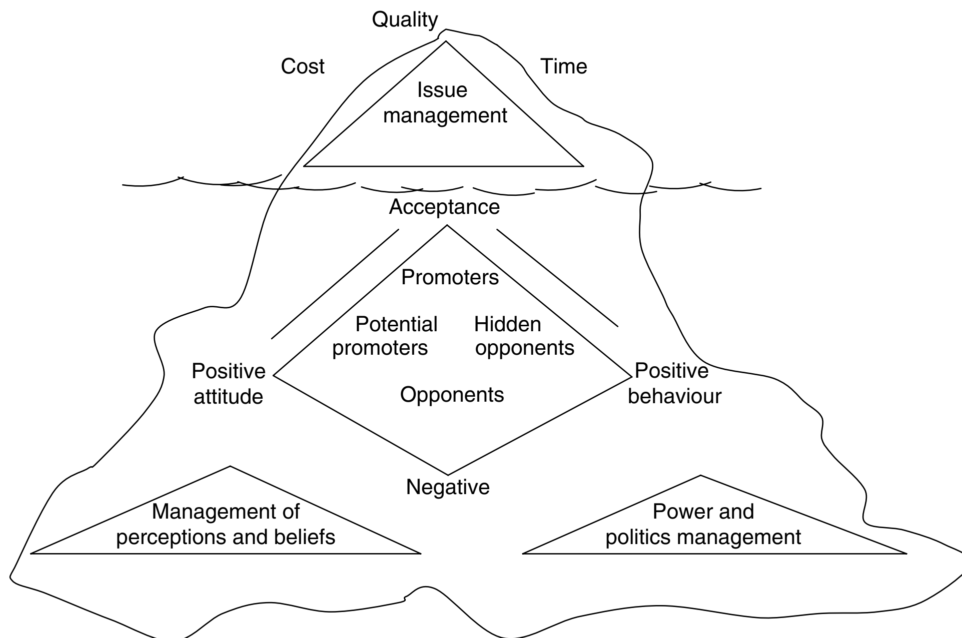

Figure 7.2 Change management iceberg. Source: Adapted from 12manage 2009.

The iceberg model also offers insight into the types of people who might be involved in the change and, like stakeholder analysis, Kruger asks that the people involved in the change are incorporated in the assessment. They are described as one of the following:

- **Opponents** have a generally negative attitude to the change and behave negatively towards it. Their minds need to be changed by managing their perceptions and beliefs (as far as this is possible).
- **Promoters** have a positive attitude to the change, seeing it as an advantage and offering their support.
- **Hidden opponents** appear to be supporting the change on a superficial level, but have a negative attitude to it. They need more information or involvement so that their attitude can be swayed to one of support.
- **Potential promoters** remain unconvinced or sceptical. They are open to the change and generally positive, but may need further influencing to gain their full support.

In the change management iceberg model it is recognised that change is a constant feature of a manager's (leader's) task, but that superficial (tip of the iceberg) issue management can only achieve results on a limited level (structural change). For greater impact and control of the change, the interpersonal and behavioural dimensions, cultural dimensions, power and politics, perceptions and beliefs all need to be addressed and considered when the change is planned and implemented. The model supports the concept of a complete and thorough assessment of the barriers that may have impacts on change, so that it is likely to be implemented with a greater chance of success.

PEST or STEP

PEST (political, economic, social and technological) analysis (sometimes called STEP by changing the letters or words around) performs an overall environmental scan of an organisation. It is not generally as beneficial as some of the other change tools at a local or ward-based level. However, it is very useful to gain an overview of the 'health', sustainability or resilience of an organisation as a whole.

The factors assessed are the following:

- **Political** factors including tax policy, employment laws, environmental regulations, trade restrictions and tariffs, and political stability.
- **Economic** factors including economic growth, interest rates, exchange rates and inflation rate.
- **Social** factors including health consciousness, population growth rate, age distribution, career attitudes, emphasis on safety and generational make-up of the workforce.
- **Technological** factors including research and development (R&D) activity, automation, technological incentives and rate of technological change.

This tool may take a considerable amount of time to use and may also be undertaken by a range of individuals with specialist skills in the various areas suggested. It may also be employed in conjunction with a range of other change management tools, for example SWOT analysis.

Kotter's Eight-stage Change Process

John Kotter (1996) offers an eight-stage process for progressing change. The model is quite simplistic, although it offers a pattern or map that can support and direct clinical leaders and others when initiating or planning change (Jones & Bennett 2012). The steps are as follows:

1) Establish a sense of urgency.
2) Create a guiding coalition (involve people at all levels to construct a shared vision and address specific needs).

3) Develop a vision and strategy (this needs to work towards the planned change).
4) Communicate the change/vision to others.
5) Empower employees for action (let people know that their opinions matter).
6) Strive for short-term wins (good leadership is essential for short-term achievements).
7) Consolidate gains and produce more change (address resistance and strengthen leadership approaches).
8) Anchor new approaches in the culture (which is harder than it sounds).

Nominal Group Technique

The nominal group technique is an excellent change tool for helping groups solve problems or propose changes. It may not be as useful for driving change through, but it is very handy for identifying where scarce resources and personnel with limited time can focus their energies. It is also an excellent approach for helping to engage wide numbers of people in the change process.

The technique establishes what problems exist and what priority is placed on these various problems. Significantly, it employs the stakeholders in the process of decision making, so that the priority problems or change issues have been identified from within the stakeholder group. The process for the nominal group technique is relatively simple, but it takes time to set up and requires the majority of the stakeholders to engage in it for it to be successful.

Have all the stakeholders gather together and follow these steps:

- Ask the group to split into smaller groups and discuss the first question: ‘What are the problems with …?’ or ‘What are the bad aspects of …?’ (you can add the relevant problem/issue). Have them write their problems clearly on kraft or flip-chart paper, because it will need to be put up on a wall for all the other groups to see. Make it clear that each group has a certain time frame (you will need to decide this based on the total time available or the nature of the problem being discussed). Once the groups are finished, ask them to put up their lists for all the other groups to read. Make sure that the group’s discussion sticks to the one question asked: ‘What are the problems with …?’ or ‘What are the bad aspects of …?’
- Ask the same small groups to discuss the second question: ‘What are the good things about …?’ Again, give them kraft or flip-chart paper to record their lists and a suitable time frame, and once they have finished once again put up the ‘good things’ list on a wall for all the groups to read. I have used this method a few times and just to get to this point has taken between one and two-and-a-half hours.
- Have the whole group review the smaller groups’ problems and good points. Ask them to read and possibly discuss these informally as they review what the other groups have written.
- Now ask everyone to vote for their top three problems. To do this, offer a large number of felt-tip pens and have each person vote for the three main problems by ranking them 3, 2 and 1. After everyone has voted, calculate the results, with the highest number being the issue of most concern to the majority of participants (stakeholders).

In this way the whole group has considered all the issues and decided for themselves what the three primary issues are. This can be very empowering for stakeholders. Identifying the good aspects as well is important to retain a fair perspective on the issues being discussed. The process is not over, though: the final step is to ask stakeholders to focus only on the three main problems identified. In their smaller groups again, ask them to propose potential solutions.

Of course the problems will still need to be addressed, but using this approach means that implementing change (which is often suggested by the stakeholders) has a greater chance of success, as the

people involved have had a significant hand in identifying the issues and the possible solutions. They have also had a public and detailed opportunity to express their feelings among people who are often in a position to support or direct resources for change. I used this technique once with students who were upset about aspects of their course of study. It produced a number of concerns that soon became a few essential issues to be dealt with. Students could see that they had a voice, that they were being heard and included, and to their surprise found that they were overlooking a number of very positive aspects of the course. In the end they also proposed a number of solutions that in time were implemented to their satisfaction.

Process Re-Engineering

Process re-engineering can be a very complicated process to implement, but it is also a clear and practical response to certain problems. It is all about sticky notes (small, usually yellow, low-adhesive notes that can be removed and repositioned easily).

The process is to decide on an issue or process that you would like to change, such as how patients are moved through a busy accident and emergency (A&E) department. Meet with all the relevant stakeholders, in one place. Give out or have handy a stack of different-coloured sticky notes for each participant. Depending on the process under review, it may be wise to break the large group into smaller groups. Usually the group needs to have representation from all areas involved in the process under review for it to be successfully assessed and replanned. For example, it would be foolish to plan process re-engineering in an A&E department without including the clerical staff who are central to the patient's journey through the department.

The next step is to brainstorm what the issues/problems/current processes are. These are then written on a separate sticky note. Thus everything is broken down into its smallest part (like taking a clock apart). Then with everyone's input, put the issue/problem/process back together using the sticky notes to manipulate the process, make changes or suggest new aspects.

It is helpful to foster discussion by physically moving the sticky notes around to see if a new process evolves. This requires a great deal of creativity and may also need people to suspend established ideas about 'how things get done around here'. This approach has the potential to offer a whole new set of solutions to significant problems or issues. It may imply restructuring (in terms of job activities and physical environments) and could need to be used in tandem with some of the other change management tools, for example stakeholder analysis or SWOT.

Process re-engineering can also be an empowering tool and often brings all the stakeholders together by valuing everyone's input. As such, a key to its success is skilful facilitation of the sticky note activity.

Force-Field Analysis

Force-field analysis (FFA) has a clear advantage over the other models in relation to its use in the health arena; that is, it allows the change agent to place themselves clearly in the picture and see their part in the process of change. The other advantage of FFA is that it is very easy to follow and use. Brager and Holloway (1992) describe it as a tool for assessing the prospects of organisational change and Egan (1990) sums it up by describing FFA as an analysis of the major obstacles to, and resources for, the implementation of strategies and plans for change.

The 'field' theory was developed by Kurt Lewin as early as 1947, but subsequent developments in the late 1960s led to the development of FFA. By 1969 what we now know as Lewin's FFA model of change management was developed. It was born from the realisation that stability within a social system is a dynamic rather than static condition, and is therefore the result of opposing and

constraining forces. Lewin (1951) speculated that these operate to produce what we see or sense as stability. Changes occur when the forces shift, thus causing a disruption in the system's equilibrium.

Lewin's model is therefore a way of listing, discussing and dealing with the forces that make change possible or obstruct it (Jones & Bennett 2012). An analysis of these forces helps generate options that can help achieve or work against the objectives:

- **Restraining forces** work against the change
- **Driving forces** or **facilitating forces** work for the change

Analysing these forces can determine whether a solution can get the support needed, identify obstacles to successful solutions, suggest actions to reduce the strength of the obstacles and determine where the change agent's part in the change process might be. It will be beneficial for an individual or for an organisation.

Egan (1990) also indicated that there are four reasons why FFA may be useful:

- By focusing on the potential or real environmental influences, the nature of these perceptions becomes open to scrutiny, revision and test. In effect, there is an opportunity to test out what you feel the situation or 'lay of the land' is.
- A complete account of the obstacles and resources decreases the likelihood that pitfalls or potential opportunities will be overlooked. This will avoid any surprises when the change process begins.
- Using knowledge of the influences in the environment (ward/unit/workplace) helps to capitalise on opportunities. These may even be extended to go beyond the resources under your direct control.
- Alternative strategies to implement an action plan can be created and assessed in the context of the force field.

In effect, an FFA is a judicious look at the potential future and can save a little grief, since forewarned is forearmed. The various forces involved are discussed in what follows.

Restraining Forces

These are the potential and actual obstacles (and people, donkeys) in the external or internal environment, and can include a self-analysis. They represent a census of the probable pitfalls (rather than a self-defeating search for every possible thing that could go wrong). Once the pitfalls are identified, then ways of coping with them can be identified too. Sometimes being aware of a pitfall is enough; sometimes you may need to take more explicit action.

Driving or Facilitating Forces

These can be the resources or things you have to hand, other people who can help (lions perhaps) or those with power or influence and evidence to support the change proposal. The aim, though, is not so much to list every possible factor, but to capture an insight into the force or strength of the features that will support, drive, facilitate or restrain the planned change.

How Do You Find Either Restraining or Facilitating Forces?

There are many approaches to discovering or realising the restraining or driving forces. They can be discovered alone, or it may be useful to employ a collaborative approach to identifying the relevant factors. Approaches can include:

- Brainstorming
- Mind maps

- Considering what is in it for you, them, others
- Asking what the key issues are and whether you have thought of everything
- Check or think steps, used as a bridge between planning and action. Stop, question what you have done, consider it again. Is a re-plan required?
- Social support and challenge (clinical supervision)
- Seeking advice from others, experts, people who may have more experience or insight than you. Ensure that you have the support you need to take on the challenge of a change
- Feedback on performance: get confirmation that you are on the right track
- Education and training: can these provide the information you are looking for? Will they give you more information to place you in a stronger position?
- Research and development: has someone else done it before you?

In Box 7.3, the aim of the perineal wound change is to introduce a new care practice. The FFA indicates that the 'force' of the items on the 'driving' side of the model is stronger. Thus the change is likely to be driven through. Another way to show FFA is to use numbers, as in Box 7.4. In this view of the model, the 'forces' are represented by numbers. The side with the higher total numbers is likely to shift the centre line, again driving the change through.

To be clear, though, FFA is all about the 'force' and not the items as such. It is not a pros and cons list. Once the analysis is complete, consider how you can address the restraining forces or bolster the driving forces to bring about the change. While the driving forces matter and should be supported, the gift of the FFA model is that it allows you to take stock of the restraining forces and plan ways to limit or minimise them.

Kassean and Jagoo's (2005) case study used an FFA model effectively to consider changes in handover practice and Laight's (1995) article outlines how an FFA approach was used to change management aspects of eye care.

Box 7.3 Changing practice for perineal wound care (arrows)

Driving forces	**Restraining forces**
Some evidence base →	← Traditional views of care
Progressive/supportive manager →	← Increased resource implications
Potential benefit to patients →	← Some poor staff attitudes to change
Presence of students on the ward →	
Save staff time →	

Box 7.4 Changing practice for perineal wound care (numbers)

Driving forces	Restraining forces
Some evidence base (5)	Traditional views of care (5)
Progressive/supportive manager (2)	Increased resource implications (4)
Potential benefit to patients (4)	Some poor staff attitudes to change (2)
Presence of students on the ward (2)	
Save staff time (2)	
Total (15)	Total (11)

As 15 is greater than 11, so the driving forces are likely to succeed.

Reflection Point

The change management models offered in this chapter may also be applied to other aspects of your life. Choose SWOT analysis and apply it to a professional or personal issue that you are facing at the moment. What are the advantages and disadvantages of the SWOT analysis? Would other models be more or less useful for the issues you have considered?

Other Approaches

Edgehouse et al. (2007) and Jones and Bennett (2012) indicate that there may be other ways to facilitate change. Five new ways to manage or lead change are mentioned briefly here to indicate the wide range of approaches to consider.

Initiating, Envisioning, Playing, Sustaining: A Theoretical Synthesis for Change

This model offers a cyclical approach to change with four stages. The first is for the change to be **initiated**. In effect, goals are set and the problem is stated. The second stage is **envisioning**, where a vision for the future is outlined. In the third stage, **playing**, the vision and goals are tested throughout the organisation. The implication is that the 'leader' observes how the vision and goals are being implemented and makes appropriate adjustments to lead followers to success. The final stage, **sustaining**, implies that the change has taken root and with evaluation can be seen to be sustained change. It is concluded that the process never really stops, since evaluation and initiation are ongoing, so that as new problems arise and new goals are set the stages renew and develop (Edgehouse et al. 2007).

Seven S-Action Words Model for Organisational Change

The seven S-action words are words that leaders can use to develop strategies to develop and lead change. They are scan, select, sense, sicken, sift, speak and spread. Change leaders need to understand that to move from the status quo to successful change, they need to use and employ the various S-action words in their change model (Edgehouse et al. 2007).

Beckhard and Harris's Change Equation

This model places staff engagement at its heart, with the equation offering a solution to resistance encompassing dissatisfaction (D) with the present situation, a vision (V) for what can be achieved and the first steps (F) taken towards the vision (Jones & Bennett 2012). All of these lead to a path to overcoming resistance (R). The model is expressed as

$$\mathbf{D} \times \mathbf{V} \times \mathbf{F} > \mathbf{R}$$

In keeping with sound mathematical principles, if any one of the variables is not addressed, the net result will be zero or an inability to negate the resistance to change.

People-Mover Change Model: Effectively Transforming an Organisation

This model has four parts: reflective motivation, team-based preparation, strategy implementation and evaluation. It begins with the change agent asking themselves vital or key questions about the planned change. The aim is to identify their passion for the proposed change. The next step is to select partners (team members) who will work with the change agent to support the change. In the third stage, strategy implementation, the change is communicated to others, and finally the impact of the change is evaluated. The process is about moving people along by motivating them and winning them over to the proposed change (Edgehouse et al. 2007).

Instituting Organisational Change: An Examination of Environmental Influences

In this model it is suggested that sustainable change is best achieved if the environment is most suitable for change to occur. In this regard, organisations need to have a high value placed on change, a safe environment for change to occur and open dialogue with those affected by change. This implies that a change-willing organisation will be prepared to assess its strengths, weaknesses and resources, plan for future development and then apply itself to effective change (Edgehouse et al. 2007).

Change is Never Simple, Even with a Model

Thus there are many change management models and many approaches overlap or encroach on the methods and theories of others. In this regard, choosing a model or set of change models is crucial if clinical leaders are to make effective plans for change. However, change is not an easy thing to effect and it is never just a matter of selecting or applying a model. Clark (2008) suggests that change fails because either strategy, operations or people are to blame. He claims that mostly it is people who negatively affect change. However, successful change requires all three areas to function effectively, so choosing an appropriate change model is only part of the issue.

Banutu-Gomez and Banutu-Gomez (2007) also propose several factors that are important for leaders in bringing about organisational change. These are:

- Having a vision of where you want to go
- Having a clear sense of your goals
- Valuing others' skills and experiences
- Courageously accepting responsibility for problems
- Communicating clearly
- Challenging the status quo

- Empowering others
- Setting examples and showing the way
- Motivating others
- Positively influencing the culture of the organisation

As mentioned, understanding change management models may not be enough and, as Banutu-Gomez and Banutu-Gomez (2007) point out, this is not even mentioned in their important factors for bringing about organisational change. However, I would argue that having some change management literacy is vital, because understanding the steps of a change model gives novice or new change agents a framework for planning and assessing their part in change, including the steps and actions needed to be successful. Health professionals are not routinely taught change models, yet change is a central part of the health service environment. Therefore, if clinical leaders are to influence and support better-quality care, they need to have a sound knowledge of models for change, as well as having an insight into some of the other key factors outlined in this chapter (Banutu-Gomez and Banutu-Gomez 2007).

Resistance to Change

In the health arena change is often difficult to implement and frequently faces stiff resistance. This may be the case in other areas too, but in the health service it seems particularly to be the case. This may be a phenomenon of the culture that seems to dominate in the health service, where hierarchical structures and constant rounds of change produce scepticism on unprecedented levels. Therefore, if clinical leaders are to facilitate or lead change, they need to acknowledge that resistance is common and they should be aware of both its likely cause and strategies for combating or acknowledging resistance.

There are a number of reasons why people may resist change and these are discussed in what follows.

Self-Interest and Conflicting Agendas

Some health professionals resist change because they do not see it as in their best interests (Jones & Bennett 2012). They may fear a loss of power, influence, status, money or position. Weihrich and Koontz (1993), Griffin (1993) and Daft (2000) suggest that fear of loss may be the greatest obstacle to change within organisations. Such a fear may stem from professional rivalry, issues of low self-esteem or a lack of personal resources for dealing with change. Nurses (often perceived to have low self-esteem) may react to change negatively, feeling that change will undermine them, whereas professionals with high self-esteem will generally see change as an opportunity, confident in their capacity to exploit the change or find benefits for themselves within it. It is suggested that clinical leaders will find themselves more commonly in the latter group, but they will need to be aware that reactions labelled self-interest may come from deeper feelings of insecurity or fear. Failing to recognise these deeper feelings or deal effectively with them may stall or affect the success of a change proposal.

Increased Stress

Dent and Galloway-Goldberg (1999) propose that resistance may in fact be a result of the perceived consequences of change. Any change requires a readjustment and this, good or bad, implies an increase in stress. If it is combined with fear or feelings of loss (of position, power or status), increased stress in itself will lead to growing resentment and resistance to the change. Again, this should be acknowledged and addressed along with the actual change proposed.

Uncertainty

Being aware that change is planned and that it will affect them may create a level of uncertainty that can push people into rejecting the change, even before they understand it (Jones & Bennett 2012). Announcing a change and then expecting people to follow the organisation on a journey into the unknown, without providing information or insight, remains a main reason for people offering resistance to planned change. Fear and uncertainty are again the net result (Weihrich & Koontz 1993; Griffin 1993; Daft 2000). Uncertainty often produces the sense that people are not in control of their destiny and this can have significant negative consequences for any planned change. Knowing what is coming allows people to make a decision to support the change, or at least to make decisions about any action that they feel is appropriate for them. Uncertainty again produces fear and increases stress. Organisations keen to hold onto power over their employees may favour uncertainty, but this approach is seldom successful, as staff who are fearful, destabilised, uninformed and anxious are seldom productive and useful within any organisation.

Diverging Points of View

Festinger (1957) labelled this issue 'cognitive dissonance'. What the managers see as an appropriate change may not be change that employees or staff consider appropriate. Such a situation commonly leads to conflict, as management and staff's goals, values or beliefs are at odds. The battlelines are about core beliefs and if new systems or models of practice are being introduced, only behavioural change on the part of one side or the other will lead to effective progress. However, behavioural change will only result if there is a change in thinking about the new system or model. Some people will refuse to modify their thinking, believing that the planned change is improper, unhelpful or unnecessary. The fight goes on in their mind as much as it does in the open as they struggle to accommodate the new values that the change will herald (Jones & Bennett 2012).

The introduction of care pathways was such a change. It led to many nurses changing their work environment or resigning altogether, because the principles behind the new model of care were so different to the care planning system they had become used to. Cognitive dissonance may continue even after the change has taken hold, with resistance in the form of non-compliance with all aspects of the change, or a form of cognitive rebellion as individuals seek to superimpose some of their values back onto the change without being seen to oppose it overall. In order to combat this form of pernicious rebellion, clinical leaders need to effectively 'sell' any change that may challenge cultural ideals or long-held practices. The main reason clinical leaders are followed is that their values and beliefs are on show and in this regard, bringing followers along with a change in values or beliefs may require considerable preparation and role modelling.

Ownership

Resistance may also follow if participants in the change do not feel connected to it or have ownership of it. Understanding the purpose of the change is a key factor in bringing participants along. Introducing change 'because you can', because you have authority over others, or doing so in an insensitive way will result in resentment, uncertainty, distrust and dissociation of participants from the planned change. Simply not allowing participants significant participation in the change process will ensure a negative result and resistance. A word of caution here: participation is not what the management or the change instigator thinks it is, but what the participants think it is. This may be a confronting concept, but many a useful change proposal has come unstuck when resentment at a lack of inclusion was increased by management's insistence that collaboration was achieved when the vast majority of participants were convinced that they remained in the dark and were under-valued.

Recognising the Drivers

People may resist change simply because they see it as a threat to their self-worth or personal integrity. People like being in control or consulted; they do not feel comfortable if their values and beliefs are under threat or at risk of assault. Therefore, initiating change successfully may involve assessing the motivational forces that sit behind the people the change will affect. This implies being compassionate to them and in a collaborative relationship or partnership. However, the planned change will have a better rate of success and be less prone to attracting resistance if those who will be affected by the change are involved, consulted and respected.

Some People Just do not Like Change

It needs to be acknowledged that some people with specific personality types are more inclined to be resistant to change than others. Individuals bring with them their own beliefs, values, support systems, cognitive levels, personality types, languages, behaviours, cultural influences, maturity levels, emotional intelligence levels, emotions and emotional needs, and in the end some people have a low tolerance for change (Jones & Bennett 2012). Planning for these individual variances is impossible, so it could be expected that with every change, on some level, there will always be individuals within a group who will feel compelled to rebel or resist. These issues can be anticipated, but it is hardly an exact science, so even with personality type indicators, determining where resistance will come from may be impossible to predict. The best a change agent can hope for is to be aware that resistance is likely on some level and to be prepared with inclusive approaches, easy access to information about the change, and effective communication and information.

Recognising Denial and Allowing Time for Reflection

When faced with change people commonly go into an initial period of denial (Rashford & Coghlan 1994). This is normal, as adjusting to the concept and reality of change takes time, and denial offers a period of reflection and thought. It is during this time that information should be provided, explanations offered and time given for the proposal(s) to take form in people's minds. Those planning change need to recognise that denial will occur and remember to have information about the planned change ready, respect the time this process of assimilation will take, and not rush participants into accepting the change without sufficient reflection time. Forcing participants to accept change without allowing them some time to grasp its consequences may force them into a pattern of resistance based on many of the reasons cited in this chapter.

Reflection Point
Why do you think some people are resistant to change? Do you think nurses and other health professionals are generally risk takers or conservative by nature? Speak with some colleagues about changes that have occurred in the past. How did your colleagues cope? How were these changes viewed then, and what impact do they have now?

Successfully Dealing with Change

Marquis and Hudson (2012) and Curtis and White (2002) suggest that managers, leaders and change agents should not only expect resistance, but also be prepared to deal with it when it occurs. They also recommend consideration of the following points for change to be successful:

- Introduce change slowly, allowing time for thinking about and assimilating the change proposal.
- Participation of those involved or affected is essential, allowing all to take an active part in the change.
- Participants need to be able to take ownership of the proposed change at a cognitive level; that is, they need to feel that as individuals they are invested in the process of change.
- Information about the proposed change needs to be accessible and put forward as early as possible to allow people to adjust and accept or take part in it.
- Open and honest communication needs to be established. This will facilitate trust and limit misunderstanding. It will also promote two-way communication, questioning and feedback.
- It is important to offer support (psychological/emotional/informational) for people struggling with the proposed change.

Dignam et al. (2012), writing from an educational perspective, further suggest that collaboration is essential for change to be successful. It may also be helpful to employ an external change agent, an objective outsider who may be able to facilitate the change. However, this outsider may also be viewed with cynicism or mistrust if they do not follow the recommendations given here.

Organisations reflect the dynamics of small (and sometimes large) communities and working within them requires considerable skill. There are champions and heroes, cynics and nay-sayers. Change, no matter how positive, has the power to promote feelings of stress, anxiety, anger, hope, liberation and indifference, and whatever the change being proposed, managing it and dealing with the inevitable resistance will be central to the clinical leader's role and function.

Recognising that resistance may be prevalent and acknowledging the complexities of planning and implementing a programme of change, Robbins et al. (2001) claim that to bring about change successfully there needs to be a clearly defined action plan, adequate resources to facilitate the planned

change, the incentive to change, the skills to push through what is required, and a vision of what is to be achieved that is shared with all stakeholders. If confusion, anxiety and frustration are to be avoided and if resistance is to be addressed or minimised, planning the change process requires the application of a suitable change model and the steps that Robbins et al. (2001) suggest.

It is clear that for the health service and care practices to improve, nurses and health professionals need to be able to recognise what does not work well and develop strategies and solutions to change care practices, attitudes, systems and processes.

This is relevant to clinical leadership practices because service improvement and developing the health service are based on effective change and innovation, which leadership is central to bringing about and facilitating, with clinical leaders often in the role of 'change champion' (Hendy 2012).

A range of tools for effectively managing change have been considered in this chapter, including SWOT analysis, stakeholder analysis, Pettigrew's context/content/process model, the change management iceberg, PEST, the nominal group technique, process re-engineering, FFA and other lesser-known approaches. Learning to employ these change management models reduces a haphazard approach to change and innovation and offers nurses and other health professionals an opportunity to make a genuine impact on change in a planned, measured and strategic way.

Case Study 7.1

Marie Curie was born at a time when women were seen as secondary to men, in a poor family and in an area of Europe were women had few rights and limited access to education. Yet she was able to contribute significantly to our knowledge in the realm of science. Read the outline of her story and consider the challenge that follows.

Female Leaders: Marie Curie

Marie was born in Warsaw (then part of the Russian Empire) in 1867. Her early years were spent in and around the city, where she was supported and instructed by her father. At the age of 10 she attended her mother's boarding school, but her mother died from tuberculosis when Marie was 12 and after this she attended a gymnasium (school) for girls.

She came from a relatively poor family and in order to support herself (and her older sister Bronislawa), Marie did some tutoring and then took a number of positions as a governess, first in Krakow, then with a prominent family in Ciechanow who were relatives of her father. Here she fell in love with a son of the family, Kazimierz Zorawski, and although it was reciprocated, the match was considered inappropriate by the head of the family and Marie lost her position as governess. Her sister asked Marie to join her in Paris, but Marie was still hoping to marry Kazimierz are remained with her father, where she did some further tutoring and began practical scientific training at a laboratory at the Museum of Industry and Agriculture. In 1891, at the age of 24, when it was clear that any relationship with Kazimierz Zorawski was impossible, Marie moved to Paris.

She studied at the Sorbonne during the day and tutored at night. She quickly earned a degree in physics and then mathematics. In 1894 she met Pierre Curie. Marie was studying the magnetic properties of various metals, and it is ironic that they were drawn together by their mutual interest in magnetism. Marie returned to Warsaw, but was denied a place at Krakow University because she was a woman. She returned to Paris – and Pierre. They were married in 1895 and after this the two

(Continued)

Case Study 7.1 (Continued)

physicists hardly left the laboratory, although they shared two hobbies, long bicycle rides and journeys abroad.

In 1896 Marie and her husband began to explore uranium. Their systematic research led to many discoveries, including the radioactive properties of the element thorium, the element polonium and radium. Radium was an incredibly difficult element to isolate and a tonne of the base metal pitchblende produced only one-tenth of a gram of radium chloride. The idea to look for an element with greater radioactive properties than uranium was Marie's, and her biography makes it clear that there was no ambiguity about who made the discoveries.

In 1903 Marie Curie and Henri Becquerel were awarded the Nobel Prize in physics, making her the first woman to be awarded a Nobel Prize. In 1897 and 1904 Marie gave birth to daughters (Irene and Eve, respectively) and in 1911 she was awarded a second Nobel Prize for services to chemistry. Marie was also the first person to share or win two Nobel Prizes, and she is one of only two people to have been awarded a Nobel Prize in two different fields. In spite of these achievements, the French Academy of Science refused her admission on the grounds that she was a woman. It would be one of Marie's students (Marguerite Perey) who would be the first woman admitted to the Academy, over 50 years later in 1962.

In 1906 Pierre Curie was killed in an accident. Marie was left devastated, but she focused on her work to regain some meaning in her life. This was facilitated by her appointment as a professor at the Sorbonne, the first woman to hold this type of post. In 1910 Marie began an affair with a former student of her husband's, creating a degree of scandal, but her hard work, the second Nobel Prize in 1911 and her determination persuaded the French government to overlook her personal life and provide funding for the establishment of what is now the Curie Institute. The building, a research centre, was completed in 1914 and became a hotbed of Nobel Prize winners, including Marie's daughter Irene and son-in-law.

During World War I Marie donated both her own and her husband's gold Nobel Prize medals to the war effort, and worked to provide mobile radiography units, known popularly as 'little Curies', which were used to treat wounded soldiers.

Following the war Marie travelled to the USA twice to raise research funds to establish a research institute in Poland. She died in 1934 from aplastic anaemia, almost certainly contracted as a consequence of her exposure to radioactive substances in her research work. Due to their radioactivity, her research papers from the 1890s – and even her cookbook – are still considered too dangerous to handle and are stored in lead-lined boxes.

During her life Marie Curie had to overcome many societal and equality barriers. The fact that she was a woman and from a poor eastern European country presented many obstacles to her progress in the field of science, and she is regarded as a genuine pioneer, emancipated and independent. Albert Einstein suggested that she was the only scientist not corrupted by the fame she had achieved.

Challenge: Change is seldom achieved without great courage and conviction. Models of change are therefore only a small part of the process, for without courage and determination even the best laid plans for change are likely to fail. Marie Curie faced numerous obstacles and was still able to achieve much. What sorts of obstacles do you face in your workplace, and how can you overcome them? Consider the change management tools in this chapter. Can these be used to address or support any plans you have for change? And how can you deal with or find the courage and determination to hold on to the ideas you have to improve your work or the experience of your clients/ patients?

Summary

- Clinical leaders need to recognise and develop strategies and solutions to address what is not working in their clinical area.
- Workplaces are not machines, they are communities, and as such dealing with change involves recognising and dealing effectively with the people affected by it.
- There are a number of tools that will facilitate a measured and strategic approach to change. Choosing an appropriate tool to support the planned change is crucial for health professionals to effect positive and genuine change.
- When choosing a change management tool, remember to consider your own place within the change process and model of change to avoid bias and an ill-considered evaluation.
- For change to be introduced successfully, clinical leaders need to appreciate that often what is really required is for culture to be shaped, modelled and remodelled.
- For lasting cultural change to be effective, people need to be rewarded for actions that support and promote the culture or new culture being proposed.
- There are a number of reasons why people are resistant to change: self-interest and conflict, perceived stress from the proposed change, uncertainty, cognitive dissonance, issue of ownership, conflict over values and denial that things need to change. Dealing with resistance to change sensitively will help support both the change proposal and those involved in or affected by the change.

Mind Press-ups

Exercise 7.1

Listen to the songs 'The times they are a–changin' by Bob Dylan (1967), 'Changes' (1971) by David Bowie and 'Revolution' by the Beatles (1968). Are the times always 'a-changin' or was it just that the 1960s and early 1970s were a key time of change? Why do some people want change to be quicker and more revolutionary? Which approach do you think will best support the future of healthcare? Is David Bowie's struggle with change common?

Exercise 7.2

Draw up your own version of the FFA model. Think of a problem you want to address. It can be personal or work related. Begin by listing the driving then restraining forces that have an impact on the problem or issue you want to change. Look at your lists. What power does each element bring to bear on the force for or against the change? Represent the forces with thick or thin arrows on your diagram or with numbers showing the strength of each factor. Use the structure in Box 7.5 to support this exercise.

Box 7.5 Force-field analysis

State the issues or problem here :____________________________________

Driving forces (Indicate the strength of each force)	Restraining forces (Indicate the strength of each force)

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8

Clinical Decision Making

Veronica Swallow, Joanna Smith and Trish Smith

> *As soon as questions of will or decision or reason or choice of action arise, human science is at a loss.*
>
> Noam Chomsky, American linguist, philosopher, cognitive scientist and political activist, b.1928

Introduction: A Choice

This chapter will focus on how clinical practitioners and leaders make decisions and the relevance and significance of decision making for clinical leaders and for care and services delivery. It is impossible to deliver healthcare and nursing without making decisions, and poor decision making can have devastating consequences for patient safety and care. This chapter outlines the theoretical background underpinning clear, effective decision making, explores why decisions sometimes go wrong and considers how clinical leaders use more than technical rational approaches when they make decisions.

Why do We have to make Decisions?

The provision of healthcare invariably requires patients and/or carers to make treatment choices, and health professionals to make clinical care decisions. Ultimately someone has to take a lead in making a decision about an issue in order to prevent events taking their course in a haphazard way (Russell-Jones 2015). Without health practitioners' ability to make decisions in the clinical area, the quality of care that results may be questionable. Hough (2008) outlines the importance of decision making for nurses in critical care and supports the value of having experienced clinical leaders or mentors for junior nurses to learn from. Hough (2008) suggests that it is not just ethical issues that dominate in terms of the decisions health practitioners make, but that decisions in the nursing and health domain really relate to myriad issues, needs, problems and potential problems. Marquis and Huston (2009, p. 1) link decision making with problem solving and critical thinking (describing these as the 'critical triad'), reinforcing the significance of decision making for clinical practitioners.

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What is a Decision?

> Alice was a little startled to see a Cheshire cat sitting on a bough of a tree a few yards off …
> 'Would you tell me, please, which way I ought to go from here?'
> 'That depends a good deal on where you want to get to', said the Cat.
> 'I don't much care where—' said Alice.
> 'Then it doesn't matter which way you go', said the Cat.
>
> *(Lewis Carroll, Alice's Adventures in Wonderland, 1865, pp. 62–3)*

In healthcare it *does* matter which direction individuals take and which decision they make. Decisions are made to determine an outcome, in order to end something, resolve something or make up one's mind about something. The Latin root of the word 'decision', *decisio*, means 'to cut away'. So decision making should cut away the surrounding clutter to enable one to see a path to an objective, which one can follow with all of its implications (Russell-Jones 2015, p. 4). Rider-Ellis and Love-Hartley (2009) define a decision as a systematic cognitive process in which healthcare professionals need to identify alternatives, evaluate those alternatives and come to a conclusion. More recently, decision making has been described as the crux of patient-centred care, with shared decision making (SDM) being the process by which a patient and the healthcare professional make health-related decisions together based on the best available evidence. However, there has been a tendency to consider SDM primarily in terms of making treatment decisions (Entwistle 2009).

A broader conceptualisation of SDM, whereby patients and health professionals jointly take an active role in decisions concerning the patient's health, can be applied to a range of decision-making activities such as the patient's contribution to identifying and articulating the nature of their problem, treatment monitoring and the way care is delivered. SDM presents new opportunities to improve health outcomes and healthcare services (Couët et al. 2015). Marquis and Houston (2009) view decision making as a complex, cognitive process related to choosing a particular course of action and Carroll (2006, p. 93) supports this, indicating that decision making is the 'process of establishing criteria by which a nurse leader can develop and select a course of action from a group of alternatives'. Therefore, a decision may lead to a specific action or refraining from action, depending on the situation in which individuals find themselves.

Accountability

The delivery of safe, high-quality patient care is dependent on the skills, judgement and decisions of health professionals, often working in teams (Mannion & Thompson 2014). Increasingly, nurses are leading and taking responsibility for making clinical decisions. All nurses and healthcare practitioners are accountable for their actions, and actions are based on decisions, whether those decisions are made consciously or unconsciously (AHPRA 2013). In 2014 the Royal College of Nursing (RCN) in the UK undertook the 'Defining Nursing' project and defined nursing as:

> The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death. … At all times however, they [nurses] remain personally accountable for their own decisions and actions.
>
> *(RCN 2014, p. 3)*

In the same year, the RCN's Nursing Policy and Practice Committee (NPPC) confirmed that the definition is fit for the following purposes:

- Describing nursing to people who do not understand it.
- Clarifying the role of the nurse in the multidisciplinary healthcare team.
- Influencing policy agendas at local and national levels.
- Developing educational curricula.
- Identifying areas where research is needed to strengthen the knowledge base of nursing.
- Informing decisions about whether and how nursing work should be delegated to other personnel.
- Supporting negotiations at local and national levels on issues such as nurse staffing, skill mix and nurses' pay.

While it is focused on nurses, this definition offers two key positions that have broader applicability. First, health professionals (in this case nurses) are accountable for what they do; and second, they are also accountable for any decisions they make, which may include decisions to delegate tasks to others or choices about not acting. To be accountable means that an individual agrees to be morally responsible for the consequences of their actions – in other words, to be answerable. Thus, one individual cannot be accountable for another's action (Marquis & Huston 2009) and our actions or failures to act are based on our decisions.

Terms

There are many terms used in nursing and healthcare that relate to decision making. These are often used interchangeably and should not be confused. The list includes:

- Making judgements: reaching a considered choice
- Clinical judgement: reaching a considered choice in clinical practice based on reflection, previous knowledge, data and client preference
- Clinical inference: an educated guess about a clinical issue, often based on heuristic insight
- Clinical reasoning: the process of applying logic to the clinical decision-making process
- Diagnostic reasoning: using the decision-making process to reach a diagnostic decision
- Problem solving: a systematic approach to analysing a difficult situation

Judgement, inference and reasoning are commonly employed to make decisions. However, decision making can occur without the complete analysis that is commonly seen in problem solving (Marquis & Huston 2009). A useful distinction between judgements and decisions is offered by Dowie (1993, p. 8), in that a judgement is about assessing the alternatives, whereas a decision is about choosing between alternatives.

Decision-Making Approaches

If it is the case that decision making is a central part of healthcare and nursing, then it is important to explore how health professionals come to make decisions. Think about the following three decisions:

- Choosing to buy one product over another in a supermarket
- Choosing what to wear to a formal gathering (say a wedding)
- Choosing to implement a particular care intervention over another in the clinical environment

Now consider these questions:

- What influenced your choice in each situation?
- How did you gather the information to make your choice effectively?
- Was there more than one factor involved in influencing the choice you made?

Here are some approaches to decision making that may be commonly employed (but hopefully rarely in the execution of your professional role):

- throwing the dice
- tossing the coin
- crystal ball gazing
- horoscope or tarot cards
- the easy-way-out method (take the path of least resistance)
- darts (put your options up and leave it to your skill at throwing a dart)
- Balaam's ass (unable to decide and so make no choice at all)
- waiting for divine inspiration (leave it to God)

Most of these methods are really about *not* making a decision. Although some methods are useful and appropriate in some circumstances, in terms of decision making within the health service there has to be a better way than leaving things to luck or chance, relying on divination or, indeed, letting things work out for themselves. It is also useful to consider that many of the choices we make may be influenced by the environment we are in (at the shops, at home or at work) or by external factors (e.g. cost, finances, the weather, the influence of others) and internal factors (e.g. how we are feeling, how the choice will make us feel, our emotions, past experiences or our desires). The reality is that our decisions can be influenced by a wide variety of issues and factors. As such, being able to make decisions in a considered, consistent and judicious way is vital, particularly so in the dynamic, changeable and ethics-laden environment of healthcare.

In healthcare, where quality and safety issues dominate, it is essential to use a decision-making model to aid in the decision-making process. Internationally, professional bodies are increasingly offering support for health professionals to assist them with making planned, considered choices and to minimise the 'ad hoc' nature of decision making. For example, the professional bodies for nursing and midwifery in Australia and the UK provide such guidance (ANMC 2007; NMC-UK 2015). Relevant guidance also includes advice from NHS England, which advocates SDM as a process in which patients and their carers, when they reach a decision crossroads in their healthcare, can review all treatment options available to them and participate actively in making that decision. In this model, patients and their carers are helped to work through any questions they may have, explore the options available and take a treatment route that best suits their needs and preferences. To achieve this, NHS England encourages the development of new relationships between patients, carers and clinicians, where they work together, in an equal partnership, to make decisions and agree a care plan. In addition, shared decision making is being introduced at the strategic and commissioning levels, with patients involved in the co-design, co-commissioning and co-production of healthcare (NHS England 2015).

These definitions can potentially help healthcare professionals, working with patients as appropriate, to make decisions in everyday clinical practice, to facilitate the planning, negotiation and implementation of care and to support an improvement in the quality of decision making in the practice environment (ANMC 2007; NMC-UK 2015). They are also significant aids to the appropriate delegation of care practices to other health professionals. The tools were developed because it is acknowledged that decision making is complex. The template tools (while not defining activities or procedures) are designed to assist nurses, midwives and others (health consumers, governments, employers,

professional groups and workforce planners) to understand, be confident with and consider the factors having impacts on decisions related to practice. Examples of such resources include the *Nursing Practice Decisions Summary Guide* (http://www.nursingmidwiferyboard.gov.au/Search.aspx?q=Nursing+Practice+Decisions+Summary+Guide).

Reflection Point

Have you ever made a great decision? Was it something that no one else had considered or because your decision was based on 'better judgment'? What was the decision? Was it accepted with good grace or did you have to 'fight'? Write a short reflection on your experiences, positive or negative. What would you do differently if you had to make a similar decision in the future?

The *Nursing Practice Decisions Summary Guide* is only one of many tools used to support consistent, effective decision making. There are many other models, but they all include some or all of the following characteristics:

- Identification of the problem or issue about which a decision is needed
- Consideration of the causes and/or consequences of the problem or issue
- Determination of the required goal(s) or objective(s)
- Stimulus to gather all relevant data
- Identification of all possible alternatives or solutions
- Exploration of all possible consequences of the alternatives or solutions and analysis of the risks
- choices about the alternatives or solutions that will best achieve the goals or objectives
- Encouragement to plan a strategy for implementation
- Implementation of the chosen alternative or solution
- Evaluation of the actions or outcomes

Russell-Jones (2015) offers an example of a decision-making framework, suggesting that in any decisions there are potentially seven steps:

1) Define (the real issues to be decided on)
2) Understand (the context within which the decision is needed)
3) Identify (the options)
4) Evaluate (the consequences of each option)
5) Prioritise (the options from one choice)
6) Review (the decision taken)
7) Take action (to effect the decision and live with the consequences)

A useful starting point when considering options is to begin by framing the decision and thinking about how the process should be implemented. Should the choice be made alone? Would it be better made in a group and, if so, who should be involved? Health professionals are becoming increasingly aware that many decisions that we have taken ourselves in the past are now better left in the hands of appropriately informed clients, patients or their relatives in some cases. What urgency is placed on the decision? Does it need to be taken at all? Finally, has this type of choice been made before and what was the outcome? Is there something that can be learnt from past decision-making episodes that were similar to the one being considered?

The characteristics of an effective model are essentially a representation of a traditional problem-solving process. While they are robust, there is some weakness in the time it takes to solve problems

Box 8.1 A simple scenario involving a hair dryer

You are drying your hair with a hairdryer and it suddenly stops working

You assess the situation	Has the electricity supply been cut? Has the plug come out? Has the appliance 'burnt out'?
You make your diagnosis	The plug has come out of the wall socket
You make your plan of action	Plug in the hairdryer again and switch it on
You implement your plan	Carry out these actions
You evaluate your actions	The hairdryer works and your assessment/diagnosis/plan of action was successful – job done Or they were not successful and you start the process again

Table 8.1 Comparison of the nursing process and the decision-making process.

Nursing process	Decision-making process
Assess	**Assess**
Plan	Diagnose
Implement	Set objective or goal
Evaluate	**Plan**
	Implement
	Evaluate

Source: Berman et al. 2014, p. 183; Marquis & Huston 2009, p. 7.

using these approaches when often – especially in clinical practice – problems require a speedy solution. It is clear that a systematic approach is required and that health practitioners already employ some sort of systematic approach on a daily basis in the clinical area – and indeed everywhere – when decisions need to be made. The real value of the *Nursing Practice Decisions Summary Guide* and other decision-making frameworks is that they make explicit the decision-making process, and can at times be employed very quickly when faced with critical clinical decisions.

See Box 8.1 for an example of an everyday decision. It may seem simple, but this is what you would do in reality, even if you did not consciously think about each step. It is also how decisions are made when planning or delivering care in clinical practice. Central to the principles of the profession of nursing is identifying patient priorities, which direct possible interventions and their implementation in order to provide individual, humanised care (Faust 2002; de Souza et al. 2015). Such a framework directs nursing care by identifying patients' health and illness status and planning care interventions and is widely used by nurses globally, across diverse practice settings (de Souza et al. 2015). The cognitive processes involved have resulted in the nursing process being described as 'the basis for critical thinking in nursing' (Alfaro-LeFavre 1998, p. 64). The similarities between the nursing process and decision making/problem solving are outlined in Table 8.1. Depending on the role, responsibilities and their expertise, nurses could work across frameworks to reflect their practice and patient needs.

In order to make an appropriate clinical decision, practitioners should first consider the knowledge they already have regarding the following:

- the client/patient about whose care you are about to make a decision
- the personal impact your decision may have (on your patient, on you, on others)
- the decision-making process in use
- the impact of the decision on the quality of care
- the external factors that will influence the decision
- whether the decision is within the scope of professional practice (for your professional role) and whether the *Nursing Practice Decisions Summary Guide* has been used
- whether you have the appropriate skills, knowledge and attitudes to make the decision

There are also other issues that should be considered when applying a systematic approach to decision making:

- Can the patient make a choice or contribute to the decision?
- What are the patient's wishes?
- Are you the most appropriate person to make a decision in this circumstance?
- What information is available?
- Are there other options?
- Which option would be best for this patient at this time?
- What will be the implications of the decision?
- What evidence is available to support the decision?

Theories of Clinical Decision Making

A range of theory-based models attempt to explain how health professionals make judgements about patient care and reach clinical decisions (Thompson and Dowding 2002). It has been suggested that the process of decision making is influenced by professional roles and socialisation processes (Hamers, Abu-Saad & Halfens 1994).

When considering theories of clinical decision making it is important to reflect on where our knowledge and information come from, as being conscious of this can help practitioners avoid some of the common errors. Knowledge and information may stem from:

- tradition (vital knowledge within all cultures and subcultures)
- trial and error (from experience, but not very reliable)
- intuition (from experience, built up over time)
- personal experience (based on a person's individual clinical or life experiences. We all have vast and varied personal experiences and this negates the use of the phrase 'common knowledge' when thinking of decisions that might or could have been made
- authority figures (advice, guidance, coaching and leadership from those whose experience we value)
- education (what we have learnt, what professional development or life experiences have supported our learning)
- logical reasoning (our capacity to apply logic and reasoning to the events in our life)
- reflection (our capacity to draw on past experiences and build a frame of reference to the past; Schon 1987; see also Chapter 15)
- research (our capacity to ask searching questions or analyse others' ability to ask and then answer questions

Tradition, trial and error, intuition and personal experience all have their place and help in the development of knowledge and skills and the decision-making process. However, caution is required, as none is necessarily based on evidence or critical thinking. We often make decisions unconsciously, without the use of a systematic approach, which may lead to quick decisions. Indeed, it is proposed that people in emergency, real-life situations who are confronted with time-sensitive or life-threatening situations (such as nurses, doctors, firefighters or the military) apply modified decision-making strategies that are less formal or less structured (Wolgast 2005; Sinha 2005). This unconscious process, known as heuristics (Marquis & Huston 2009), allows professionals to maximise what is already known, recognise patterns and as a result make a decision or solve a problem quickly and efficiently (Pritchard 2006). This type of decision making can work a great deal of the time, but not always, and is therefore not foolproof.

We also learn from authority figures and, of course, education, in whatever form that may take. Logical reasoning or using a technical rational approach (Fish & Coles 1998) is useful in the problem-solving or decision-making process, and through reflection we can learn much from decisions that were made in the past. In the health arena it could be argued that the most important facet of knowledge generation in the decision-making process is research- or evidence-based practice, which provides the facts or knowledge on which to base our decisions. All these points are considered when established theories of decision making are employed. These include the following examples.

Intuitive-Humanistic Model

This approach to decision making accepts expert intuition in the reasoning process, but is rarely given any real credence (Hansten & Washburn 2000). Intuition does, however, appear to be a legitimate and essential aspect of clinical judgement and decision making so long as it is remembered that intuition can be overruled by a person's emotions, thus weakening it as a tool for systematic, rational decision making (Benner & Tanner 1987). The characteristics of intuitive decision making are that the context within which the decision is taken is usually quite specific (e.g. an occupational therapist could employ it in their area of specialism, say hand rehabilitation, but not in an area outside this, say paediatric spinal cord rehabilitation). The outcome of the decision is usually unknown, the practitioner is more accountable and the decision is based on frameworks and theories rather than formal, scientific rules. This remains a valuable decision-making approach, nevertheless, and sits at the heart of the debate in the nursing literature (and nursing tearooms) about whether nursing is an art or a science. The example in Box 8.2 may help in understanding this issue.

Box 8.2 The art/science dichotomy

If you were to study painting (instead of your current profession), the potential curriculum would be full of sessions on canvas construction, paint choice, how to prime a surface, hold a brush, mix the paint, use light and shade, subject composition and a host of other information central to the practice of painting. In effect, these are the technical skills and knowledge behind painting (the science stuff). However, the application of this knowledge and the craft with which the skills are employed or demonstrated, and the choices about which colours to use, surface to paint on and subject matter, would be the measure of the artist and their personal application of the science. As such, the 'art' becomes an individual expression of the science of, in this case, painting. It is the same for nursing, or indeed any other healthcare or people-centred profession. It is how nurses and health professionals practise the science that brings out an expression of the art or the craft.

Weber (2007) undertook a qualitative analysis of how advanced practice nurses (APNs) used clinical decision-support systems in the US Midwest, and found implications for decision making based on how art and science are seen. What Weber (2007) demonstrated was that APNs were most comfortable with the capacity of an electronic clinical decision-making system's ability to forecast patient outcomes when the predictions that the software presented were consistent with the practitioner's personal judgements about the potential patient outcomes. Therefore, if the clinical decision-making system 'failed to support, confirm, or substantiate the APN's professional clinical judgment, it was disregarded' (Weber 2007, p. 667).

The fact that the nurses involved in Weber's study were 'advanced' clearly had an impact on their confidence to 'override' the predictors of the system's software, but it also highlighted the application of the artistry that healthcare practitioners employ in relation to decision making. Weber's results are supported by Andrews (2009), who proposed that the implementation of intuition in decision making is one of the critical skills that separates good from great leaders, with lesser leaders relying on traditional (technical rational) approaches when making decisions. Chen et al. (2016) also found similar results in a later study with nurse practitioners where they were discovered to use an intuitive-analytical model in clinical decision making.

Systematic-Positivist, Hypothetico-Deductive and Technical Rational Models

The systematic-positivist, hypothetico-deductive and technical rational approaches are all very similar. They rely on hypothesis generation, formal scientific rules, deconstruction and outcome prediction, and use schedules or protocols to interpret problems and make decisions. These would seem highly appropriate, but in fact they leave little room for heuristics, intuition, creativity or, indeed, what the patient may want. Fish and Coles (1998) also offer a view on how professionals make decisions, outlining a combined technical rational (scientific) view and a professional artistry view of how clinicians act in terms of decision making. This supports Andrews (2009) and Chen et al. (2016) in their findings, in that clinical leaders who combine their expertise with technical rational approaches achieve greater success in decision making.

Integrated Patient-Centred Model

The integrated patient-centred approach involves a process in which the clinician, interacting with the client or their significant others, structures meaningful goals and health management strategies based on clinical data, client choice, professional judgement and knowledge. This offers a combined approach to decision making that specifically focuses on the patient or client when framing goals.

IDEALS Model

This is similar to other models for supporting decision making. Its primary advantage is that it offers the mnemonic 'IDEALS' to help practitioners recall the relevant steps (Facione 2010):

- **I**dentify the problem
- **D**efine the context
- **E**numerate the choices
- **A**nalyse the options
- **L**ist the reasons for change explicitly
- **S**elf-correct

Managerial Decision-Making Process

There are a number of different managerial decision-making models. Most offer a modification of the traditional decision-making model with the addition of goal setting or objectives into the process. The steps involved may include the following:

- Determine the context of the decision
- Set objectives or goals
- Search for alternatives
- Evaluate alternatives
- Choose
- Implement
- Follow up and control

The model selected should preferably be one the clinical leader is comfortable and familiar with, and should be appropriate to the decision being considered. Using a specific model consistently is likely to increase the user's critical thinking skills and development of intuition (artistry) within the rational structure of the model (Marquis & Huston 2009).

Clinical Leadership and Decisions

Leadership is commonly seen in terms of the leader's capacity to take decisions, to make the big call, to choose a course of action or a strategy (Marquis & Huston 2009). The big decisions that politicians or CEOs take are significant in the course of a country's progress or a corporation's success. However, in the scheme of people's lives the choices that professionals make each day, each hour or each minute are as big for the individuals they affect. The point here is that health professionals who are in any doubt about their leadership capacity need only tally the number and impact of the myriad decisions they make each day to gain an insight into their leadership role.

Barriers to nurses' and health professionals' participation in decision making should be explored and interventions developed so that nurses and other clinically focused health professionals may be able to participate fully in decision making that affects both patients and the work environment (Bacon, Lee & Mark 2015). Globally there is a growing emphasis on the importance of transforming the education of nurses, doctors and public health specialists to develop a shared vision and common strategy that reach beyond the confines of national borders and the silos of individual professions. Transformative learning involves a fundamental shift from fact memorisation to searching, analysis and synthesis of information for decision making (Frenk et al. 2015).

Daly, Speedy and Jackson (2014) suggest that nurses in leadership positions are ideally placed to support 'first-line managers' in their search for greater resources or stronger staff and patient advocacy, adding that the degree of influence will increase with the nurse's level of authority. However, it is proposed here that leadership influence and authority are not directly linked. Thus the capacity of clinical leaders to make informed decisions and support colleagues, interprofessional working and patient advocacy is more likely to rest on their skill in the application of decision making. Professionals in positions of authority or power who make poor decisions soon lose respect and influence (although they may not lose their power). Clinical leaders who are skilled and confident with decision making and are able and encouraged to exercise their confidence offer a valuable resource to a healthcare organisation and to a clinical environment.

Why Decisions Go Wrong

It would be foolish to suggest that health professionals always make the right choice or decision, in spite of the existence of decision-making frameworks. There are a number of reasons for this.

Not Using the Decision-Making Framework

Not using a decision-making model or critically applying a decision-making framework is the surest way to an ill-informed decision in clinical practice. These tools and models have been designed to support clinicians and help develop a culture of informed decision making that employs critical thinking and a technical rational approach to care choices.

Flawed Data

If we have the wrong information, we make mistakes in our choices through lack of knowledge. Thus it is incumbent on all health practitioners to gather the most relevant and up-to-date information from all available sources before effecting a decision.

Bias

Called 'filtering' by Russell-Jones (2015, p. 10), this implies that we do not believe the data or evidence because we have a personal bias (prejudice) against the method used to collect the data, or the person who collected it. Furthermore, if the results contradict long-standing views, then our capacity to make effective decisions is compromised. Florence Nightingale's slow awakening to the possibility of germ theory can be used as an example of this type of bias (Bostridge 2008). She had for some time been engaged in an argument with William Farr, a scientifically minded member of her 'circle', and in a letter in 1859 he asked her to be more 'scientific in her arguments'. She replied that she did 'not venture to argue with' him and added:

> I only modestly and really humbly say, I never saw a fact adduced in favour of contagion [disease passed from person to person by germs] which would bear scientific enquiry. And I could name to you men whom you would acknowledge as scientific who would place 'contagion' on the same footing as witch-craft and other superstitions.

Nightingale was not the only doubter in her day, but her faith in sanitation, and in the idea that 'filth' was the cause of disease, meant that she was particularly slow to recognise the evidence building from the scientific work of Louis Pasteur, Joseph Lister, Robert Koch and others.

Seeking to Avoid Conflict or Change

Decision making is not easy and may not always be fair on everyone affected by the decision. This means that sometimes choices are made to avoid conflict or to negate change rather than solving the problem at hand.

Ignorance

If we do not have all of the available information, or worse, if we just do not bother to get the data or find the relevant information, the result is what is commonly called a guess. Patient care and a quality health service would be poorly served if health professionals routinely employed guesswork in their clinical decision making.

Hindsight Bias

Mistakes can be made because of second-guessing or poor or biased reflection. In effect, this means using new decisions to justify previously made decisions, especially if the previous decisions were incorrect or inadequate (Carroll 2006).

Availability Heuristics

Going by a 'rule of thumb' (Russell-Jones 2015, p. 10) or hoping that 'close enough is good enough' is essentially a failure to recognise that everyone is different and that a decision made for client 'A', even if the intervention worked, may not be relevant for client 'B', even if they have the same condition, wound, illness and so on.

Over-Confidence in Knowledge

Trusting that what we know is correct every time is where practitioners may jump to conclusions that are in fact wrong (Russell-Jones 2015).

Haste

This is not about speed, it is about poor decisions because they are made before all the facts are gathered (Russell-Jones 2015).

Reflection Point
Consider your work or home environment. What do you recognise as barriers to effective decision making? There may be none, but if there are some, list the barriers and, using the information in this chapter, see if you can make a further list of potential barrier-busting interventions to help promote your decision-making capability.

Group Decision Making

Depending on the decision, it may be appropriate to employ group decision making. This has some advantages and some disadvantages over individual decision making (outlined shortly), but when groups are encouraged to participate it is important that group members feel they are free to express themselves and state their opinions and ideas without duress or pressure to conform. Group decision making has real advantages when the impact of the decision will be felt by the group; therefore, they may prefer to be actively involved in the process of making that decision. Because group decision making takes longer, it is also important to recognise that more time will need to be assigned to the data collection and reflection stages of the decision-making process (Carroll 2006).

When supporting groups in making decisions, it is important to aim for a consensus decision and as such it may be useful to employ a nominal group technique (see Chapter 7) or, if the group cannot meet, the Delphi technique (see Box 8.3).

The Delphi technique allows many people to contribute to the decision-making process and it may reduce the dialogue and chatter or even conflict between members of a larger group. However, it may be a very protracted process. Choosing the best approach to engage the group will depend

Box 8.3 Delphi technique

The Delphi technique has the following steps:

- Send out a questionnaire addressing the issues to be decided.
- When the results are returned, summarise them and send out another questionnaire influenced by the summary data.
- Continue this process of questionnaire and summary results until the group feedback demonstrates a consensus.

on the group size, as small groups tend not to generate as many options and large groups may lack structure and consensus (Yoder-Wise 2015).

There is also evidence to suggest that groups take more risks when they engage in decision making (Russell-Jones 2015). This may be because a group has a shared feeling of responsibility and, as such, the risks are either explored in greater detail or the collective responsibility makes groups less cautious in general.

Advantages of Group Decisions

Groups bring more complete information and knowledge, as it is generally considered that two (or three or ten) heads are better than one. Groups tend to have more diverse views and thus group decisions are more likely to be accepted. There is also the issue of 'safety in numbers', since one person will not be held responsible for the decision. Group decisions tend to be more accurate and more creative than those made by individuals.

Disadvantages of Group Decisions

It can take a great deal of time to organise a group, ensure that appropriate personnel are among its members and find a convenient time for them to meet. Consensus may not be reached within the group, so potential actions may be delayed. Quick action is rarely the result of group decisions. There can be arguments and difficulties among the members, but a group can also lead to conformity, as some members can dominate, influencing their less assertive colleagues and potentially skewing the group view, making any decisions less effective. Moreover, Mannion and Thompson (2014) draw on theories from organisation studies and decision science to explore the ways in which patient safety may be threatened as a result of four systematic biases arising from group decision making: groupthink, social loafing, group polarisation and escalation of commitment.

Characteristics of Effective Decision Makers

Effective decision makers take a 'step approach' to finding the root cause of an issue before acting and do not jump to conclusions. They employ an analysis and problem-solving approach and are wise enough to understand when they have reached their limitations. Effective decision makers avoid 'paralysis of analysis' (Russell-Jones 2015, p. 93) and learn from each decision-making experience.

Case Study 8.1

Jo Brand is a popular and respected comic and television personality. She was also a mental health professional and offers some unique insights into nursing. Consider her story and the challenge that follows.

Female Leaders: Jo Brand

Josephine Grace 'Jo' Brand was born in 1957 and has established a career as a notable English comedian, writer and actor. After working in a number of service jobs, she took a joint social science degree with a registered mental nurse qualification at Brunel University. She then worked as a psychiatric nurse for ten years, at Cefn Coed Hospital in Swansea and the Bethlem Royal Hospital and Maudsley Hospital in London.

Jo's personal life and career as a comedian have been consistently linked to healthcare; she proactively uses her high public profile and popularity to promote the well-being of people with health problems, in particular but not exclusively those with mental health problems. As a staunch advocate for and campaigner on behalf of people with mental health problems, in 2007 she was awarded an honorary doctorate by the University of Glamorgan for her work as a psychiatric nurse. Professor Donna Mead, Dean of the School of Health, Sport and Science, who read her up for the award, commented, 'Jo incorporates much of her experience working in the field of mental health into her current work as a comedienne. This has increased awareness of the work done by nurses in the mental health field. She has also used her experiences of working with individuals with conditions such as Alzheimer's to promote awareness of and raise funds for the Alzheimer's Society.'

In 2014, Jo was awarded a second honorary doctorate by Canterbury Christ Church University, for her work in raising awareness of mental health issues and challenging the stigma surrounding such illnesses.

In her entertainment career in the alternative comedy stand-up scene, Jo has appeared on various television shows, including being a regular guest on *QI*, *Have I Got News for You* and *Would I Lie to You?* In 2003 she was listed in *The Observer* as one of the 50 funniest acts in British comedy.

During her first gig as a comedian, she was scheduled to perform last in front of 'an audience from hell' and drank seven pints of lager while waiting. She humorously described how she therefore faced her first live audience with a 'bursting bladder'. As she climbed onto the stage, a male heckler started shouting 'Fuck off, you fat cow' and kept up the abuse until her performance finished. There was no applause at the end of her act. However, she persevered and her early comedy style involved her delivering jokes in a bored monotone, one line at a time, with pauses in between. She drew heavily from pop culture and the media, with many jokes containing references to well-known celebrities and public figures. Her appearance and material led to false rumours that she was a lesbian. She married Bernie Bourke, a psychiatric nurse, in 1997 and has two daughters.

Jo delivered a guest lecture on the subject of psychiatric nursing to the University of Derby Psychology Society in 1997 in return for a donation to Derby Rape Crisis. Also in 1997, at Lambeth Hospital in South London, she opened the first major exhibition of the Adamson Collection since the death of Edward Adamson, the pioneer of art therapy, in 1996.

Jo co-created, co-wrote and co-starred in the BBC Four sitcom *Getting On*, for which she won the 2011 Best TV Comedy Actress BAFTA. The series, set in a geriatric ward, is a funny and realistic satire on the UK National Health Service.

In 2010, Jo took part in *Channel 4's Comedy Gala*, a benefit show in aid of Great Ormond Street Children's Hospital. She is a supporter of a number of charities and she was one of the celebrities, along with Tom Hiddleston, Benedict Cumberbatch, E. L. James and Rachel Riley, to design and sign her own card for the UK-based charity Thomas Coram Foundation for Children. In 2014, Jo was a part of the *All Star Choir*, who released a cover version of 'Wake Me Up' to raise money for BBC's *Children in Need*, which entered the UK Singles Chart at number one. She is the president of the Ectopic Pregnancy Trust and is a patron of the National Self Harm Network, the Prader-Willi Syndrome Association and London Nightline. In 2016 Jo Brand completed a highly publicised 150-mile walk across Britain in aid of Sport Relief.

Challenge: This chapter on clinical decision making focuses on how clinical leaders make decisions and the relevance and significance of decision making for clinical leaders and for care and services delivery. Jo Brand never forgot her education and experience as a mental health nurse. On the contrary, she used the opportunities presented by her 'second career' as a comedian to advocate for and champion the causes of those in society who need support due to their health conditions. She campaign for national and international charities and draws on her experience of clinical decision making when she was a practising nurse to highlight to national and international decision makers the challenges for those living with the consequences of health problems. She puts herself under considerable pressure in order to raise much-needed charity funds and help develop and promote healthcare services so that current healthcare professionals can work with patients to participate in shared decision making. Do you use your privileged knowledge and understanding within your area of healthcare to help ensure that shared decision making is a reality? Think about how you promote shared decision making in healthcare and whether there are areas of your personal life in which you could advocate for the wider political and societal needs of those in your care. Are there ways in which you use your professional education and experience to help others understand the needs of the groups or individuals you involve in decision making around their health problems?

Summary

- Much of what health professionals do involves decisions and decision making and clinical decision making occurs in different ways.
- Health professionals are accountable for their decisions, actions and failures to act.
- Nursing and healthcare cannot be carried out without making decisions –decisions are fundamental to a health professional's role.
- Poor decision making can have devastating consequences.
- Patients and clients are complicated, thinking, feeling individuals, so decision making can be complicated, but always keep the patient as your focus and, indeed, base your decisions on what the patient wants whenever possible.
- Nurses and other clinically focused health professionals need to ask how and why we do things, constantly challenge decisions and therefore practise to ensure that we do the best for patients.
- Decisions should be based on the best available evidence at all times.
- The application of a range of approaches, including intuitive-analytical decision making, can help us make better decisions.
- Understand how clinical judgements and decisions are made and develop data collection and interpretation skills to develop and use evidence-based guidelines. Make this a habit.

Mind Press-ups

Exercise 8.1

Undertake a small survey where you work. Ask a number of colleagues if they have ever made a mistake with a clinical decision. Do not focus on what they did wrong or the outcome, but ask about why they think they made a poor decision and how they think they could avoid doing so in the future.

Exercise 8.2

Access the internet and see if you can find references to the decision-making approaches detailed in this chapter. Once you have found the information, try the techniques out. Consider decisions you have made and see if you can use these models or if they help with a particular problem.

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9

Creativity

David Stanley

Praise without end the go-ahead zeal
Of whoever it was invented the wheel;
But never a word for the poor soul's sake
That thought ahead, and invented the brake.

Howard Nemerov, American poet, novelist and critic, 1920–91,
from 'To the Congress of the United States, Entering its Third Century',
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Introduction: A New Way Forward

This chapter looks at the issue of creativity: what it is, why it is important for nurses and other health professionals to develop creativity skills and how to develop creativity. The chapter also addresses the barriers that hinder creative development and how creativity and leadership are linked. There is very little formal training in undergraduate or even postgraduate health education that deals with the issue of creativity. It is implied perhaps in learning goals for critical thinking and problem solving, but creativity and idea generation are seldom the focus of specific learning goals. However, recognising that clinically focused leaders commonly act to initiate and propose new ideas and solutions for often complex problems, it is important that the matter of creativity is considered in terms of the catalogue of tools to support innovation and implement values and beliefs in practice.

What is Creativity?

Like leadership, creativity can be a difficult concept to pin down and define (de Bono 2015). Doyle (1993) and Rickards, Runco and Moger (2008) suggest that creativity is much easier to detect than define. However, Barez-Brown (2006, p. 30) sees creativity as 'simply doing something new and differently that creates some benefit'. He adds that 'creativity gives us choices, gives us hope that in some way we can be special, we can be ourselves, we can create our own futures' (Barez-Brown 2006, p. 31). The *Oxford Dictionary* (Tulloch 1997, p. 336) suggests that to be creative is to be 'inventive and imaginative' or to 'originate', be 'artistic, original, ingenious or resourceful'. A broad view of creativity is that it is the ability to generate new, novel or useful ideas, solutions and propositions to everyday

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problems and challenges. De Bono (2015, p. 16) describes it as 'bringing into being something that was not there before'. Rickards, Runco and Moger (2008) suggest that a definition of creativity needs to satisfy two requirements. First, an idea needs to be original, surprising and novel; and second, it needs to be adaptive, effective and functional.

Sharma (2010, p. 231) states that the essence of creativity is original thought, offering the phrase 'see what all see, think what none think' to describe creativity in practice. Sharma (2010) adds that to foster innovation in organisations it is vital to create a workplace that rewards curiosity and recognises new ideas.

Thinking creatively is a highly desirable human trait, as it enables and supports us to keep up with or drive change. In this regard, most (if not all) people may be considered to be creative; it might be that some people just do not act on their ideas to the same extent as people consciously identified as 'creative', such as artists, painters, musicians or architects. However, if creativity is understood to be a basic human ability, then we all have the capacity to become creative or express our creativity (Klemm 1990). Creativity can be learnt and therefore it may be that some people are simply encouraged to do so more than others.

Creativity is rarely identified as a desirable skill for nurses or health professionals, so maybe its expression within nursing and the health professions is simply not encouraged, or it may even be suppressed in favour of processes, procedures and techniques or organisational structures that – hopefully unwittingly – discourage innovative thinking. However, nursing and other health professions are commonly described as both an art and a science, and other health professionals are likewise supported to develop 'artistry' in the expression of their professional skills. The extraordinary talents of people whom we consider 'creative' or who work within creative fields (the arts, advertising or music) are commonly recognised when they combine their talents with determination and persistence to achieve mastery in their field. However, there may be a tendency not to recognise the 'creativity' expressed by others in areas not traditionally seen as creative, such as healthcare, education or business. Each person can be creative in their own domain by recognising their own skills and talents and developing mastery of them. Creativity is described as the ability to develop unique ideas and solutions to problems and challenges and, in the health arena, health professionals are constantly employed in thinking about problems and searching for solutions to often complex and demanding issues.

Nevertheless, creativity is not a talent in the sense that it is inherited. Creativity is not a gift, even though some very creative people are often described as 'gifted'. Creativity is more a state of being, and being creative is about accepting that someone has new ideas and novel solutions and is prepared to act on them to help solve a problem. In this way it can be seen that creative ability can be studied, learned, developed, improved on or increased over time (de Bono 2015).

In the 1920s, Graham Wallas (Doyle 1993) described the creative process as having four parts, which he called preparation, incubation, illumination and verification. Each is thought to set out how the creative process may be explained and offers an understanding of creativity so that we may learn how to develop creative skills and evaluate the effectiveness of the creative process.

- *Preparation:* This can only come from a solid grasp of the area or a degree of specialist knowledge. Writers, in order to become great writers, must have developed their craft, practised their art and understand the principles that underpin the writing process. They also need to know their subject and maintain an open, inquisitive and confident attitude to their endeavours. Following a formula or established practice may result in a new novel, but its potential creative impact is likely to be diminished. Preparation is about getting ready to build ideas and creative opportunities.
- *Incubation:* Wallas felt that while the conscious mind may help develop the ideas, it is in the subconscious that ideas and creative thoughts germinate (Doyle 1993). Solutions are therefore commonly described as being 'revealed' rather than arrived at consciously.

- *Illumination:* Wallas describes eureka moments as the issues being illuminated (Doyle 1993). As an extension of incubation, the idea may arrive without warning and may be accompanied by the feeling that a solution has been found.
- *Verification:* This involves critical analysis and assessment, evaluating the idea for its practical application and verifying its suitability to solve the problem or address the issues at hand.

Barez-Brown (2006) describes the creative process more simply, suggesting that it involves three steps: **insight**, which is about becoming clear about what your opportunities may be; **ideas**, which are about how to make the opportunities work for you; and finally **impact**, which is about doing something with the ideas. He indicates that because the process is so straightforward it can work on anything and lead to inspiring opportunities. Barez-Brown (2006) is also clear that ideas and thoughts are different, in that ideas change the world while thoughts do not. The difference he proposes is that you can 'do' ideas.

Creativity, therefore, may be more than simply having a thought about an issue or even just discussing a concern (say in the tearoom at morning coffee). Creativity implies a capacity or willingness to act on an idea and follow it through. This does not mean you have to be a genius, just that you need to apply yourself to an issue or problem and spend conscious or even unconscious or subconscious time ruminating positively on a solution. In the health service, nurses and other health professionals do this constantly, often with problems that they or their colleagues have encountered before. The application of creativity is why we are not still using scarification or blood-letting techniques for the treatment of, well, practically everything, and why new and enlightened approaches are being suggested for how we deliver health services across the globe.

De Bono (2015) suggests that the sources of creativity are the following:

- **Innocence** – like that of a child, so that if you do not know the usual approach, or the way things are 'normally' done, then you might have the advantage of 'fresh' eyes on the problem.
- **Experience** – the opposite of innocence and dependent on some people knowing because they have been there before, so they know what might work and what might not.
- **Motivation** – having the willingness to focus and look for novel solutions.
- **Tuned judgement** – recognising the potential of an idea at an early stage.
- **Chance, accident, mistake and madness** – history is full of advances that were not planned or even imagined, but happened because luck or misadventure played a part.
- **Style** – while not always generating new ideas, styles lead to creativity within existing approaches.
- **Release** – where the brain or person is freed to engage their creative options.
- **Lateral thinking** – the use of creative thinking techniques specifically and deliberately to focus the mind on being creative.

Here is a selection of statements that people have made about creativity to elaborate on these concepts further:

> We are what we repeatedly do. Excellence then, is not an act, but a habit.
>
> *(Aristotle)*

> An idea can turn to dust or magic, depending on the talent that rubs against it.
>
> *(Bill Bernbach)*

> Imagination rules the world.
>
> *(Napoleon Bonaparte)*

> Blessed are the flexible, for they shall not be bent out of shape.
>
> *(Anonymous)*

> This telephone has too many shortcomings to be seriously considered as a means of communication. The device is inherently of no value to us.
>
> *(Western Union internal memo, 1876)*

> There is no failure, except in no longer trying: no defeat, except from within; no insurmountable barrier, except our own inherent weakness of purpose.
>
> *(Elbert Green Hubbard)*

> The analysis of data will not by itself produce new ideas.
>
> *(Edward de Bono)*

> Live and work, but do not forget to play, to have fun in life and really enjoy it.
>
> *(Eileen Caddy)*

> We have to understand that the world can only be grasped by action, not by contemplation. The hand is more important than the eye … the hand is the cutting edge of the mind.
>
> *(Jacob Bronowski)*

> The essential conditions of everything you do must be choice, love and passion.
>
> *(Nadia Boulanger)*

Building Creative Capacity

Nurses and health professionals are commonly not perceived as possessing creative thinking skills or as being creative. In the past, as a nurse educator, I have had occasion to express myself creatively and the most frequent response to these occasions has been: ‘Why are you still a nurse, why not do something that allows for fuller creative expression?’ I have always been satisfied with the capacity of nursing to allow me to be creative and believe that nurses and other health professionals are indeed creative, expressing their creativity every day in each and every healthcare environment. For example, the occupational therapist who employs a new moulding technique to make a physical aid or the physiotherapist who develops a new patient record system are both acts of creativity. Or it could be a play therapist who notices that a toy can be creatively used to encourage a child to develop strength in their upper body as they play. All these types of interaction offer evidence that creativity and innovation have a place in clinical practice in the hands of clinical leaders.

However, I accept that many health professionals and nurses may not see how creativity can be developed or applied to their work environment. Enhancing your creative, innovative or critical thinking skills is not a one-off activity and it requires attention over the course of your career.

Techniques for Developing Creativity

The following activities or suggestions offer practical advice and a range of skills that can be used to foster greater creative capacity.

Relax

Listen to music (I find the classics particularly relaxing). Sit on the lawn in the sunshine. Take a walk, do some meditation, ride a bike, swim or have a spa. These activities allow you to take time for yourself and unwind, enabling your subconscious to take you out of yourself. Establish a ‘work/life’ balance that you are happy with.

Keep a Notebook or Journal

I have a small notebook with me all the time. In it I write ideas and notes about significant events. Some I transfer into more elaborate reflections in my professional portfolio. Most remain just notes made from day to day. I don't keep a diary, although this might do as well. I record thoughts, ideas, observations and wonderful quotes I come across or I write affirmations. Some authors recommend that you use different colours to emphasise parts of your notes and make the notebook or journal your constant companion. I use underlines or bold print to highlight different parts of my notes.

Journaling

This is more specific than just keeping a journal. Here you need to wake up each morning and write a few pages about anything. Typically it will be about the events of the previous day, but it could include dreams, ideas, thoughts, problems, solutions, needs or things to be thankful for. You may have to get up earlier than usual, but you will develop a deep insight into many areas of your thoughts and creative talents.

Record Your Ideas

Your brain is always working. The trick is to keep up with it and capture what it is thinking about. As well as a notebook or a journal, you can use cartoons, drawings, mind maps, index cards, a range of coloured pens or pencils, whiteboards, jotter pads or even a tape recorder. A laptop or tablet computer (particularly if marketed for audio and visual media such as books) now offers all these tools in a portable and readily accessible format, boosting the capacity to record ideas and thoughts easily. Take care with online social networking websites, though. You can record these thoughts on one of these, but everyone can see what you write, and someone might either react negatively or take your idea further without your consent.

Do or Learn Something New Each Day

Maybe there is no need to do one new thing absolutely every day, but the idea is to stimulate your creativity by learning or doing something different, something you might not have ever considered before or something you have wanted to do for a long time. Learn a new language, learn to parachute, learn new clinical skills. Take a course in history. Develop an interest in gardening or cooking or massage.

Learn to Draw

There are courses and books about drawing skills and what is wonderful about drawing is that it uses the right side of your brain (the creative side). Learning to draw helps you grow your creative brain. It also helps you learn about perspective, light and shade and might help you meet new people.

Become a Cartoonist

Cartoonists see the world from a unique perspective, yet they can encapsulate simple humour, satire, political commentary and a wide range of other perspectives in their work. Cartoons appeal to the right side of the brain and Mukerjea (1997) refers to them as 'ideavisuals', where the imagery used bolsters the viewers' understanding because our eyes take in more detail than our other senses. Like drawing, cartooning can allow creative expression that ranges from doodling to carefully crafted and detailed images.

Learn to Map Your Mind

Mind maps are great tools to help you capture a concept or develop an idea. Use coloured pens, large sheets of paper or online programs and even as you start the process you are being creative.

You can develop your own style with icons, symbols, lines, links and space supporting your developing insights into a particular topic.

Try Associational Thinking

This is like mind mapping. You can use stories (your own and other people's) to compare your thoughts on a particular topic. Again, the technique uses a large sheet of paper, a trigger word and links that join your thoughts about the word. You can ask others (friends or colleagues) to do the same and then compare how each person thought about the same topic.

Go for a Walk

If you are stuck with a problem, take it for a walk, work in the garden, wash the dishes or go for a drive in the country. Change your space and ideas sometimes flow. Even if they do not, the fresh air and exercise are good for you and your brain.

Adopt a Genius

There are people we recognise as having been gifted and creative, such as Leonardo da Vinci, Abraham Lincoln, T. S. Eliot, Andrew Lloyd Webber or Albert Einstein. Why not read about them, or look into their lives for clues about creative thinking?

Open a Dictionary

Sometimes if you are stuck for an idea, just open a dictionary and random words may stimulate some creative thoughts. In a way, the point is to restrict or direct your thinking, and while some people may feel that it is 'freedom' that stimulates creativity, a disciplined mind may also embrace restrictions to guide the creative process and help it to flow.

Study Books About Creative Thinking

Do not stop at this chapter. There is a fascinating range of books and web pages about creativity that will be a great support in developing your creative abilities. Edward de Bono's books are especially wonderful.

Flood Yourself with Information

Choose an area of interest and immerse yourself in it. Attend to this new interest fully so that you become completely respectful of the new topic or subject. Respond to your own needs to learn and feed yourself with knowledge. The internet makes this task much more accessible.

Attend Courses

You could do a course in anything you want to learn, but I am specifically recommending developing your creative potential. Creativity needs feeding and the best food is the diversity of human life. If all you do is work, you will become dulled and blunt. Attending a course is an extension of the idea that you should be active and involved, opening doors for your mind.

Listen to Baroque Music

Wolff (2009) suggests that baroque music synchronises brain waves to about 60 cycles per second and it produces a relaxed alpha state, which is frequently associated with creativity.

Face a New Fear Every Day

This is about being challenged. It may not be every day, but facing challenges is a great way to help create solutions. If you are worried about riding a motorbike, is it because you are afraid, you have

seen the consequences of accidents in A&E or because your mother, husband or partner said you cannot? Maybe there are other solutions to facing this fear. Perhaps your fear is of swimming, or rock climbing or spiders. If fear is stopping you having a full and happy life, then finding a creative solution to it would be an excellent approach to developing more creative skills.

Develop Your Imagination

A great way to enhance your creative capacity is to foster a deep and active imagination. There are a number of ways to do this in a positive and healthy way. Here is a list of a few recommendations:

- Travel is a fabulous way to refresh your outlook and widen your tolerance and horizons. Travel also fosters greater self-reliance, so that you become more dependent on your own capacity to think, solve problems and generate new ideas.
- Develop personal contacts and associate yourself with creative people, fun people with a sense of humour and interesting views and those who stimulate your mind.
- Learn from children. A child's world is full of fun, games, fantasy and play and interacting with children is a great way to get in touch with your own imagination.
- Play games and do puzzles to get to grips with your creative side. Not everyone likes games and often you need to find a partner to play one. Puzzles are better if you can only try these activities alone. Both challenge your strategic skills, communication skills and creative talents. Sport can offer the same rewards, but is not everyone's cup of tea.
- Take up a new hobby of the hundreds you could consider. Any hobby will help get your creative juices flowing. Many new hobbies can be undertaken from home and on the computer, so that expense, or time, or having to stand on a train platform for hours can no longer be offered as a valid excuse for not having a go.
- Read more, of anything. I find time to get through a book or so a week and while there are some genres I do not enjoy reading, I do like to have a go at a range of different books to see what I can learn, or just to escape for a while. If you are time poor, listen to a 'talking' or audio book.
- Write something. This is not for everyone, but putting pen to paper or finger to keyboard can be a very creative and stimulating activity and a wonderful outlet for your imagination.
- Learn to recognise your own abilities. Understand and acknowledge that you are a creative person. Remember that your imagination is there to be activated and developed. While you may need to nurture these skills, they exist and you do not need permission, just opportunity.

Leave Things Alone for a While

It may be that the best thing to do is just put the problem down and walk away for a while. Getting away can offer a fresh perspective or allow you to 'sleep on it' – as long as you remember to come back!

Find a Creative Space

When singer songwriter Joni Mitchell needed to create music, she retired to a cabin in a remote part of Canada. Other creative types use similar approaches, taking themselves away from distractions and into environments that foster and feed their creative spirit. In the film *Love Actually*, a writer, played by Colin Firth, took himself off to Portugal and a rented cottage. Maybe this is a bit extreme, but the idea of a place or space where you can escape and think is a sound one. It might be why some men have sheds. You could try to develop a creative space too. The core of this idea is to create a sensory, stimulating environment.

Develop Your Sense of Humour

Having a creative bent means having a sense of fun and developing skills in, and an appreciation for, humour. Sometimes we need to see the funny side of things to allow the emergence of a new perspective about an issue we may have become too close to. De Bono (1985) describes humour as the most significant behaviour of the human mind, because it employs a different form of logic. Humour can therefore liberate our thinking and allow us to take different paths in our thinking journey, leading to greater creativity.

Define Your Problem

Know the problem you face. Often people struggle to find solutions because they have not taken time to define or name their problem. Once this is done, you might find that ideas come more freely. Brainstorming or mind mapping may be a useful tool to start this process.

Know Yourself Well

To a large degree, becoming more creative means being able to learn to listen to your inner voice or intuitive side. If you are not in tune with your inner monologue, then you may miss creative opportunities because your personality or beliefs might shield you from possible solutions or insights. The key here is to know yourself well.

Use Guided Reflection

This is reflection (see Chapter 14) with the use of a diary or notebook, or even the use of a mentor or guide, to support, direct or channel your thoughts and positive ideas.

Be Mindful

Mindfulness is about engaging in the 'now' and focusing on ways to open your mind to greater choices and possibilities (Goldstein 2014).

Focus

De Bono (2015, p. 149) suggests that 'simple focus' can be a powerful creative tool, as it allows you really to consider the issues you are hoping to be creative about. Goleman (2013) also describes focus as the hidden driver of excellence.

Do not be Afraid to Fail

Failure is likely in any endeavour, but even failure can lead to new positive insights and fresh possibilities. As mentioned earlier, there is no failure except in no longer trying. So even if the goal of becoming more creative takes time, attempting and failing is really only a way of finding other paths to your goal.

Develop Some Techniques for Creative Thinking

This might involve setting a measurable goal to a problem that requires a solution (e.g. streamlining the discharge process in the minor injury unit in which you work). The next step would involve establishing criteria related to reaching this goal, then gathering information that will help develop your creative response. You might want to read books, go to conferences, speak to other people, access networks, or search the Internet or library resources. Once you have formulated some ideas, sound other people out about them and prepare yourself for the potential risk that you may be about to take. Celebrate your success and start thinking of yourself as a creative person.

Table 9.1 Techniques for creative thinking.

Assumption smashing	Fuzzy thinking	Six thinking hats
Random input	Breakthrough thinking	Problem reversal
Attribute listing	LARC method	Ask questions
Storyboarding	Idea 'toons'	Imitation
Lotus blossom technique	Metaphorical thinking	Applied imagination
Roger Olsen's DO IT! method	Morphological analysis	Unconscious problem solving
Neuro-linguistic programming	Forced relationship	Visual thinking
Brainstorming	Discontinuity principle	Checklists

Table 9.1 lists some of the other techniques that can be used to promote creative thinking, and there are many others. Like tools in the tool shed, these techniques can be used individually or collectively to bolster an individual or a group's collective creativity. The Internet offers the greatest range of these ideas, and you can access a vast number by simply going to a search engine and entering "Techniques for creative thinking". I came across a wide number in preparing this chapter; some I could recognise, many were a mystery, but most looked like they were worth considering or using in a number of situations.

Reflection Point
Access the Internet and see if you can find reference to five of the 'techniques for creative thinking' listed in Table 9.1. Once you have done so, try them out. See if you can use them or if they help with a particular problem. Then, reflect on the value or otherwise of these techniques.

Barriers to Creativity

A number of barriers can hamper and hinder creativity. Evans (1993) suggests that we all carry with us culturally produced barriers to creativity. Many relate to our work or home environment or to the organisational structure; however, the main barriers are within the individual as a result of their cultural development.

Organisational Barriers

Competition

In the work environment competition can hinder creativity if people focus more on their own advancement and share fewer ideas. There is a myth, particularly in finance and high-tech industries, that internal competition promotes innovation (Breen 2004). What was evident from Breen's (2004) research was that this belief can hinder productivity, research output or creative suggestions, as colleagues – who perceive themselves to be in competition for research funding or promotion – become less willing to share ideas, time or resources for fear of missing an opportunity or helping a colleague to advance over them. Sharma (2010) adds that if the workplace is not risk free, creativity will be hindered. If people feel they have something to lose, their creativity will be stifled.

Organisational Structure

Organisations that favour hierarchical structures over more democratic or meritocratic structures tend to support less creative endeavour. In hierarchical organisations people feel that it is often up to those at the top to come up with the ideas, or they may have had ideas only to have had them taken by those above them as their own. Reward in these organisations is in the hierarchical climb and less in the joy of solving or addressing problems. Organisational restructuring is also counter-productive if creativity is to be fostered. When organisations downsize creativity suffers (Breen 2004) and there can be residual effects on employee creativity for up to five months after the restructuring. Restructuring can be essential in times of economic hardship, but the impact on creativity can be negative, diminishing communication and collaboration (Breen 2004).

Being Too Busy to Address a Problem

Often employees are kept so occupied that there is no time for them to have ideas or express these formally. Nurses working on a busy medical ward may recognise a solution to a problem, but be so caught up in their survival of the shift that the solution remains unvoiced and so unheard. Breen (2004) suggests that there is a myth that time pressure fuels creativity; however, the research demonstrated that when people work under great pressure their creativity went down – not only on that day, but remaining low for the next two days as well.

Too Hectic an Environment

Like being too busy, this implies that there is no time to stop and reflect, no place or time to have a 'quiet moment' and become introspective or to focus. It is often only on such occasions that solutions and ideas can germinate.

A Sterile Environment

I know operating theatres are meant to be like this, but this barrier allows no stimulation in the work environment to foster creativity and free thinking, such as whiteboards for mind maps or thinking exercises, places to relax, dream or contemplate, colour, variety, space, comfortable seats and places to talk. A sterile environment produces sterile thinking and stifles creativity. In the 1930s Walt Disney commissioned and designed a new studio to house the increasing workforce at his company, but many of the older employees suggested that the new, specifically designed studio had lost the 'soul' of the original workplace and as a result creativity was diminished for a time. Sharma (2010, p. 236) suggests that setting up a 'contest committee' can help energise an organisation or department. This committee's role is to dream up all sorts of play and fun activities to help people laugh and smile and grow (and become more productive) while at work. This approach may motivate staff, improve communication and increase job satisfaction. The team, department or company that plays together stays together, and grows (Sharma 2010).

Poor or Harsh Feedback

People like to know that they are doing well. If they are not, telling them that in front of patients or other staff, or in a harsh way, will not foster their creative input. It may lead to very negative consequences for how they see or value themselves, or for the productivity and harmony of their work environment.

Rules

Rules are often essential for reasons of safety, to support economic constraints and to maintain order and production. Nevertheless, they can be a limiting factor if they are applied illogically, inhumanely or unfairly. Rules are great guides, but apart from some natural laws of nature, social rules that govern

behaviour and other structures of the workplace may actually prevent staff from gathering information, meeting others or finding opportunities to develop. In the day-to-day running of an organisation this can lead to bureaucratic constraints and the proliferation of task forces, committees or think tanks with no power to act (Klein 1990). Rules or 'sacred cows' have had to be broken or slain for any sort of progress in almost every field of endeavour, and leaders have been pivotal to these occurrences (von Oech 1990).

Unrealistic Production Demands

As with being too busy personally or organisationally, if people are required to meet unrealistic targets and feel under pressure to perform at work, then stress and dissatisfaction can result, having a negative impact on creativity.

The Boss is Always Right

If the 'boss', ward manager, team leader or head of department signals that they know they are always right and should not be challenged, this will hinder people's willingness to approach them with other and better ways of working or solutions to the problems of the area. Even the most creative people will not put their jobs at risk by challenging a boss who has an autocratic attitude (Klein 1990).

Poor Communication

When communication is open and information is shared effectively, teams and individuals are permitted to take risks and team work, creativity, innovation and empowerment result (Vogelsmeier & Scott-Cawiezell 2009).

Personal Barriers

Fear of Criticism

If we do not have an idea or take a risk, then no one will have a reason to be critical. When Breen (2004) studied the impact of fear on creativity, he initially set out to test the hypothesis that fear, sadness and depression fostered creativity, as some psychological literature had suggested. Breen found, though, that creativity was more positively associated with joy and love and negatively associated with anger, fear and anxiety.

Our Belief that we are Not Creative

Many people see creativity residing in the domain of the creative arts, musicians and other people specifically assigned a creative role in society. They fail to recognise that creativity can be part of any occupation or job. In turn, this may lead to the belief that we are not, or do not need to be, creative.

Fear of Change

Being creative may imply that we are not happy with what we have or that we want things to change. Change can be a difficult thing to deal with, and being the instigator of change may compound the risks and threats. Initiating an idea brings with it responsibility and risk and for many people this alone is enough to keep them from creativity's fire.

Ego

Having a powerful ego or identity can stop us from accepting new ideas or lead to us expressing our own ideas forcefully, to the point where people may even be threatened, less by the proposal and more by the style used to communicate it. Our ego, linked to our beliefs, may lead to an aggressive

defence of our ideas and this can hold us back from finding creative new ways to see where we might relate to the rest of the world.

Beliefs

Beliefs can act in the same way as routines, if they become so entrenched that they cannot be challenged or reviewed. Our beliefs act like a filter for how we respond to information, gather data, perceive the world and process information. Like routines, holding fast to our beliefs can lead us to a personal reality tunnel that keeps us from seeing what else may be about us and from understanding 'reality' in new ways.

Lack of Confidence

Some people may simply not feel confident enough about their place in an organisation to speak up, or they may lack sufficient faith in their talents to take the risk of putting them on display. They may have tried before, or may never have spoken up or taken the time to explore a new idea fully. People who lack confidence may find that their creativity is stifled because they are trapped by fear and lack the capacity to take a risk.

Stress

It is very difficult to be creative when we are stressed. Our mind is tied up with negative feelings or bound by the energy it takes simply to cope with the stress.

Previous Negative Experiences with Risk

If we have had negative experiences when we have attempted to be creative, it is not unreasonable to see that taking a further risk may require great courage. Overcoming negative emotions or simply gathering the courage to reapply your mind to the creative act can be a serious barrier.

Negative Self-Talk

Stress, previous negative experiences and a lack of confidence can all result in negative self-talk. Negative thoughts can lead us into false or hopeless traps, reinforcing our self-limiting belief that 'we are no good', 'our ideas are not right for the problem' or 'why would anyone listen to me?' Before the idea is expressed it is defeated by our mind's own limitation on ourselves – possibly the saddest of all barriers.

Routines

Having a set way of performing a task or job can lead to us becoming too entrenched in a way of life, a way of work or a way of thinking. This approach will limit the responses we can employ when faced with new problems and can result in a bureaucratic response to problems, in our personal and work life. Routines create the chains of habit that are too weak to be felt, until they are too strong to be broken. Being creative in these circumstances becomes very difficult.

Other Barriers

Daily Distractions

Being creative requires space for our brain to think, reflect, focus and mull over ideas without distractions and interruptions. Yet the modern world is overwhelmed with sounds, motion, activity and visual stimulation. Television, radio, the press, magazines, movies and even advertising on billboards as we drive to work – or that pop up on our computer screen – never leave us with a minute's

peace. The main issue that stifles creativity in the modern world is television. Creativity and television rarely match. Routine activities also have a negative impact on creativity; childcare, school runs and housework can all sap our creative spirit, if we allow them to.

Not Having a Place to go or Time to Get There

Many people lack a special thinking place or a hobby where we can think as we 'do'. Alternatively, they may not have a relaxing habit like fishing that allows us to reflect and think while we sit or stand in silent contemplation.

Drugs

Some 'creative' people see drugs (legal and illegal) as essential, but they rarely support significant creative developments. Medication of any kind is not helpful in this context.

Reflection Point
Look around *your work or home environment. What do you recognise as barriers to creativity? There may be none. If there are* any, list them and, using the information in this chapter, see if you can make a list of potential barrier-busting i*nterventions to help promote your creative output. Reflect for a moment on your relationship with creativity*. Is it the environment or you? Do you feel the need to refrain from creativity in your home or work life? Are you the barrier?

Leadership and Creativity

There are two take-home messages from this chapter. One is that to be an effective leader it may be necessary to possess a highly developed creative streak. This is not always the case and interestingly, in the clinical leadership research that underpins the theory of congruent leadership, creativity was not rated highly as a clinical leadership attribute (Stanley 2006, 2008; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer, & Atkinson 2014; Stanley, Hutton & McDonald 2015). Indeed, clinical leaders were commonly not followed because of their creativity. This does not mean that they were not creative or did not offer creative solutions to the problems they faced, just that their creativity was not the reason or attribute that others used to identify them as a clinical leader. Nevertheless, this was not the case with Cook's (2001) research, in which clinical leaders were indeed identified as being 'shapers' who employed creativity in the fulfilment of their role.

The other message is that effective clinical leaders may be people who can recognise, stimulate, motivate or direct the creative energies of the people they lead, supporting them to contribute creative ideas and solutions that foster better client care, more effective processes or new and better ways of doing things (Price 2006). The key to this rests in clinical leaders' ability to use their communication and information-sharing skills to create a cohesive and empowered team (Reiter-Palmon & Illies 2004; Price 2006; Vogelsmeier & Scott-Cawiezell 2009). Clinical leaders may generate creative solutions of their own or support others to voice or develop creative contributions. However, if innovation and change are to develop, or if new and better healthcare is to evolve, it will only come from health professionals who are courageous or bold enough to speak out or propose their new ideas (Gentile 2010), or if clinicians have the support and encouragement of clinical leaders to foster others' innovations.

There are two reasons why clinical leaders should foster creativity: it helps prevent obsolescence, and it promotes productivity and innovation (Klemm 1990; Price 2006; de Bono 2015). Organisations where creativity is rewarded and where new ideas are supported grow and develop, thrive and survive far more effectively than organisations that suppress creativity and reward people for maintaining the status quo (Klemm 1990; Reiter-Palmon & Illies 2004; Hall 2005; de Bono 2015). We see creativity being rewarded in industries such as information technology or the arts, and in possibly the best-known Internet search engine, which is a great example of an organisation that thrives on the back of its creative and innovative drive.

Although healthcare or the healthcare industry is commonly not perceived in the same way, it is in fact no different. As Sharma (2010, p. 242) states, 'every human being is creative'. The role of the clinical leader is to foster a workplace or clinical environment that liberates and supports the expression of creativity. Price (2006, p. 54) is also clear that innovation is more likely to be successfully implemented in practice when the leader is 'clear about what they are doing and what they hope to achieve'. While the clinical leadership research results at the core of this book do not agree with Cook's (2001) findings, intuitively it makes sense for clinical leaders – who are at the forefront of client care – to be involved in the development of new and innovative ways to develop care practices or to support clinicians who have the ideas. Klemm (1990, p. 449) agrees, suggesting that leaders know 'in their gut' that creativity and innovation are the lifeblood of their organisation. It may be that this is not the reason clinical leaders are followed, but don't let that stop you. Brainstorm away!

Case Study 9.1

Jane Austen was a leader with creativity, an elegant, witty and important female novelist. Her works of romantic, comedic fiction marked a shift in English literature away from the neo-classical style. Consider the description of her life and read the challenge that follows.

Female Leaders: Jane Austen

Jane was born in Steventon in Hampshire in 1775, the seventh of eight children. She was educated by her Reverend father who acted as a tutor to his children and other children of the district. However, in 1783 Jane and Cassandra, her older sister, were sent to Oxford to be taught by a Mrs Ann Cawley. Here both girls caught typhus and Jane nearly died. The pair were inseparable almost throughout their lives and they spent much of their childhood happily writing and performing plays and charades. Their father had a rich library and Jane read widely and was encouraged to write from an early age. At the age of 14 she wrote her first novel, 'Love and Freindship' [sic]. This was followed by 'A History of England by a Partial, Prejudiced and Ignorant Historian' (with 13 illustrations by Cassandra), but Jane was in her 20s when she penned the first drafts of her novels Sense and Sensibility, Pride and Prejudice and Northanger Abbey. As a young woman Jane enjoyed long country walks, attended church regularly, socialised frequently, supervised the family servants, made clothes and attended balls with local gentry. Between 1793 and 1795 she wrote Lady Susan, a short epistolary novel, described as her most ambitious and sophisticated early work.

She had many friends in Hampshire and it was a shock when the family moved to Bath in 1801. The Reverend Austen moved there to retire, but he died in 1805 and Jane, her sister and their mother had to rely on their brother's support to survive. It was also during this time that Jane fell in love, but the young

man died and she was heartbroken. Soon after she accepted a proposal of marriage from a wealthy landowner, Harris Bigg-Wither, but she changed her mind the next day, leading to considerable upset for her family and friends. Jane, like her sister Cassandra, was never to marry.

After 1805, Jane, her sister and their mother moved to Southampton, where Jane found herself unable to write. To some extent their fortunes changed for the better in 1809 when her brother Edward provided a small but suitable residence on his estate at Chawton in Hampshire. This cottage offered the stability Jane sought and she revised *Sense and Sensibility* and *Pride and Prejudice* to the point where they were able to be published in 1811 and 1813 respectively. At Chawton cottage Jane found time to focus on her writing, since her mother and Cassandra took a larger share of the domestic duties. The Austens socialised little apart from some teaching for local children or charity work among the poor of the estate, so their lives were commonly described by their relatives as 'quiet'.

In 1814 Jane wrote and published Mansfield Park, while *Emma* followed in 1816. She also worked on *Persuasion* and a redraft of *Northanger Abbey*, which were both published posthumously in 1818. She began work on *Sanditon*, but became ill before it could be completed. She died in 1817, with none of the books published in her lifetime bearing her name; instead, they were described as written 'By a lady'.

It is thought that Jane died from Addison's disease (although bovine tuberculosis is also suggested as the cause) and during her illness – as with the rest of her life – her sister Cassandra was never far from her side. In 1817 they moved together to Winchester to be near Jane's doctor and it was in her sister's arms that Jane died in July, aged 41. She was buried in Winchester Cathedral.

Much of Jane's correspondence is missing and most of what is known about her comes from potentially biased family sources. Nevertheless, her literary works remain a vivid reminder of the contribution of women to the artistic world. Jane Austen was little regarded during her lifetime due to her decision to publish her works anonymously, and it took almost 50 years after her death for a popular appreciation of her work to take hold. However, she has since been recognised as a powerful author, achieving belated critical acclaim.

Challenge: Jane Austen's books are some of the most read and most beloved in English literature. They capture a piece of history, offering a critical commentary on the social practices of the period and with realism that brings the books to life. Her works focus on moral issues and women's dependence on marriage to secure social and financial security. Jane lived her entire life as part of a small, close-knit family unit, often facing financial insecurity, and it was not until she was in her mid-30s that she experienced success as a published author. Her books were out of print for a number of years after her death, but in 1832 her novels were republished as an illustrated set and they have remained in print ever since. Jane kept her *writing* talent hidden *by* choosing to remain anonymous. It is possible that many health professionals do the same for different reasons. Is creativity, seeking new ways, finding new paths or being innovative valued in everyday clinical practice? Have you had a great idea about improving care or changing practice, but kept it to yourself or been dissuaded or discouraged from taking the idea forward? Why was this? How could you have managed the situation differently? As a leader, how can you draw good ideas from your colleagues in a way that supports and encourages them to feel safe and supported to contribute? Have you ever had a great idea? *Have you t*hought of a new way to care for a particular client group or a new type of documentation that saved time or captured the right information in the right way? What was it? What did you do about it? Write a short reflection about your experiences of generating a new idea, positive or negative. What would you do differently if you had a similar idea in the future?

Summary

- Leadership and creativity are clearly linked.
- Developing creativity requires the application of the creative process, which includes being prepared, allowing ideas to incubate, illuminating the ideas and verification of ideas with their application.
- There are many ways to foster creativity. These include relaxing, keeping a notebook or journal, journaling, learning new skills, drawing, using mind maps, walking, looking at others' creative output, using a dictionary, studying creative thinking skills and attending courses, using associational thinking, facing your fears, grasping information, developing and releasing your imagination, recording your ideas, finding or making a creative space, developing a sense of humour, cartooning, defining the problem at hand, getting to know yourself well, not being afraid, using guided reflection and actively developing some creative thinking skills.
- There are many barriers that prevent the development or application of creativity. These include barriers at work such as competition, organisational structure, being too busy and a sterile environment. There are also personal barriers, which include fear of criticism, fear of change, lack of confidence and routines.
- There are often barriers to the development of creativity in our daily lives too. These include daily distractions like television, having no time or place to reflect or the inappropriate use of drugs.
- Clinical leaders are not often identified as such because of their creativity. Yet this does not mean that they are not creative or that creativity is not a highly valuable trait for clinical leaders to have.
- Clinical leaders can also be effective at facilitating or recognising creativity in others and helping them to develop their skills and talents to further promote change and innovation.

Mind Press-ups

Exercise 9.1

Look at something as if you were a child: a policy, a relationship or a problem. Ask yourself 'What does this look like to me?' or 'What does this make me think of?' Try to consider the questions from a child's perspective.

Exercise 9.2

How do you find time to focus, to be mindful, to be present and deal creatively with the problems you face? Try looking now at one problem. Write it down. Give some time to considering it. Focus on it and really make finding a solution a priority.

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10

Team Working

David Stanley

Hail, ye indomitable heroes, hail!
Despite of all your generals ye prevail.
Walter Savage Landor, English writer and poet, 1775–1864, in 'The Crimean Heroes'

Introduction: Effective Teams

To some extent considering clinical leadership implies attention to the power of one: to the self, to your values and beliefs. Aspects of clinical leadership such as motivation, conflict resolution, clinical decision making, innovation and managing change imply a need for the leader to gain personal insight and a grasp of their own values and beliefs, strengths and weaknesses. However, team work relates to the power of many: to the leader's capacity to recognise the strengths and limitations of those about them, and even to recognise that the team members do not have to possess all the faculties that make a team effective. However, a leader should know how to develop, build or maintain effective teams, even interdisciplinary teams (Nancarrow et al. 2013), so that the team can support and achieve change and facilitate improvements in quality.

In modern healthcare environments an ideal organisation is made up of cohesive teams in which people pool their skills, talents and knowledge to address complex problems and come up with creative solutions. Effective teams are able to develop a unified purpose and cohesive ethos, so that the barriers they face are few or easily overcome, resulting in consistently high-quality work. Team work promotes a sense of shared responsibility and rewards (Nancarrow et al. 2013; Frandsen 2014; Cantwell 2015) and from the perspective of a physiotherapist working in the multi-professional realm of an emergency department it is seen as paramount (Kilner & Sheppard 2010).

The earlier description outlines the ideal team, but the reality is that teams are almost universally hard to make work well (Lencioni 2002). If the leadership is poor, it may be that the only team work is in a shared sense of dissatisfaction as disgruntled workers pull together against ineffective management or weak leadership (Cantwell 2015). In many cases, teams may have the public face of cohesion, but if you scratch the surface, explore them further or put them under a little pressure, they stretch to breaking point. You may even find that people within them are unsupportive, uncooperative, in competition, have personal grudges, are in open conflict or fight 'turf wars'. As a result,

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talented, skilled people, frustrated by the limitations of a poorly performing team, fail to deliver their best work.

> How is it that every snowflake is different from the others, yet they can work so effectively as a team when it comes to stopping trains and disrupting transport? (Anonymous)

Team working is very, very hard to get right. Nevertheless, although it is difficult, team working remains one of the best ways to organise people and tasks (Lencioni 2002; Pedler, Burgoyne & Boydell 2004; Kalisch, Lee & Rochman 2010; Marlow et al. 2016). Borrill et al. (2000, p. 371) take this further and claim that 'good team work can make a critical contribution to effectiveness and innovation in health care delivery, and contributes to team members' well-being'. This view is supported by Falcone et al. (2008), Capella et al. (2010), Deering, Johnston and Colacchio (2011), Siassakos et al. (2011) and Steinemann et al. (2011), who found that it was demonstrated following the introduction of general team-work training, or specific team-work training for multidisciplinary simulation with early trauma interventions. Guise and Segel (2008), writing from an obstetric perspective, take the case for effective team work further by claiming that failures in team working may account for over 70% of sentinel events.

The ability to work in teams is highly prized as a valuable organisational asset and team working feels right because this is what we have grown up with in our educational systems, sports clubs and early life experiences. Indeed, it is a feature of our deep history, with teams used in hunting and conflict representing our cultural development for millennia.

Effective team working is also identified as a requirement for enhanced clinical outcomes (Leggat 2007; Lyons & Popejoy 2014). Recognising the need for team-working skills is particularly important in an organisation like the modern healthcare environment, where 'customer' service is important (Handy 1999) and where interdisciplinary team working is front and centre (Nancarrow et al. 2013). This is because often teams can make the best local decisions and are becoming largely self-managing (Elloy 2008). Organisations where teams work well have a common purpose, and a culture of trust, support, interdependence and collaboration.

Therefore, while in general teams are hard to get right, great things can come from them and they are beneficial to the organisation if they are well supported, and if the organisation recognises their value and invests in them. This chapter looks at what a team is and why it is different from a group. It also considers how to build and manage effective teams, and considers the value of support and challenge in helping teams work well.

Healthcare Teams

Over 20 years ago the World Health Organization (WHO) attempted to define healthcare teams and captured the epitome of such a team's goal in the title of a report: *Learning Together to Work Together for Health* (WHO 1988, p. 6). WHO defined a healthcare team and teamwork in the following way:

> **Health team:** A group of people who share a common health goal and common objectives, determined by common needs, to the achievement of which each member of the team contributes, in accordance with his or her competence and skill, and in coordination with the functions of others. The manner and degree of such cooperation will vary and has to be determined by each society according to its own needs and resources. There can be no universally applicable composition of the health team.

A number of observations can be made about this definition, but two elements are conspicuous. First, the definition seems to attempt to provide a non-achievable standard. Even placed in the context of the 'Health for all by the year 2000' (WHO 1978) objective and the culture of healthcare at that time, it is reasonable to assume that some of the idealism associated with the Declaration of Alma-Ata (WHO 1978) was still alive and well 10 years later, and that this contributed to the production of the definition. The definition also makes it clear that there is no one way to define a healthcare team, alluding to the goal of creating greater interprofessional interaction within such a team.

Stanton and Chapman (2010) add that teams achieve through interdependent collaboration, open communication and shared decision making and that the notion of working in teams within healthcare instinctively feels good, particularly so in relation to a multidisciplinary and patient-focused context.

These definitions do not indicate that getting team work right can be difficult, or that being a member of a team is hard work, as all too frequently individuals are not supported, coordinated, cooperative, open, honest or collegial. However, if teams are so difficult to get right, do we really need them?

Do We Really Need Teams?

This seems like an odd question given the introduction to this chapter, but sometimes teams are developed to address problems that they are not suited to solve. There are many tasks that can be done either through good allocation of work to individuals or by a group working more or less cooperatively (Lessard, Morin & Sylvain 2008). Before the decision is taken to establish a team, consider the degree of complexity of the work and the extent to which a group is required to work cooperatively.

Teams are not really needed if the task relates to a simple exchange of information, or if it involves simply sharing out work, updating each other and/or making simple operational decisions. These interactions relate mainly to reference and consultation groups with low levels of interaction, requiring only clear lines of communication (Lessard, Morin & Sylvain 2008).

Teams are needed if the work is uncertain, difficult and complex, or where a high degree of collaboration and interdependence is required (Casey 1993). Lessard, Morin and Sylvain (2008) refer to these types of teams as 'coordination' or 'collaboration' teams, citing the need for harmonisation, interdependence and shared decision making (Figure 10.1).

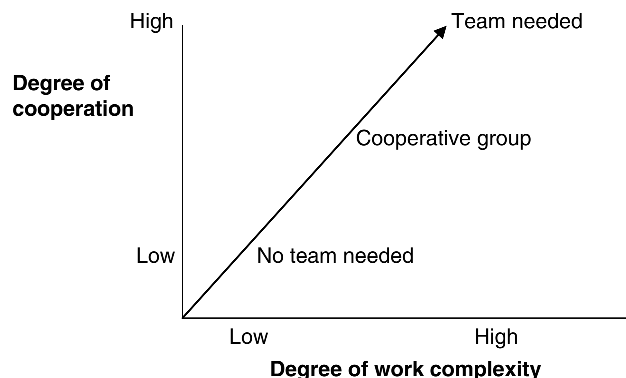

Figure 10.1 Cooperation and complexity in team work. *Source*: Pedler, M, Burgoyne, J, & Boydell, T, *A manager's guide to leadership*, © 2004. Reproduced with the kind permission of The McGraw-Hill Companies. All rights reserved.

Teams and Groups

A **group** is defined as a number of individuals assembled together or having some unifying relationship (e.g. members of a church, or all the people in a cohort of students). These are groups because all the various members are related in some way because of their involvement in a certain endeavour.

A **team** is described as a number of people associated together in specific work or a particular activity. Parker (1990) indicates that a group is not a team and that a team is based on a highly interdependent set of people that:

- have defined goals and objectives (Markiewicz & West 2011)
- have an ongoing relationship
- are focused on accomplishing a task

Added to this is the idea that teams work best if they recognise the value of:

- effective communication (Vogelsmeier & Scott-Cawiezell 2009)
- a singleness of mission
- a willingness to cooperate
- a commitment to each other

The attributes of effective teams include the following:

- clarity of purpose/shared objectives or goals (Markiewicz & West 2011)
- informality
- participation
- listening
- meeting regularly
- interdependent working
- civilised disagreement
- consensus decisions
- clear roles and work assignments
- shared leadership
- diversity of styles/life experiences/thought (Leanne 2010)
- small to moderate size
- self-assessment and self-regulation

Jelphs and Dickinson (2008) and Markiewicz and West (2011) suggest that for a healthcare team to function effectively it requires a number of health professionals with complementary skills and common goals, and the employment of a dynamic process to assess, plan and evaluate patient care. They add that this can only be accomplished with collaboration, interdependent working, effective communication and decision making that is shared among team members (including clients). This approach to healthcare team working should result in better care and add value to organisational and staff-related outcomes (Jelphs & Dickinson 2008; Andersen et al. 2010; Kalisch & Lee 2010, 2013).

Leggat (2007) and Dawson, West and Yan (2010) suggest that the majority of healthcare workers work within team-based structures, but they may not work in effective teams. Healthcare teams could develop into pseudo-teams that are large, have a weak or non-existent requirement for interdependent working, fail to meet regularly as a team and have few or no shared goals. Dawson, West and Yan (2010) suggest that while 90% of NHS staff reported working in teams, less than 40% of them reported working in teams that actually met the criteria of shared objectives, small to moderate size,

interdependent working and regular meetings. If teams are to function well they need the right mix of people with diverse skills, who communicate effectively, manage conflict well and know and are all working towards common goals.

Reflection Point
Do you work in a team? Look at the attributes of an effective team described in this chapter. Does your team meet these attributes? If not, what are the consequences for your workplace, the clients or patients and your own work satisfaction?

Established Teams

Established teams usually fall into three basic sets. These are:

- high-performance teams
- OK teams or functional teams
- struggling teams

High-Performance Teams

These teams need recognition and resourcing. They have their own (good) working habits and address their own learning and development needs. These teams tend to offer what is called 'synergy' (where 2 + 2 = 5), or what Leanne (2010) calls an 'all-hand' culture, with the rules for creating synergy related to:

- an established and clear purpose
- active listening
- compassionate interteam behaviour (Rathert & Fleming 2008)
- truth telling
- being flexible
- commitment to a resolution (agreeing to disagree, but moving on)
- high levels of passion and commitment
- a sense that team members' perspectives and efforts are valued
- a strong sense of 'ownership' of the team/organisational goals/values (Guttman 2008, p. 35)

Rath and Conchie (2008) support these ideas and suggest that strong teams have some key attributes in common: healthy debate within the team so that conflict is used positively and not avoided (Leanne 2010; Dunlap 2010); an eye for the big picture or organisational goals; a commitment to areas of their lives beyond the team; and balancing their work and personal lives successfully. In addition, Rath and Conchie (2008) and Leanne (2010) propose that high-performance teams embrace diversity and act as magnets for talent, with their success attracting other talented people. These suggestions were confirmed in a study by Rathert and Fleming (2008), who sought to explore the impact of the ethical climate on team work in an acute care setting, and how continuous quality improvement leadership behaviour moderated the relationship between the ethical climate and team work. What they found was that clinicians who perceived the ethical climate to be benevolent (supportive, encouraging and blame free) were significantly more likely to indicate that the team work was better.

High-performance or effective teams also demonstrate good team cohesion, where team members stick together and remain focused on the pursuit of their common goal. Effective teams are also

described as self-directing, where members are seen to work together, sharing authority and decision making, as if leaderless (although in reality the leadership role is being shared by various team members at different times depending on the team's needs). Self-directed teams excel at using their team members' differences and sharing the team resources and assets to their overall advantage. It has also been proposed that transformational leadership approaches are useful in support of innovation in high-performing teams (Eisenbeiss, van Knippenberg & Boerner 2008) and that teams where a climate of excellence already exists use their excellence as a liberating force to support further innovation and generate a cycle of team interaction that leads to greater excellence (Eisenbeiss, van Knippenberg & Boerner 2008).

While strong teams are desirable, they can have negative aspects too. The main areas of concern are that they can become exclusive, complacent, competitive and big-headed. Another issue with strong, high-performing teams is that they may lose sight of the big picture and focus on their own goals. They may build power through loyalty to the team and create barriers and competition with other teams to the detriment of the organisation as a whole. They may hold on to their own staff, stifle adaptability or innovation and reject newcomers. Thus, the balance between the potentially positive and the potentially negative issues needs to be monitored carefully for success to be sustained.

Ok or Functional Teams

A large number of teams can be described as OK or functional. They may need no intervention at all and some OK teams do not want or need to adjust their habits. They might not work brilliantly, but they work well and they have a competent balance. These teams may have tried-and-tested ways of addressing problems, but lack the confidence to try new approaches. Functional teams are based on a traditional hierarchical composition with a supervisor and subordinates, usually with formal communication and authority lines. These teams can be recognised right across the health service in wards, departments and a raft of clinical environments, and are often evident as they are commonly uni-professional in membership.

These sorts of teams can be good at puzzles. They are made up of people with the skills to know the way to find answers. However, these same teams may struggle with complex problems. A lack of confidence might mean that they are unable to create new partnerships, motivate each other and fail to act collectively or collaboratively.

Another type of OK team is called a 'cross-functional team'. These are composed of multi-professional members, often at the same or a similar hierarchical level. These sorts of teams are commonly seen where a specific project has been proposed, or where activities cross specialist boundaries. Leadership in these teams is frequently shared, but members from a dominant professional group (such as medicine) may feel that they have leadership authority (Sangvai, Lyn & Michener 2008; Cherry, Davis & Thorndyke 2010; Stanton, Lemer & Mountford 2010) and some professionals may continue to focus on their own and not the overall team goals.

Struggling Teams

Struggling teams pose the biggest challenge and may offer the closest reflection of a pseudo-team. Look for:

- fighting turf wars within the team
- individuals avoiding any work activity that will make them look bad
- avoiding disagreement and plain speaking
- going along with 'consensus' decisions that nobody wants
- poor-quality leadership

- poor personal relationships
- unresolved conflicts

The main issue is often a lack of trust or commitment. Teams that are not committed to working together will not learn together and will often fail to develop. In these cases the collective output may be less than if the individuals had acted alone. Lencioni (2002) suggests that there are five key areas evident in struggling teams: absence of trust, fear of conflict, lack of commitment, avoidance of accountability and inattention to results.

Grenny (2010) adds that one reason for teams struggling is if they are 'virtual' or if members are located in disparate sites. These sorts of teams are becoming more common in the business world and even in healthcare, with the advent of tele-health and other electronic media. To combat this, Grenny (2010) recommends that even more effort is required to create a team identity with a focus on mission, values and operating rules. It is also suggested that communication skills should be enhanced and supported, that social contacts should be established and fostered (with photos or images of all the team members readily available), that motivation should be monitored and rewarded appropriately, and that team performance should be tracked in terms of daily or weekly progress on key indicators.

Other questions to ask if teams are considered to be struggling are:

- Do they really need to be a team?
- Why is there no trust or commitment?
- Could they be managed better?
- Can their work be redesigned?
- Is it this team that is the problem, or is the problem related to the wider organisation?
- Should the team be broken up and reformed?

If a team is not working well, it may be that the team as a whole is failing to function, or it may be that there are some pernicious individuals within it that are – through bullying or controlling behaviour – bringing down the contribution of the whole team. Assessing the core problems with struggling teams is vital before taking action, because if the issue is destructive individuals, reforming the team without addressing that will only transfer the problem to the newly created team, making its formation a more difficult process. Dubnicki (1991) developed an excellent team assessment questionnaire to facilitate a team's self-evaluation of its roles, activities, members' relationships and the work environment. Used correctly, this tool can support an assessment of the success or otherwise of a team, and identify areas where remedial action needs to be applied.

Reflection Point
There are three basic types of teams described in this chapter: high-performance teams, OK or functional teams and struggling teams. Which type of team do you think you work in? Why is this? How can you change the team's fortunes if necessary?

Creating Powerful Teams

There can be something liberating, even inspiring, about setting up a new team (MacDonald 2010). Clearly, the objective at which it is aimed will influence the make-up of the team, but in general begin by selecting team members carefully. Look for members and leaders with sound innovation skills who can offer a diverse range of roles and ensure that they can all be relied on from the outset. New

teams should also be provided with a solid network of support and team cohesion should be fostered from the beginning (MacDonald 2010). Creating a new team, while difficult and time consuming, can often be very rewarding, because it avoids the sort of historical baggage that can interfere with working practices and allows communication channels and subcultures to develop as the new team does. In order to set up or create a new team, the following issues need to be considered:

- Clarify the team's purpose (objectives and goals) and task (Hart 2010; MacDonald 2010)
- Establish and understand the team roles (MacDonald et al. 2010)
- Create working processes and ground rules
- Set up and run productive meetings
- Make good decisions
- Establish effective communication (Vogelsmeier & Scott-Cawiezell 2009; Dunlap 2010)
- Build the capacity of the team (Calendrillo 2009)
- Encourage a reciprocal relationship whereby the leader and the led are able to influence each other (Zaccaro, Rittman & Marks 2001)
- Practise action learning
- Keep all of these processes under review
- Establish support and trust within the team (Dunlap 2010)

Tuckman (1965) proposes that teams go through forming, storming, norming and performing stages, which illustrates the basic reality that it takes time to achieve maturity (Pedler, Burgoyne & Boydell 2004). Not allowing time for a team to develop creates problems, as the team members are thrown together and expected to be at their peak performance at once. The forming stage is vital, and is too often a neglected element of team building (Figure 10.2).

Support and Challenge

Successful teams have usually created a balance between support and challenge. To enable teams to function well, they need to feel supported in their risk taking and sufficiently challenged to perform at their best. Kouzes and Posner (2010, p. 91) suggest that 'challenge is the crucible of greatness' and that challenges act to bring people together and guide them through adversity, hardship and uncertainty. Nothing supports team members more than being listened to, and nothing challenges more than opening the team members up to a good question or problem that makes them think about what they are trying to achieve and why (Handy 1999). To facilitate support and challenge, try one or more of the following:

- Customer surveys (staff, patients, user groups, colleagues), which suggest potential issues and may lead to projects or challenges for the team to solve
- Using a facilitator from outside the team to act as a stimulus for discussion and debate

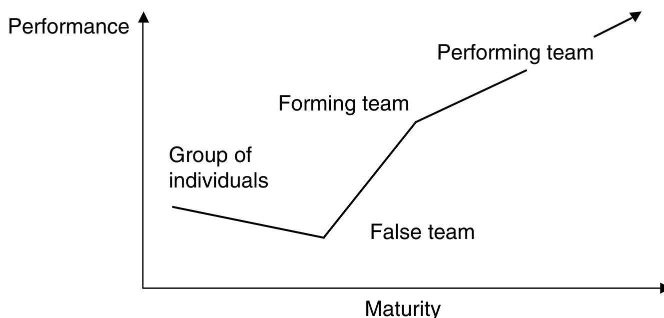

Figure 10.2 Team development curve. *Source*: Pedler, M, Burgoyne, J, & Boydell, T, *A manager's guide to leadership*, © 2004. Reproduced with the kind permission of The McGraw-Hill Companies. All rights reserved.

- Applying action learning sets to focus the team on key issues and open dialogue
- Using a T, P, N (total, partial, not at all) analysis approach
- Encouraging team members to undertake self-analysis, such as Myers-Briggs Type Analysis (Kroeger, Thuesen & Rutledge 2002)
- Having team members meet on a regular basis
- Setting up a forum for discussion, with open, honest conversation encouraged
- Tell the team when they have done a good job, praise the whole team and
- keep a record of their achievements (Balmer, Richards & Giardino 2010; Cantwell 2015)

Team Building

Often when there are problems within a team, the proposed solution is to engage in 'team building' in one form or another; indeed, in healthcare environments strategies to improve team work commonly include team-building or team-work training (Dietz et al. 2014). Dyer (1987) and Dietz et al. (2014) suggest that team-building and team-work training can be enhanced by:

- Setting the goals or priorities for the team
- Employing a team-building/training framework
- Defining the parameters within which the team works
- Allocating or describing the way in which work is performed
- Considering the manner in which the team works: its processes, norms, decision making and communication
- Focusing on the relationships among the people doing the work

However, these approaches often generate no more than minor, short-lived improvements in morale and performance (Holland 2008) and are only of use after some sort of assessment has been undertaken to identify the team's problem. There is also a view that team building can be a 'bit of a laugh', avoiding the real 'at work' issues. This perspective has grown from a number of 'play'-like approaches to team building, with paintball and similar adventure activities used to build team spirit and cohesion. Another issue may be that the team seems to function well while away from the work environment during the team-building activity, but old habits prevail when back in the thick of a negative work culture that has not been addressed.

For team-building and team-work training (or indeed team work) to be successful, clear and present leadership is required (Holland 2008). When groups are struggling, effective leadership is even more important, as is understanding what matters to team members. Leaders need to know, at least in part, what the problems are so that they can avoid becoming defensive and simply window-dressing the problem. The advantage a clinical leader has is that they are often very much a part of the team and can support and facilitate better communication and more attention to problems and solutions.

The Value of Team Work

Meterko, Mohr and Young (2004) claim that organisational culture has come to be viewed as an important factor in the adaptability and performance of healthcare institutions (see Chapter 5). Moreover, the degree of emphasis placed on team work and collaboration appears to be a pivotal dimension of organisational culture; for example, studies have shown that hospitals with a culture emphasising team work were able to advance further in their efforts to implement quality

improvement processes (Shortell et al. 1995; Rathert & Fleming 2008; Hood et al. 2014). A further study of rehabilitation teams (Strasser et al. 2002) demonstrated that work cultures accentuating team work were associated with more effective rehabilitative professionals. Nancarrow et al. (2013) also indicate that positive leadership and management attributes and clear communication are central to establishing effective interdisciplinary team work. Finally, Gifford et al. (2002), in a study examining the obstetric units of seven hospitals, found that a culture of effective team work was associated with lower turnover among nurses. It is also worth noting that teams construct their own internal culture and therefore occupy the position of a subculture within the larger culture of the organisation (Seago 1996). Understanding this and assessing team effectiveness can sometimes facilitate useful insights into the nature of team difficulties.

There is some evidence to support the connection between organisational cultures that espouse the value of team work and improvements in a number of team performance indicators. In 2004, Meterko, Mohr and Young published a study that established a strong relationship between patient satisfaction and a team work culture when compared with other types of culture (i.e. entrepreneurial, bureaucratic and rational). They also stated that prior to 2004 there appeared to be no studies connecting an organisational team work culture with patient satisfaction, even though WHO's definition of a health team (WHO 1988) implicitly links the work of health teams to the needs of the community, and therefore to patient satisfaction. A raft of studies have focused on the benefits of interprofessional learning as a tool to facilitate greater attitudes towards team work in the clinical environment (Balmer, Richards & Giardino 2010; MacDonald et al. 2010; Newhouse & Spring 2010; Deering, Johnston & Colacchio 2011; Hood et al. 2014) and it is clear that health professionals who learn together will find better ways to work and communicate with each other.

Team Roles

One key to effective team working is to support and promote diversity. To achieve this, teams need to be made up of a variety of different people with a variety of skills and talents (Handy 1999; Frandsen 2014). Imagine a soccer team made up of eleven goalkeepers. Their potential for match success would be limited by their over-specialisation. Belbin (1981) undertook research into team roles that suggested the idea that a team made up of the brightest and best did not always produce the best results; this was called the Apollo syndrome. He also proposed, after considerable research, that successful teams are composed of people who fulfil a number of different roles, identifying eight (or nine) key team roles.

The result of the research was a questionnaire used to support team members to identify their 'preferred' team role and to help teams gain an insight into their composition and development needs. Belbin's (1981) approach to team role assessment offers a robust and highly effective insight into how teams work, and represents an accurate approach to assessing individual behaviour and its impact on team functioning. In Belbin's words, 'Nobody is perfect … but a team can be'. Therefore, gaining an understanding of teams and how they are made up and of individual team roles can be of great benefit to team success (Belbin 1981; Frandsen 2014). The eight key team roles described by Belbin (nine including the role of the 'specialist') are:

- **Plant**: Introverted, but intellectually dominant. The source of original ideas and described as creative, imaginative and unorthodox.
- **Coordinator**: Presides over the team and coordinates its efforts. Described as mature, confident and clarifies goals.

- **Monitor/evaluator**: Intelligent and directed towards analytical rather than creative energies. Described as sober, strategic and an accurate judge.
- **Implementer**: Turns ideas into manageable tasks. Schedules, charts and plans are their thing. Described as disciplined, reliable and a doer.
- **Completer/finisher**: Checks details and makes sure that schedules are met, drives others on to complete their tasks. Described as painstaking, conscientious and delivers on time.
- **Resource investigator**: Usually a popular member of a team. Described as sociable, relaxed, extrovert and enthusiastic. Their role is to make or bring in new contacts, acting as a salesperson or liaison for the team.
- **Shaper**: Described as highly strung, outgoing and dominant; can also be challenging, dynamic and courageous.
- **Team worker**: Holds the team together, supporting others, listening, encouraging and acting as a link person for others. Described as diplomatic, mild and cooperative.
- **Specialist**: Often called into a team for special knowledge or skills, and frequently does not stay in the team beyond its immediate requirements. May be seen as single-minded.

Significantly, no one role is affiliated with leadership in the team, and the advantage of understanding team roles from Belbin's perspective is that the team needs will often dictate the most appropriate leader at the most relevant time. Thus, different roles may be required to different degrees at different times. For example, when the team is struggling it may be that a coordinator is needed to focus the team's efforts on its goals and objectives. Or if a team is being formed, it may require a strong shaper or plant to motivate team members or generate ideas. Times of competition may demand the intervention of a plant with good ideas or an evaluator to avoid high-risk activities.

It is not essential that teams have eight people, each undertaking one of the eight main Belbin roles, but teams do need people to be aware of these various roles and find ways to fulfil them. In small teams people can assume more than one role, while in larger teams it would be reasonable to expect that different people undertake the same team role. Establishing team roles is also beneficial when it comes to team decision making. At times teams struggle to make effective decisions, so having set ground rules and clear team roles can facilitate confidence and allow teams to reach alignment in decision making (Frisch 2008).

The point of Belbin's (1981) team roles is that teams are made up of a variety of different people with different skills and that the most effective teams recognise this and act to include these various roles. To function well teams need all types, team workers, coordinators and finishers. This perspective was supported by Leggat (2007), who suggested, after a significant research project among Australian health service personnel, that team-working competencies were perceived to be different for management and clinical teams, further reinforcing the value of having different people with different skills populating teams. However, it should be remembered that in spite of having well-defined team roles, the interaction of people in teams and the impact of their personalities can – and often does – have an effect on team friction or relationships within the team. The key in these circumstances is to manage conflict constructively (see Chapter 12).

Leadership and Teams

As well as possessing key attributes for teams to function, having effective leadership within the team is considered vital (Borrill et al. 2000; Lencioni 2002; Harkins 2008; Kalisch & Lee 2010; Nancarrow et al. 2013). When building a team it is even more essential. Team leaders have to demonstrate their

confidence in the team and in themselves. Once fear sets in and confidence is eroded, the team's belief in the leader falters and building or maintaining the team becomes very difficult.

Harkins (2008) proposes three things that team leaders should achieve in order to lead a team effectively. First, they should ensure that the team goals are clearly defined. Second, they should establish team roles so that team members are clear about the part they play in the team. Third, team leaders should use language and role model actions to build trust (LaBrosse 2008), motivate others and build positive energy. Achieving these three steps sets team leaders apart as 'high-impact' team leaders (Harkins 2008). Lencioni (2002) adds that leaders need to demonstrate genuine 'vulnerability' as a way of building team trust. Feigned vulnerability can be seen as manipulation and will only destroy trust. In addition, leaders need to foster excellent conflict management and conflict resolution skills and be comfortable making decisions (Lencioni 2002). In Borrill et al.'s (2000) study, teams without effective leadership reported poor participation, a lack of clarity about objectives, lower commitment to quality and innovation and poor mental health among team members. In summary, efficient team leadership leads to effective team processes, higher performance, greater innovation and greater staff satisfaction (Kalisch & Lee 2010). As Siassakos et al. (2011) state, better team work (and a better-led team) leads to better performance.

Leaders are often people who care about people and this care translates into a willingness to focus time and energy on members of the team. From this perspective, caring is risking being with the team and sharing both suffering and joy. Behaviours that demonstrate caring include giving of oneself in terms of warmth, passion and, particularly, time. The second aspect of caring is truly listening to team members, really hearing and understanding them. The third aspect is being 100% present for them. The fourth is to honour team members and see their wholeness, their possibilities and their hope.

Leading a team is one of the most difficult things to do. Wageman, Fisher and Hackmann (2009) suggest that a key leadership skill is the capability of team leaders to judge the right time for action or analysis within the team. Being a team member is also difficult, because the reality is that being part of a team is the same as being part of a relationship and, as with any other relationship in our lives, involves risk and requires commitment, trust and character, both personal and professional. The team leader's role should be very much focused on sustaining the relationships needed for the team to be effective (Calendrillo 2009). Crosbie (2006) undertook a significant research project in Canada that sought to explore leadership behaviour, autonomy over the team members' roles and team members' inclusiveness in decision making. He found that failing to provide effective leadership diminished autonomy and resulted in a lack of inclusiveness in decision making, which had a negative impact on team members' job satisfaction. The key factors were when leaders employed control or a hierarchical structure in the team, or when they failed to demonstrate appreciation for team members, offered favouritism to only some team members, failed to provide direction, were poor decision makers or failed to demonstrate caring or trust towards their team.

Health professionals are increasingly working in interprofessional teams. Moreover, as the benefits of effective team working become clearer, many educational institutions are focusing more and more on learning and education that employs an interprofessional focus. However, if different professional groups are to employ genuine team working in the clinical setting, training and education need to focus specifically on the skills and attributes of team cohesion (Guise & Segel 2008; Andersen et al. 2010; Capella et al. 2010; Siassakos et al. 2011; Steinemann et al. 2011). Learning about teams will not come from just being in one, and considerable benefits for quality improvement, innovation and patient safety will flow from attention to enhanced leadership and insights into team work in undergraduate programmes.

Teams do not always work in all situations and they can sometimes stifle dissent and creativity. However, they can produce really powerful work-based groups of people who need little direct management and often appear to be 'leaderless'. In some respects, teams are becoming the new management.

Self-Led Teams: The New Management

These 'leaderless' teams are commonly referred to as self-led or self-managed teams. Of course they are not 'leaderless'; the leadership responsibilities are simply devolved to the team, so that the team assumes responsibility for its own systems, processes and 'management' duties. In many respects, this is the fulfilment of 'followership' crossing over or amalgamating with leadership roles (Kellerman 2012; Raffo 2013; Malakyan 2014). These teams are often given a broad set of goals or objectives and then allowed to 'get on with' the job of addressing them without traditional manager or supervisor oversight. Hurst, Ford and Gleeson (2002) evaluated a set of integrated self-managed community health teams in the UK. These teams were relatively new, but they were found to face a number of barriers. These included a loss of 'corporateness' (associated with the previous structure) and poor communication processes as information struggled to cascade to the teams from the 'top' of the organisation. However, there were benefits for these teams, since they enjoyed greater autonomy in decision making, undertook greater interprofessional sharing of health information and better team-working strategies. The teams also felt that they had greater cohesion and that at a local, 'team' level communication was more positive (Hurst, Ford & Gleeson 2002, p. 478). These benefits were supported by Stoker's (2007) study of leadership in self-managed teams, where flexible leadership styles were found to increase the effectiveness of individual team members and to support an increase in team autonomy.

Self-led teams, sometimes referred to as having 'team leadership' (Jones & Bennett 2012), offer a 'flat' structure (unlike the hierarchical structure of 'traditional' teams) and facilitate the engagement and participation of followers in the activity of leadership. Elloy (2008) noticed that the leadership approach required to support a self-managed team is also different. Leaders within self-led teams need to focus carefully on trust building, effective communication, giving feedback, goal-setting activities and encouragement of innovation and decision making (Elloy 2008). Paterson (2013) claims that leaders operating within a team leadership model or in self-led or self-managed teams need to ensure that they foster trust, stability, compassion and hope, in order that they can answer the question of 'Why would anyone want to follow me?' Traditional teams required these issues to be addressed too, but in self-led teams they are the factors that appear to link directly to success and team effectiveness (Jones & Bennett 2012).

Case Study 10.1

Anita Roddick was a British environmental campaigner, business leader and human rights activist. Consider her story and read the challenge at the end.

Female Leaders: Anita Roddick

Anita Roddick is most famous as the businesswoman who built up the cosmetics business The Body Shop. However, she was also a leader in other areas. The Body Shop was started in 1976, in Brighton, UK, with the aim of making Anita an income while her husband was away in South America. By 2004 there were 1980 stores all over the world serving an estimated 77 million customers. The idea for the shop (and much of its original literature) was copied from an enterprise also called The Body Shop, which Anita had visited in San Francisco in the early 1970s.

The concept of the shop was to offer skin-care products in refillable containers, marked with genuine information rather than 'hype'. The Body Shop only used products that had not been tested on animals

(Continued)

Case Study 10.1 (Continued)

and promoted fair trade with developing counties. The concept struck a chord with British shoppers and in 2004 The Body Shop was voted the second most trusted brand in the UK and the 28th top brand in the world.

In 2006 L'Oréal purchased The Body Shop for £652 million, causing controversy as L'Oréal is affiliated with Nestlé and both of these businesses are known for their less than ethical practices in terms of animal testing and for their treatment of developing-country producers. However, Anita was retained as a consultant to The Body Shop brand and up to her death in 2007 was able to participate in corporate decisions and influence the direction of the company she once owned.

Anita was involved and active in environmental campaign group Greenpeace and *The Big Issue*, a publication sold by homeless people, and was a strong advocate for environmental issues. She worked as a member of the Demos think tank's advisory council and with a group called Children on the Edge (COTE) that she founded in 1990 in response to the needs of disadvantaged children in eastern Europe and Asia who were affected by natural disasters, conflict, disability and HIV/AIDS. In 2005, Anita gave away a fortune (£51 million) and retreated from the world of commerce where she had had so much success.

Anita Roddick was the recipient of multiple awards, including Dame Commander of the Order of the British Empire (DBE) in 2003.

Challenge: Here is the real question. Could you have given away your fortune? What could you give up or sacrifice for a better ward, better clinical environment, better way of life or better world? How is this question connected to the concepts discussed in Chapter 4 in relation to congruent leadership? Why does this even matter? Anita Roddick was incredibly successful and very wealthy, but was she driven by the desire to be wealthy or the desire to make the world a better place? Her shop, her charity work and her involvement with COTE all point to her being driven by her values and not by the pure pursuit of money. Or do you have to have money to be as gracious? Effective team work is about trust, listening, giving of our time and being present. How much of Anita's success was based on her ability to build a team with her business? How much does this matter in the health service where you work, very often in teams?

Summary

- Teams do not always work in all situations.
- Teams and groups are different.
- Effective teams have a clear purpose, are informal, meet regularly, feature interdependent working, civilised disagreement, consensus decisions, shared leadership, a diversity of styles, are usually small to moderate in size, and employ self-assessment and self-regulation.
- Teams can sometimes stifle dissent and creativity.
- Teams fall into three basic sets: high-performance teams, OK or functional teams and struggling teams.
- Creating a new team can be liberating or even inspiring. It can also be difficult and require considerable time. Creating a new team requires clarity of purpose, the establishment of team roles, clear working processes and ground rules, clear decisions, effective communication and the establishment of support and trust.
- New teams need time to settle and grow.

- There are a number of different roles that team members can take to make the team function effectively: plant, coordinator, monitor/evaluator, implementer, completer/finisher, resource investigator, shaper, team worker and, in some circumstances, specialist.
- Sometimes effective teams can produce really powerful work-based bodies of people who need little direction and may even appear to be 'leaderless'. These are known as self-led or self-managed teams.
- The key to effective teams is to create a balance between support and challenge.
- Teams involving a variety of people undertaking different roles offer strength and diversity.
- Team leaders care about team members by listening to them, giving of their own time and being present. This is expressed as trust in the team.

Mind Press-ups

Exercise 10.1

Look at the change models in Chapter 7 and use a SWOT analysis to assess the team you are in.

Exercise 10.2

Look for the Belbin Team Role questionnaire online (or go to Belbin's original text, Belbin 1981) and complete the questionnaire. Assess what your team role is.

Exercise 10.3

Do teams from different professional disciplines work differently or are their team working principles the same? Does it matter?

Exercise 10.4

Are you a leader within your team? If so, how do you use support and challenge to strengthen or achieve team cohesion?

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11

Networking and Delegation

Linda Malone

You can delegate authority, but you can never delegate responsibility by delegating a task to someone else. If you picked the right man, fine, but if you picked the wrong man, the responsibility is yours—not his.

Richard E. Krafve, General Manager Edsel Division,
Vice-President Ford Motor Co., in Eigen & Siegel 1991, p. 222

Introduction: Strength in Numbers

This chapter looks at the issues of networking and delegation. It explores what networking is and why it is important in terms of clinical leadership for health professionals. It also considers what delegation is and the skills essential for effective delegation. For health professional leaders, networking is a useful way to extend professional connections and opens up lines of communication with others (Kiefer 2011; Weird-Hughes 2010). Networking is about placing people in touch with friends, friends of friends, their friends, parents, partners, co-workers and so on. It also supports the success of an organisation (or the people in it), because networking brings knowledge, information and influence to both the organisation and the people who belong to it. With the boom in information technology (IT) and the widespread use of social media, the ability to network has been enhanced. Delegation supports networking, because if it is done well and with the right motives it can be a powerful team-building and leadership-enhancing tool.

Networking

Networking can be defined in a number of ways, such as 'the exchange of information or services among individuals, groups or institutions, specifically the cultivation of productive relationships for employment or business' (Merriam-Webster 2014). Increasingly the term networking is associated with information technology and the development of social networks or in reference to the interconnection of computers. However, in its broadest sense a network can be defined as an interconnected system of things or people. Networks can be informal interconnections (Marquis & Houston 2012) or associations between individuals or groups of people where the association can be personal relationships with family, friends, members of a sporting club or social group, or indeed anyone.

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Networks can be formed with people with whom we have a business relationship, a professional relationship or the clients and customers encountered in the course of our professional activities.

Opportunities for networking happen whenever people meet (Chichester 2014) and in many respects networking is about how things get done. This applies to our personal life, the business world, in industry, in sports and entertainment, and in our professional life. Networking is a formal term for the informal connections and interconnectedness that come about as we move through our lives as social beings.

We are networking when we:

- talk with a product representative who visits our place of work
- meet a former colleague at a conference
- engage with friends and friends of friends on the internet's social networks
- talk to the person behind us in the line at the checkout
- strike up a conversation with someone while waiting in the doctor's waiting room
- talk over the fence with our neighbour
- attend a meeting at work
- stand on the sidelines at our child's soccer match at the weekend
- take up an evening class
- interact socially in any way

Pedler, Burgoyne and Boydell (2010) suggest that networking is one of the most underrated forms of power and influence. For them, influence, informal authority and inspiration are exercised through the creation of informal networks, and are a vital source of knowledge, energy and information within an organisation. Therefore, establishing effective networks is an essential aspect of a clinical leader's role, particularly if formal power is not an option. Networking gives a clinical leader access to contacts, information, resources and support so that they can accomplish a range of tasks, employ creativity and offer innovative solutions to clinical and other problems. In the same way that evidence-based information can facilitate power and influence or clarify decision making, the collective wisdom and influence of a successful network can support clinical leaders by adding to their capacity to get things done.

The Skills of Networking

Becoming a good networker can be achieved with a minimal amount of effort, but if you want to foster a specific network for a specific purpose, it may take a degree of attention and focus and require some thought to set up. Although networking may not come naturally to some people, being a good networker is an easy thing to achieve (Chichester 2014). One of the main reasons to network is to establish a level of influence or personal power that may help you to achieve your personal and professional goals.

Here are some ideas for establishing an effective network or developing professional networking skills.

Get Yourself Known

This can involve a number of approaches, depending on where you want to be known, and the approach you take will vary. You may want to develop local hospital, local community, clinical specialism, national or indeed international networks.

Volunteer

Make yourself available for volunteer tasks, for example as a minute taker on a committee, giving your time on open days or offering support for educational days. This can be an effective strategy if you want to be noticed in your hospital community or by the influential people in your clinical

specialism or organisation. The advantage of this is that you can then influence or gain experience in decision making and debate or meeting approaches.

Join a Professional Organisation

Membership of professional organisations, such as the Royal College of Nursing (UK), Australian Nursing Federation, Australian College of Nursing or other peak professional bodies, can bring credibility and give you access to a voice for effecting changes in subjects that interest you. Also, you will be recognised as enthusiastic and keen, as well as building a more diverse curriculum vitae and broadening your contacts and interests. Professional organisations have within them local interest groups and offer educational support as well as conferences, which also encourage greater networking opportunities (Kiefer 2011; Chichester 2014; Houston 2014).

Look Beyond Your Own Organisation

While you may work in one place or department, your networks are richer if they stretch beyond these boundaries and even beyond one organisation. In the area of interprofessional education and multi-professional working environments, looking to gain networks in other organisations or with other professional groups can be an effective way of developing interesting and rewarding contacts.

Be Professionally Committed and have Clear Messages

Know what it is you stand for and be prepared to express your views if called on. This is about knowing what you can offer and what you are looking for from a networking relationship.

Join Professional Discussion Groups

These are especially relevant if they are associated with your clinical specialism. Thus if you are a health professional involved predominantly with cardiovascular care, joining a relevant discussion group or special interest group will give you access to others in this specialism, allow you to gather information and contacts to support your professional development and have a positive impact on the care and service you could offer your clients and patients (Houston 2014).

Use the Internet

The internet may offer wonderful informal and formal links with professionals from across the globe. Social networks present both risks and opportunities for communication and networking, but these electronic networks will only grow in terms of interprofessional and intraprofessional opportunities to connect on a global scale. However, keep information about clients and patient details confidential (Ridge 2014).

Engage with Professional Development

Doing a course and gathering more information is an excellent way to learn more and meet new people who have similar interests.

Go to Conferences

Generally, at a conference you will meet people within your professional group and often beyond it, and from a wide range of locations, frequently international. It allows opportunities to talk formally and informally and incorporate a social aspect to the occasion, facilitating greater discussion and more possibilities to make links and foster professional relationships. Attending conferences – even those that at

first glance seem only peripheral to your professional sphere – can offer up wonderful new perspectives on old problems and exciting new ideas or contacts (Mata, Latham & Ransome 2010; Kiefer 2011).

Mentor Others or be Mentored

Acting as a mentor or seeking out and engaging with a mentor for yourself can enhance your leadership and learning skills and show your commitment and support for others (Houston 2014). Gaining a mentor means that you will have access to experienced and reliable clinical experts who can help shape and direct your career and offer advice or support when times are difficult or when you may need to make career-changing decisions. Supporting people in this way builds your profile as a person willing to help others and promote the growth of neophyte professionals.

Travel (for Professional Reasons)

A radical way to widen your networks is actually to go and work in other countries and locations. Nursing and other health professions are global and, apart from some language issues, the practice of nursing and healthcare is generally universal. Techniques change and skills may vary, but interacting with nursing or healthcare colleagues internationally enriches both you and them and has positive impacts on the whole profession. You can do this as a volunteer or as a paid employee.

Develop a Clinical Supervision Process

Clinical supervision supports networking because you are mixing with professionals who have considerable experience and insights into the clinical and professional issues that may arise in your career (Houston 2014).

Expand Your Informal 'Coffee' Network

Health professionals often meet over coffee or tea, and making an effort to have informal social meetings with professionals from other areas or departments will significantly expand your professional network and give you access to information from other parts of the institution.

Publish

When something is published it enters the global network of professional work, enriching others' knowledge and allowing them to recognise your professional contribution. When an article or book is published, it leaves a trail that can lead back to you.

Other Ideas

Speisman (2010) suggests that there are a number of tips for successful networking. These include being genuine and authentic so that you can build trust in your relationships; being clear about your goals when you network so that you can focus on the right networks; connecting with groups and interests that spark your interest and attention; ask open-ended questions in networking conversations; become known as a powerful or useful resource for others; regularly follow up on the contacts you have made; and be clear about how you can be of help to others, rather than just focusing on what the network can do for you.

Reflection Point

This chapter offers a considerable list of activities that can enhance your capacity to network. What are you doing now, and what might you think to include for an enhanced or improved networking capacity?

Networking through Social Media

Working on developing personal and professional networks can also help with your personal and professional development. Indeed, Moorley and Chinn (2015, p. 514) suggest that 'used wisely social media has the potential to become a tool for modern nurse [healthcare] leadership'. It allows an opportunity to meet new people, contribute to new ideas and influence professional developments. The advent of greater IT connectivity has allowed people a greater opportunity to network globally and to share ideas and information that will help any profession improve and develop. Extending your network encourages professional discussion, critique and debate. Social media use is not without its associated risks, however, and in particular health leaders need to be mindful not to breach confidentiality. A general rule of thumb is that if you would not want someone to read a particular statement, never, ever post it.

As a professional social network, LinkedIn is gaining ground. Established in 2003, it now has over 300 million users worldwide (Ridge 2014). Other social media platforms include Facebook, Tumblr, Twitter, YouTube, Instagram, Myspace, Pinterest, Friendster, WordPress, Google + and Bebo (and the list continues to grow). Through the use of social media, reaching out to people far beyond your everyday contacts has never been more easy (Roman 2014). Remember, though, that social media networks are a tool and are incredibly useful, but only when applied wisely.

To become skilled at networking, it is important to know where you may or may not have any influence, so that you can apply your personal resources wisely. Like most nurses and other health professionals, you will have other demands on your time and reaching a suitable work/life balance means focusing your networking attention appropriately. Choose where best to make your contributions and focus on professional activities that will challenge, enrich and offer the greatest impact from your energies. Networking can increase your circle of influence or allow you to take charge of situations, or indeed influence others.

Networking Tips

A number of approaches can be employed to support and enhance effective networking, but they all involve a commitment to building relationships with the people with whom you connect and remembering that our first impressions count, whether face to face or online. Look for opportunities when you meet people online through professional discussion groups or at conferences or meetings. Experienced health professionals will use networking to extend their influence by meeting new colleagues. Think about extending your network to include health professionals from a range of disciplines and at various stages of their professional careers. New starters can bring fresh perspectives; experienced colleagues can provide a wealth of information (Chichester 2014). If you are not an experienced networker, try the following icebreakers to open conversations with someone you wish to know or meet:

- Where are you from?
- What is your area of clinical specialism?
- How do they do things at your facility or organisation?
- What do you think about the actions of the meeting?
- Is there anything on the conference programme that particularly interests you?
- What professional interest groups would you recommend?

Once you have got beyond the initial opener and the conversation is coming to an end, do not forget to grab either a phone number or an email address, and to offer a business card with your contact details. With the availability of mobile phones and the ability to send text messages, keeping in contact is now even easier.

After this initial engagement, remember to follow up. Here are some suggestions:

- Send a quick text
- Send a short email

- Make a phone call to discuss something of mutual interest
- Check out the other person's LinkedIn account and send an invitation to connect

There are so many people you are yet to meet – those who are willing to network and continue working with you will let you know.

Delegation

Kelly (2012) is of the view that delegation is one of the most important management/leadership tools, yet if done inappropriately it can have disastrous consequences. Cantwell (2015, p. 169) suggests that delegation is essentially 'giving work to others that you would otherwise do yourself'. Delegation saves time and maximises the skills and expertise of team members. Giving staff respect, trust and real responsibility, together with a degree of independence, can be powerful in team building and to enhance leadership. This is how Woodrow Wilson, 28th American President, put it: 'I not only use all the brains that I have, but all that I can borrow.'

According to Marquis and Houston (2012), delegation can be described as achieving goals through the work of others, although the person who delegated the work remains accountable for the outcome (Yoder-Wise 2015). Delegation allows for a shift in decision making and, done well, is not abdication or dodging responsibility. Effective delegation uses trust with only the minimum controls; however, there must be a balance between trust and control depending on the situation. The opposite of successful delegation is micro-management (Kelly 2012). Building trust is therefore essential for effective delegation. Trust comes from:

- having confidence in your staff or team members
- being willing to take a risk
- having confidence in yourself

Control is about appropriate levels of freedom according to experience and it relates to accountability. Delegation is not simply handing over a task that you do not want to do and it means that you need to know the skills and abilities of the person to whom you are delegating. Clinical leaders need to be able to explain the task, know what is required, display interpersonal skills, offer training and monitor the team member's capacity to undertake the task. Delegation should ideally be positive for both the clinical leader and the person to whom the task has been delegated.

Reflection Point

Reflect on a time when a task was delegated to you. How was this undertaken? How did you feel? Did you feel empowered or suppressed? Liberated or used?

Effective Delegation

Effective and successful delegation allows clinical leaders to foster communication that develops the skills and confidence of the staff involved. Cantwell (2015) suggests that at its core, delegating involves any task that can be done in whole or in part by a member of the team. Furthermore, successful delegation follows these steps:

- Define the task: Be sure it is suitable for delegation.
- Select the correct individual or team: Are they the most appropriate person/people?
- Assess ability and training capability.
- Explanation: Why is the job being delegated? What is its relevance to the unit/ward/department objectives?

- Results wanted: What must be achieved?
- Resources: Agree what is needed to achieve the task (people/equipment/money).
- Deadlines: Agree when the job needs to be completed.
- Support: Offer support when necessary and make sure everyone knows that a task is delegated and that you are there to support them.
- Feedback: it is essential to give feedback and review the situation if the task is not on track.

When delegating, the following tips may also be useful:

- Give the person the whole task. Handing over part of a task or continually returning to meddle will not be helpful and will lead to frustration.
- Make sure that the delegate understands exactly what you want them to do.
- Share your picture of what a successful outcome will look like.
- Identify how success will be measured.
- If possible, determine in advance what reward the person will get or how you will thank them.
- Identify key points in the project when you want feedback about progress.

The 'five rights' to employ for successful and effective delegation (Fisher 1999) are:

1) *Right task:* Does the delegated task conform to established policies, procedures and standards?
2) *Right circumstances:* Does the staff member have the right education, resources, equipment and supervision to complete the task safely?
3) *Right person:* Is the staff member qualified and competent to perform the task delegated?
4) *Right direction and communication:* Are the directions given with the task clear and does the staff member understand these directions?
5) *Right supervision and evaluation:* Are appropriate monitoring, intervention and evaluation provided?

In nursing and other health professions, delegation is commonly related to the matter of sharing tasks and duties in terms of clinical work. In this regard it is linked to how teams work (see Chapter 9) and is also regulated by law (enforced by Acts of Parliament) in relation to the appropriateness of certain tasks that can, or cannot, be delegated to various types of healthcare professionals. Therefore, all health professionals need a clear understanding of delegation and the legislation that supports its use.

Common Mistakes in Delegation

Delegation is a skill that can be learnt. Errors that are commonly seen are under-delegation, over-delegation, inappropriate delegation and failing to provide sufficient supervision. The following discussion draws on Marquis and Houston's (2012) description of these common mistakes.

Under-Delegation

Sometimes leaders will be reluctant to delegate tasks as they perceive that if they do so, this may show an inability to perform their job. It often reflects a lack of trust or a desire to hold on to power and authority (Cantwell 2015). Delegation is about letting go, and this can sometimes be very difficult for clinical leaders who are passionately invested in their role or responsibilities. Cantwell (2015) is of the view that confident leaders despise micro-management; instead, they set achievable goals and give people the freedom to act independently.

Over-Delegation

Leaders who are poor time managers, disorganised or feel insecure about performing tasks themselves will tend to over-delegate. This often leads to conflict and mistrust of the leader, which in turn results in reduced team productivity.

Inappropriate Delegation

In appropriate delegation is assigning tasks to the wrong person at the wrong time for the wrong reason. Allocating tasks to someone who is not qualified or does not have the training needed to undertake the requested task can have significant consequences in relation to safety of both patients and staff.

Failing to Provide Sufficient Supervision

If the task has been delegated and insufficient supervision provided, particularly when the person delegating does not support or build trust, the person may feel abandoned and unsupported. This generates feelings of mistrust and is likely to result in conflict between the leader and the person to whom the task has been delegated.

When delegating, you should avoid the following:

- Offloading – delegating a task just because you do not want to do it
- Mixed messages – delegating then retaining too much control (micro-management)
- Offering a poisoned chalice – a task that you know is fraught with nasty surprises or is very difficult to achieve
- Too much too soon – involving inexperienced staff ahead of time
- Imprecise definition of the task

Resistance to Delegation

Not all team members will see the opportunities that delegation offers as a benefit; indeed, resistance to delegation is not uncommon (Marquis & Houston 2012). Some team members will feel over-burdened due to existing work pressure, being unprepared to take on new tasks, lacking in self-confidence, being reluctant to cooperate with 'new' initiatives and a perception that the task, although delegated, will be overseen too closely or micro-managed.

When faced with resistance, the clinical leader may be tempted simply to reallocate the task or undertake it themselves to avoid conflict or to get the job done. Nevertheless, it would be a mistake to miss the opportunity to investigate the reason behind the resistance. There may be legitimate

reasons for team members feeling the need to resist delegation and these should be explored and addressed appropriately. These types of opportunities may be the key to facilitating greater trust within the team and building greater team cohesion.

Reflection Point

Speak with colleagues in the area where you work. Have any of your colleagues had any formal education or training in how to delegate effectively? Have you? Reflect for a moment: what impact might the results of your informal survey have on the quality of delegation where you work?

Delegation and Clinical Leadership

Effective clinical leadership is directly related to the skills of delegation (Marquis & Houston 2012). Clinical leaders need to be aware of the relevant legislation affecting what is and what is not permissible in terms of intra- and interprofessional delegation. Clinical leaders should also act as role models for effective delegation, supporting team members and colleagues and acting as a resource person if needed. Effective clinical leaders see delegation as a time management and team-building tool and are able to identify tasks and situations that are appropriate for delegation (Marquis & Houston 2012). Clinical leaders also use effective communication skills, including assertiveness and support, to build trust so that patient safety remains a primary focus of the delegated task. Clinical leaders need also to be conscious of the potential impact of cultural issues on delegation across cultures, should this be needed.

Leaders who demonstrate congruent leadership delegate as an act of congruence, leading through delegation by demonstrating their values and beliefs in their trust and support (faith) in team members and colleagues. In this way, clinical leaders use their colleagues and team members' potential, not their job title, to decide whether delegated tasks are relevant or appropriate (Marriner-Tomey 2009). Delegation then becomes an act of elevation, lifting others' performance and confidence as they feel supported and guided to higher levels of participation.

The skills required for delegation improve with practice and clinical leaders will become more effective at delegation as their confidence and competence grow. There are real benefits from delegation for clinical teams, since team members gain new skills, develop more self-confidence, develop greater responsibility and broaden their scope of practice.

Case Study 11.1

Edith Cowan was a networking pioneer. She lived in an age when men dominated politics and yet she was able to use her connections and networks to help her to do more for her community, and specifically for children. Read about Edith Cowan and consider how she struggled to make a difference for single mothers and young children and the impact that having effective networks had on her success.

Female Leaders: Edith Dircksey Cowan

Born Edith Brown in 1861, Edith is worthy of note as the first female member of the Australian Parliament and a true Western Australian pioneer. She was born at Glengary, near Geraldton in Western Australia, the second daughter of a pastoralist, Kenneth Brown, and a teacher, Mary. Her childhood was unhappy, with her mother dying in childbirth when Edith was 7 and her stepmother being murdered by her father eight years later. He was hanged for the offence.

(Continued)

Case Study 11.1 (Continued)

Edith attended boarding school in Perth where she met James Cowan, whom she married in 1879. James was the registrar and master of the Supreme Court. His appointment in 1890 as police magistrate gave them economic security as well as a place in Perth society where they were able to network with the great and the good. Edith also gained an insight into society's wider problems. Between 1880 and 1891 the couple had four daughters and a son.

In the 1890s Edith became involved in a number of voluntary organisations, including the North Fremantle Board of Education, the Karrakatta Women's Club, the House of Mercy for Unmarried Mothers and the Ministering Children's League. In addition, in 1906 she was one of the founding members of the Children's Protection Society and pioneered a day nursery for working mothers in 1909. The Children's Protection Society was instrumental in supporting the State Children's Act in 1907, which led directly to the Children's Court. In 1915 Edith was among the first women appointed to the bench and she became a Justice of the Peace in 1920.

In 1909 she helped initiate the Women's Service Guild, which undertook fundraising activities and government lobbying, a function of which was the opening of the King Edward Memorial Hospital for Women in 1916. Edith became secretary of the advisory board to the hospital. In 1911 she was instrumental in the creation of the National Council of Women of Western Australia, serving as president from 1913 to 1921 and then vice-president until her death in 1932. She was also a foundation member of Co-Freemasonry in Western Australia in 1916, the first female member of the Anglican Social Questions Committee from 1916, and a co-opted member of the synod from 1923.

Edith supported amendments to the Health Act that proposed the compulsory notification of venereal disease. She travelled to Britain and Europe between 1903 to 1912, and in 1925 she went to the USA. During World War I she took part in a wide range of social activities, including the Red Cross, which saw her recognised with the award of OBE in 1920. The political scenery after the war also led to changes in legislation that barred women from parliament. As such, in 1921 Edith stood as an endorsed Nationalist for the Legislative Assembly seat of West Perth. She campaigned on her community service record, the need for law and order, and for the place of women in parliament to 'nag a little' on social issues. She won, narrowly, and became the first woman member of the Australian Parliament.

During her first term in office Edith proposed improvements in migrant welfare, the development of infant health centres and the promotion of women's rights. She was also an advocate for sexual education in state schools. Sadly, she lost the 1924 election, and she was defeated again in 1927, so ending her political career.

In 1926 Edith was a founder of the (Royal) Western Historical Society and in 1929 she was active in planning the state's 1929 centenary celebrations. She continued her social and committee involvement until ill health became too much of a burden. She died in 1932 aged 71. Edith Cowan is an example of an articulate and driven woman who spent the majority of her life fighting for women and children's rights, and finding ways to develop social and community support systems from within contemporary political and social structures. Edith was a genuine pioneer, forging a path and networks not previously trodden by women in both politics and social reform in Australia.

Challenge: Could Edith have done all this alone or without connections? In a political landscape dominated by men, could she have managed to make the progress she did without their support or engagement? There are parallels here to interprofessional working and interprofessional education. Can the health service grow and prosper or will better patient or client outcomes be possible without different professional disciplines finding effective ways to work together? How can we better network with different professional disciplines?

Summary

- Networking is about the interconnectedness of things and people.
- Networking is about 'how things get done'.
- Becoming an effective networker is important for success in the health arena.
- There are a number of strategies that can be employed to enhance your networking skills. These include getting yourself known, volunteering, joining a professional organisation, looking for contacts beyond where you work, being clear about your professional views, joining a professional discussion group, use of the internet, engagement with professional development, going to conferences, mentoring others, travel, engagement with clinical supervision, expansion of your 'coffee' network, publishing and developing trusting professional relationships.
- Networking is not always easy or natural, and it takes energy and focus to do it well.
- Delegation is an important leadership tool.
- Delegation is the assignment of authority and responsibility to another person to carry out a specific activity.
- Effective delegation relies on a relationship of trust.
- Successful delegation requires that the task be clearly defined, that the right people or person be selected, that training be offered if needed, that the task be explained clearly, that rewards and resources be agreed in advance, that deadlines be set and that support and feedback be offered.
- Effective delegation can be summarised as the 'five rights': right task, right circumstances, right person, right direction and communication, and right supervision and evaluation.
- Effective clinical leaders require the skills of delegation.
- Done correctly, delegation becomes an act of elevation, lifting others' performance and confidence as they are supported and guided to higher levels of participation.
- Common errors of delegation include under- and over-delegation, inappropriate delegation, delegating too late, not delegating enough and failing to support or supervise the delegatee or to build trust.

Mind Press-ups

Exercise 11.1

Are there tasks that you could delegate to others? How do you go about it? Are people generally receptive to your requests, or do they respond with resentment? Why do you think people respond the way they do?

Exercise 11.2

When delegating to people from other cultures, it is important to consider how you communicate, interpersonal space, issues related to social organisation, time, environmental issues and biological variations. How might these factors be important in your delegation to transcultural team members?

Exercise 11.3

How easy or difficult do you find the act of delegation? Reflect on why you might feel this way. Is it about your clinical competence, confidence, authority or experiences with previous delegation episodes? What has influenced your approach to delegation?

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12

Dealing with Conflict

Linda Malone

For good ideas and true innovation, you need human interaction, conflict, argument, debate.
Margaret Heffernan, US entrepreneur and documentary producer, b.1955

Introduction: Collaboration or Clash

Conflict is part of life. It is a natural and normal aspect of both home life and the workplace (Scannell 2010). We can be in conflict with ourselves or with others. Conflict is derived from the Latin word *conflictus*, meaning 'the act of striking together', and all interactions offer the potential for discord and strife, with differences over values and beliefs or behavioural issues having an influence on relationships and outcomes. In the health arena, conflict can lead to poor working relationships, a degeneration of communication, negative impacts on client or patient care and poor patient outcomes. Bad relationships and inappropriate use of conflict resolution skills can increase stress and limit innovation (Johansen & Cadmus 2015). Conflict can also result in competition or 'turf wars' that strangle communication and team work. All these can diminish the effectiveness of clinical leaders and reduce their capacity to inspire, innovate and successfully initiate or lead change.

In more positive terms, Brunetto et al. (2010), in a cross-sectional survey with police officers ($n = 180$) and nurses ($n = 1064$), found that organisations benefited from promoting effective workplace relationships and diminishing conflict, particularly between supervisors and employees. Johansen and Cadmus (2015) noted similar results, with a reduction in the stress of emergency department nurses resulting from a more positive approach to conflict resolution, following opportunities and interventions to build conflict resolution skills. Kantek and Gezer (2009) also established that student nurses favoured an integrated, collaborative and obliging conflict resolution style over styles that used domination. A key to building successful relationships is the application of emotional intelligence (see Chapter 15). This chapter suggests that it is clinical leaders who are in an ideal position to recognise and deal with conflict in the clinical environment (Padrutt 2010) and that collaboration, effective conflict resolution skills and the use of emotional intelligence may be the ideal approach for working through, managing or dealing with conflict. However, it also requires the application of a range of other skills.

For clinical leaders to have a positive impact on conflict, or manage their own styles of dealing with conflict and relationships, they need to determine what conflict means, understand conflict and know how it can be recognised and managed (Almost et al. 2016). This chapter explores approaches

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to dealing with conflict and why recognising and building skills in emotional intelligence can be vital for managing and minimising conflict. Specifically, it considers approaches for dealing with conflict such as 'self-talk' and 'I-messages'. It also discusses the value of active listening in reducing conflict and the tools for recognising and building emotional intelligence.

Reflection Point
Reflect for a moment about conflicts you may have had at work or at home. Think about what the conflicts have been about and how they were dealt with or resolved. How do you feel thinking about them now? Do you usually feel that conflict is resolved positively, or are your dominant feelings about conflict negative? Are your responses to conflict at work different from those to conflict at home or in your personal life?

Past Conflict

We tend to learn our dominant style of dealing with conflict early in life and to a large extent these responses stem from watching or being involved in conflicts within the family or in our formative social experiences. Everybody uses different strategies for managing or dealing with conflict, and once they have been learnt we tend to employ them automatically, almost naturally. Usually we are not aware at the time how we act in conflict situations, but we commonly employ our 'preferred' strategy (Marquis & Houston 2012).

A number of styles can be identified for dealing with conflict. These conflict styles relate to our preferred response or natural inclination when faced with conflict. It may be that we respond in different ways to different types of conflict situations. However, we do have a general tendency to respond to conflict in particular 'preferred' ways. As our 'preferred' response grows from learnt behaviours, understanding our strategies for dealing with conflict can allow us an opportunity to recognise positive or combative approaches and modify our strategies as needed. Learnt behaviours can always be unlearnt if they are non-productive.

Conflict Styles

The Thomas–Kilmann Conflict Mode Instrument (Thomas & Kilmann 1974; Thomas 1992) helps people assess their own preferences for dealing with conflict. Thomas and Kilmann (1974) propose that by assessing our own or others' conflict styles, an appropriate intervention can be initiated to engage, manage or diffuse conflict. The basic proposition of the model is that conflict resolution is orientated to either assertiveness or cooperation. The Thomas–Kilmann Conflict Mode Instrument is also known as the 'Conflict Behaviours Style Questionnaire' and it offers an insight into our tendencies for dealing with conflict. According to Thomas and Kilmann (1974), there are five potential strategies for dealing with conflict:

1) **Withdrawing (the turtle – avoiding)**: Turtles withdraw from conflict and tend to give up their goals and relationships. They stay away from people with whom they are in conflict as they believe that it is hopeless to try to resolve the conflict. The withdrawal can be physical or emotional and this strategy is seen as easier than dealing with conflict face to face (Thomas et al. 2008; Losa Iglesias & Becerro de Bengoa Vallejo 2012).

2) **Forcing (the shark – competing)**: Sharks compete and try to force their solution on others. Their goals are highly important, relationships less so. As such, they seek to achieve their goals at all costs and are not overly concerned with others' feelings or needs, or whether others like them. Sharks see conflict as having only two outcomes – winning and losing – and sharks want to win. Their approach to conflict is to attack, intimidate, overwhelm or overpower (Thomas et al. 2008).
3) **Smoothing (the teddy bear – accommodating)**: Teddy bears are the opposite to sharks. For them the goal is less important than the relationship. They seek harmony from conflict and try to help people discuss conflict without harming their relationships. They worry that if conflict persists, people may get hurt and relationships may be damaged. They like to smooth things over and tend to give up their goals to preserve the relationship (Candlin 2008; Thomas et al. 2008).
4) **Compromising (the fox – compromising)**: Foxes are concerned both with their goals and their relationships with others. They are prepared to give up part of their goals if others in the conflict will give up part of theirs. They seek the middle ground where both parties gain something. They compromise and are willing to relinquish a little to maintain the relationship and find common ground (Candlin 2008; Thomas et al. 2008).
5) **Confronting (the owl – collaborating)**: Owls value their goals and relationships highly. They view conflicts as problems to be solved and seek a solution that will support their own and others' goals. Owls see conflict as an opportunity to improve relationships by reducing tension and by focusing on a discussion that identifies the conflict as a problem to be solved (Brandt 2001). They seek solutions that satisfy everyone and at the same time maintain their relationships. They work hard to find a solution that addresses the conflict and that supports positive feelings and healthy relationships (Candlin 2008; Thomas et al. 2008).

The relationship between each of these strategies can be expressed as tension between assertion (concern for self) and cooperation (concern for others). Figure 12.1 demonstrates this. The Thomas–Kilmann Conflict Mode Instrument is offered in a modified form in Box 12.1. However, before you consider it, reflect on the following five statements. Which do you agree with most? Once you have

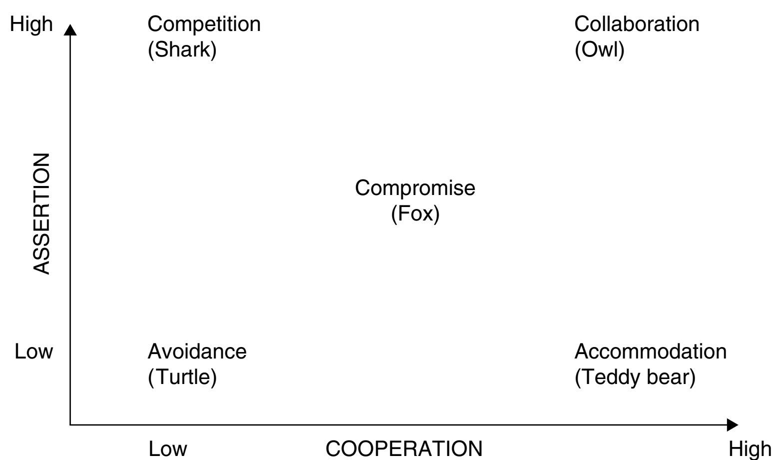

Figure 12.1 Conflict styles. *Source*: Thomas, K 1992, 'Conflict and negotiation process in organizations', in Dunnette, MD and Hough, LM (eds.), *Handbook of industrial and organizational psychology*, 2nd edn, volume 3, Consulting Psychologists Press, Palo Alto, CA, p. 660. Copyright 1992 by LM Hough. Adapted by permission.

Box 12.1 Thomas–Kilmann Conflict Mode Instrument

Read the following proverbs and use this scale to score how typical each of your actions is when in conflict: 1 = never do this, 2 = seldom do this, 3 = sometimes do this, 4 = frequently do this, 5 = usually do this.

No.	Statement	Score
1	It is easier to refrain than to retreat from a quarrel	
2	If you cannot make a person think as you do, make them do as you think	
3	Soft words win hard hearts	
4	You scratch my back, I'll scratch yours	
5	Come now and let us reason together	
6	When two quarrel, the person who keeps silent first is the most praiseworthy	
7	Might overcomes right	
8	Smooth words make smooth ways	
9	Better half a loaf than no bread at all	
10	Truth lies in knowledge, not in majority opinion	
11	He who fights and runs away lives to fight another day	
12	He hath conquered well that hath made his enemies flee	
13	Kill your enemies with kindness	
14	A fair exchange brings no quarrel	
15	No person has the final answer, but every person has a piece to contribute	
16	Stay away from people who disagree with you	
17	Fields are won by those who believe in winning	
18	Kind words are worth much and cost little	
19	Tit for tat is fair play	
20	Only the person who is willing to give up their monopoly on truth can profit from the truths that others hold	
21	Avoid quarrelsome people as they will only make your life miserable	
22	A person who will not flee will make others flee	
23	Soft words ensure harmony	
24	One gift for another makes good friends	
25	Bring your conflicts into the open and face them directly: only then will the best solution be discovered	
26	The best way of handling conflicts is to avoid them	
27	Put your foot down where you mean to stand	
28	Gentleness will triumph over anger	
29	Getting part of what you want is better than not getting anything at all	
30	Frankness, honesty and trust will move mountains	
31	There is nothing so important you have to fight for it	
32	There are two kinds of people in the world, the winners and the losers	

No.	Statement	Score
33	When someone hits you with a stone, hit them with a piece of cotton	
34	When both give halfway, a fair settlement is achieved	
35	By digging and digging, the truth is discovered	
	Total	

Scoring

Copy your scores from the proverbs to the appropriate place on the scoring grid. Then total each column. The total for each column relates to a preference for that conflict strategy. The higher the number, the stronger the preference.

Withdrawing	Forcing	Smoothing	Compromising	Confronting
Turtle	**Shark**	**Teddy bear**	**Fox**	**Owl**
1	2	3	4	5
6	7	8	9	10
11	12	13	14	15
16	17	18	19	20
21	22	23	24	25
26	27	28	29	30
31	32	33	34	35
Total	Total	Total	Total	Total

attempted the Thomas–Kilmann Conflict Mode Instrument, revisit these statements and determine whether your instinctive response corresponded with your results.

- The best way of handling conflict is to avoid it (turtle).
- Put your foot down where you mean to stand (shark).
- Soft words win hard hearts (teddy bear).
- When both give halfway a fair settlement is achieved (fox).
- Every person has a piece to contribute (owl).

The Thomas–Kilmann Conflict Mode Instrument is useful in that it often clarifies or explains our preferred conflict strategy. Knowing your preferred strategy may help you communicate more effectively, work more cooperatively or be less judging of others' behavioural or conflict styles. It is worth considering whether, as Candlin (2008) suggests, you employ different styles in different situations. Or should we all be aspiring to be collaborators (owls) in all situations?

Conflict at Work

Coan (2010) suggests that at work people commonly experience conflict around who should do what and how things should get done. Conflicts over style and personality and conflict that is unresolved can have a negative impact on team work or group dynamics (Scannell 2010). Group working and team working are also frequent areas in which conflict arises (Kelly 2012). The signs that conflicts exist are not always as blatant as might be assumed. It may be that colleagues are in open dispute, with loud verbal exchanges, but the other signs could relate to there being a drop in motivation or productivity, an increase in absenteeism or changes in behaviour. Bauer and Erdogan (2015) identify six main causes of conflict within the workplace:

- **Organisational structure** – where unclear reporting lines confuse staff as to who they should report to
- **Limited resources** – money, time and equipment may be scarce
- **Task interdependence** – where you rely on others to complete their tasks in order to achieve your goals
- **Incompatible goals** – your priority may not be the same as someone else's
- **Personality differences** – these are common within workplaces; people coming from different cultures have different values and beliefs, and the key is to understand how they see the world
- **Communication problems** – the way a message may either be delivered or interpreted is often a cause of misunderstanding, leading to conflict; the written word (emails) can be readily misinterpreted

These causes are reflected in Almost et al.'s (2016) integrative review of managing and mitigating conflict, where lack of emotional intelligence, poor working environments, role ambiguity, certain personality traits, a lack of support and poor communication are seen as influencing poor conflict management. We can choose or defer to our preferred style of conflict resolution when faced with any or all of these types of conflict.

Conflict Resolution

An organisation where staff are encouraged to adopt a conflict resolution style based on collaboration supports a more positive organisational culture and facilitates better staff relationships (Dreachslin & Kiddy 2006). This is enhanced if employees are resilient and have strong personal characteristics, an ability to organise their work and personal life and strong support networks (McDonald et al. 2016). Dreachslin and Kiddy (2006) add that there are a number of steps that leaders can take to manage or minimise conflict and build resilience:

- **Recognise hot and cold conflict**: Identify the continuity of events. Cold conflict is formed by suppressed or passive anger, harbouring a grudge or underlying resentment. To deal with this, warm it up by bringing it to the surface so that the issue can be addressed and resolved. Hot conflict is the expression of anger or the voicing of concerns without thinking them through. Here the conflict should be cooled down and then dealt with.
- **Develop emotional intelligence** (see Chapter 15): This is about knowing how to recognise and manage your feelings to build stronger relationships, enhance self-awareness and achieve a greater work/life balance (Goleman 2011, 2014). The four building blocks of emotional intelligence are self-awareness (our own feelings), self-management (managing our emotions), social awareness (recognising others' feelings) and social skills (managing emotions in others).

- **Determine who you are managing (leading)**: This involves being sensitive to the different people you are leading, acknowledging cultural differences, gender differences and historical issues in the workplace.
- **Reduce community conflict**: Recognise and appreciate that you may not be dealing just with one individual and that they are usually part of a wider community; conflicts or solutions may have an impact on that community too.
- **Build strong personal networks**: You need a range of support from both a personal and work life perspective (McDonald et al. 2016).
- **Pre-empt and resolve conflict**: In relation to the principles of congruent leadership, how you are seen to deal with conflict will reflect on how your values are perceived. Doing something about conflict will usually produce a more positive outcome than doing nothing or trying to suppress it. Dreachslin and Kiddy (2006) suggest that leaders should find time to talk (and listen), plan for dealing with the conflict, talk the issues out, keep all parties engaged and make a deal to ensure that the problem will not be repeated.

The keys to managing conflict are to be prepared to deal with it when it occurs and to employ clear, open and honest communication (Kelly 2012). Engage in positive self-talk and rehearse conflict encounters. Understand the value of emotional intelligence and your own conflict style. Dreachslin and Kiddy (2006) conclude that one of the main things people can do to resolve conflict is to listen to each other more effectively.

Kohlrieser (2007) supports Dreachslin and Kiddy's (2006) view by suggesting that there are six essential skills for managing conflict:

- Create and maintain a bond, even with your 'adversary'
- Establish a dialogue and negotiate
- Put the fish on the table (raise the issue without aggression or hostility)
- Understand what causes conflict
- Use the law of reciprocity
- Build a positive relationship

Kohlrieser (2007) feels that conflict can be productive if managed properly and that leaders who use these six essential skills efficiently can reduce conflict or manage it well.

Responding to Conflict

While we may have a preferred method or response to conflict, there are a number of ways in which we respond. Kohlrieser (2007) and Coan (2010) summarise these as follows:

- **Flight** – running away (turtle style) or avoidance of the conflict.
- **Diversion** – delay, deflection or simply changing the subject.
- **Fight** – imposing one's will on another (the shark approach). This can take the form of control, verbal abuse and even violence. It is never an appropriate way to resolve conflict. People get hurt. Conflict does not get sorted, it just goes underground and festers.
- **Deny the conflict** – wait until it goes away.
- **React emotionally** – this may involve becoming aggressive, abusive, hysterical or frightened. It may also involve finding others to blame or creating excuses. These are rarely appropriate responses and lack the potential for a successful resolution.

- **Constructive conflict resolution** – resolving conflicts in a way that is mutually satisfying allows problems to be dealt with positively and involves a commitment to dealing with the issue. This only works if both parties are genuinely willing to resolve the conflict.

Clearly, the last approach is recommended as it allows leaders to determine the real source of the conflict, decide whether this is the correct source, set time aside to deal with the conflict and search for agreement together by negotiation, mediation or compromise. The other methods are non-productive and can even be counter-productive or destructive, implying that the correct approach to conflict is vital to diminish negative consequences and build the best chance of an effective resolution.

To reach a collaborative solution to problem solving, the following steps are suggested:

- **Define the problem**: Everyone involved needs to reach a clear agreement on what the problem is before it can be addressed.
- **Establish what everyone wants to get from the conflict (what are the goals)**: For example, the goals could be 'a voice at the table', 'respect from a senior colleague' or 'influence in clinical decision making'.
- **Separate emotion and feelings from the solution/problem**: When feelings and emotions are tied up in the solution, a decision is much more difficult to reach. This does not mean that you may not have strong feelings, but you should not let those feelings get in the way of a potential solution. Using I-messages (see later in this chapter) during the discussion will help keep emotions and feelings in check.
- **Self–awareness**: Identify any of your behaviour that contributes to the conflict.
- **Brainstorm options for mutual benefit**: There may be a raft of solutions, many of which could work, but often the first solution suggested is settled on as a technique to resolve the conflict. Keep ideas coming and suggestions on the table so that creative and innovative ideas flow and are well discussed.
- **Find objective criteria to evaluate the solutions proposed**: Look at the pros and cons, and establish a criteria set or standards on which all parties can agree. This may take time and care and requires considerate negotiation. It will mean being open to good ideas and closed to threats, yielding to sound arguments rather than pressure or intimidation.
- **Reach a mutually acceptable solution**: Once this is decided on, ensure that each party takes responsibility for the decision, and clarify that a collaborative solution has in fact been reached.

These steps require participants to listen to each other and check what they have heard. I-messages and self-talk can be used so that topics stay on track and remain future orientated. These steps should be followed with action, the sharing of responsibility and the wisdom to seek help if needed.

The key is to intervene early and recognise that the process may lead to understanding rather than agreement (Archee, Gurney & Mohan 2013). A good relationship is not one without conflict, but one in which the participants can resolve conflicts so that no one is hurt or oppressed. Kelly (2012) maintains that to be an effective leader, it is essential to be able to handle (manage) conflict. This implies that leaders are able to offer constructive responses to problems and conflict, recognising their styles and overcoming or using them as necessary. These skills are implied by Dotson (2007) when she suggests that 'self-management', 'networking', 'flexibility', 'synergy with others', 'being coachable' and 'using a mentor' are all keys to conflict success. They all rely on avoiding or controlling conflict and, as such, make conflict management a central issue in developing clinical leadership skills.

Conflict Management and Clinical Leaders

Successful conflict management requires clinical leaders (champions) who demonstrate key conflict resolution principles and the ability to influence rather than wield power and authority. Clinical leaders need to bring conflict into the open (Marquis & Houston 2012) so that it can be effectively addressed in a collaborative style. This will result in greater organisational or departmental creativity and innovation and lead to satisfaction for all parties involved. Clinical leaders need to value their goals and professional relationships highly and view conflicts as problems to be solved. Solutions should be sought that satisfy all involved, allowing everyone to meet their goals and at the same time maintain collaborative relationships.

Conard and Franklin (2010) suggest that this approach requires clinical leaders to show:

- a willingness to acknowledge conflict
- open communication and support throughout
- an attitude and environment of mutual respect when dealing with conflict
- understanding, tolerance and acceptance of different perspectives
- a commitment to fairness
- support for educating or sharing conflict management strategies with others
- commitment to the policies and procedures established to support conflict management
- encouraging accountability for all involved to employ these principles when dealing with conflict

When individuals know how to employ a collaborative approach to conflict, the conflict can actually be turned into a constructive force (Conard & Franklin 2010). Collaboration fosters team working and facilitates understanding that leads to a genuine appreciation of differences, resulting in a system of shared values, shared decision making and effective communication (Bauer & Erdogan 2015), all of which facilitate the application of congruent leadership.

Northam (2009) states that conflict is common in all workplaces, and that in nursing it is a frequent source of work-related stress and disharmony. She goes on to suggest that one reason is that nurses, while trained to deal with therapeutic communication, receive very little training in conflict management. Added to this are growing tensions in the make-up of the healthcare workforce, with greater interprofessional education and workplace dependence (creating power clashes) that mix and heighten tensions around gender, race, ethnicity, age and generational values. These factors in themselves do not necessarily contribute to conflict, but they can add tension to an already stressed and highly charged clinical environment. Effective communication techniques may not resolve conflicts, therefore it is important that managers or leaders understand when conflict resolution requires escalation to the next level through negotiation and mediation. We examine this more closely in the next section.

Building Bridges: Negotiation and Mediation

According to Pruitt (2011), negotiation is where two or more parties come together to reach an agreement to resolve a conflict. Leading and participating in the negotiation process is part of the role of clinical leaders and managers (Marquis & Houston 2012). Becoming a skilled negotiator takes practice and leaders should look to undertaking additional education programmes to gain these skills (Marquis & Houston 2012). There are three phases to the negotiation process: pre-negotiation, negotiation and post-negotiation. All phases are equally important if successful conflict resolution is to occur.

Pre-negotiation Phase

- Build bridges between the two parties so that they can communicate – decide whether the meeting is to be on neutral ground, ensure that it is a suitable venue that meets all party's requirements, talk to both parties to gauge an understanding of the issues that have created the conflict (Pruitt 2011).
- Agree on preconditions before entering the negotiation, such as acceptable behaviours; aggressive (both verbal and physical) behaviour will not be tolerated in any form.
- Identify the problem clearly and gain an understanding of each side's goals or needs.
- Set an agenda for what issues will be discussed and in what order.
- Choose a spokesman for either side (when two or more people exist on either side).
- Decide on who the facilitator of the negotiation should be – this person could either be neutral or be someone whom both parties respect.
- Set a mutually agreed date and time for the meeting to occur, allowing both parties to be equally prepared to 'come to the table'.
- Make sure that all relevant information is available at the time of the meeting (Pruitt 2011).

Negotiation Phase

For the leader involved in the negotiation it is important to think about the following (Marquis & Houston 2012):

- Maintain your composure.
- Facilitate pauses in the conversation.
- Be a good role model for communication, be assertive and flexible and emulate good speaking and listening skills.
- Avoid using destructive negotiation techniques and be prepared to counter these in others if required. Such techniques include ridicule, ambiguous or inappropriate questioning, flattery, feigned helplessness or aggressive behaviour.

General rules describe by Marquis and Houston (2012) to follow during the process of the negotiation are:

- Be factual and do not give hearsay any credibility.
- Listen carefully and observe non-verbal communication.
- Keep an open mind and do not take sides.
- Seek to understand both parties' viewpoints.
- Discuss the issue, do not personalise the topic of conflict.
- Do not fix blame on either party.
- Be honest and open (deception will destroy any trust).
- Be firm and clear about expectations.
- Know the bottom line, the non-negotiable aspects, particularly if they breach safety or industrial agreements.

Post-negotiation Phase

- Notice body movements or indications that the person is forming a response and wait for them.
- Summarise accurately the meaning of what you have heard.
- Paraphrase key points and, if your paraphrasing statement was not well received, try again or ask for clarification.

- Give feedback on feelings as well as content.
- Put the focus of your attention totally on the speaker.
- Record key aspects of the meeting for future reference or for reflection.

The success of any agreement relies on having the needs of both parties met in some way (Pruitt 2011). It is important that all parties understand the outcomes of the agreement and that they commit to upholding their part of it. After a pre-determined period of time, follow-up should occur with both parties to ensure that the agreed outcomes are being maintained.

If either party does not hold up their end of the agreement or if negotiation is unsuccessful, mediation should be considered. Mediation is an extension of the negotiating process whereby an external party arbitrates with both conflicting parties in order for an agreement to be reached (Pruitt 2011). In my experience, mediation is the last resort in managing conflict. Where decisions about the outcome are taken away from the conflicting parties, neither party may be satisfied with the outcome, as generally both parties lose something that they felt was important. This may potentially lead to disgruntled and dissatisfied employees.

Non-productive Behaviour

Not all conflict is managed well and often this is the result of non-productive behaviour. Clinical environments are not free from non-productive behaviours and they can occur in meetings (Kim, Gunn & Brezinski 2004), at handovers, in educational situations and indeed in any forum where health professionals interact. Some non-productive behaviours are described in the following.

Negativity

Do not put other people's ideas down, such as saying 'It will never work'. Instead, ask the question 'How do the rest of you see this?' Or the person with a new idea could be asked to offer further explanation or even a replacement idea for the one that got zapped. Nothing kills creativity more than negativity.

Being Talkative

Some people love the sound of their own voice and use it all the time. This can be addressed by referring these people to team rules, by stating a time frame for talking before starting a meeting or by politely saying 'Sorry if I interrupt you …', then making your point.

Attention Seeking

People may clown around and disrupt the team effort. Counter such behaviour by restating the purpose of the work or discussion, or by asking them to contribute in a serious way or to offer more serious dialogue. Then reward their serious side by complimenting the desired behaviour.

Arrogance

People can be highly assertive and prefer to get things done in the way they know best. This behaviour can be very controlling and self-assured, but it can alienate others in the team. It can be dealt with by using questions to get them to expand on their ideas, or by paraphrasing to repeat their ideas, so that they can see you know what they are suggesting.

Arguing

When questioning goes beyond clarification or thoughtful debate, or when people are obviously looking for an opportunity to disagree or pick at an idea, it becomes annoying and disruptive. Change the focus of the discussion by acknowledging the person's ideas, or feelings, and limiting the speaking time so that there is an equal opportunity for all to speak. This behaviour can also be handled by paraphrasing the various positions expressed or by dealing with people individually at a later date.

Withdrawing

Some people may act indifferently or passively, or simply not get involved in discussions. They may also occupy themselves by doodling or whispering to others, or getting off the subject or being distracted by a mobile phone or tablet. These behaviours can be addressed by getting the person to share their ideas in the meeting, or by asking them to contribute their ideas in advance so that you can call on them during the meeting. If they are simply not confident, they could tell someone else their ideas or views, then contribute to the team themselves once their ideas have been 'tried'. Their participation can also be encouraged by simply asking open-ended questions.

Aggression

This can be expressed in going after others' ideas in a critical or vicious manner, blaming others or showing hostility and anger, or putting other people's ideas or status down. Keep cool and say something like 'I see you have strong opinions, but let's hear what others think'. It may also be appropriate to respond to the whole team and not just to this person or to remain neutral. However you respond, make it clear that this behaviour is unwelcome.

Complaining

Some people will find fault, blame others or whine that things are unfair, and will express dissatisfaction with the way things are being done. A response could be to remain patient and compassionate, ask the person to focus on solutions, listen for their main points or concerns, and shift the focus of the discussion to solutions.

There may be other non-productive behaviours and the solutions offered here are not exhaustive, but in general the key is to listen to the person and try to understand what might have prompted the behaviour in the first place. This requires the application of active listening, considered next.

Active Listening

One of the main reasons that conflict occurs is that we either do not hear what is communicated, or what we are trying to say is not understood or heard clearly. In order to promote more effective communication, active listening will facilitate greater attention to what is being communicated. The benefit of active listening is that it enables the demonstration of understanding by one person to another and clarifies feelings about the communication (Coan 2010). Active listening can be used as a successful approach to avoiding conflict by ensuring that communication is effective and focused.

Active listening involves:

- concentration (energy)
- focus on the speaker
- listening to the whole message
- suspended judgement
- taking note
- making eye contact
- checking and reflection
- using paraphrasing
- separating fact from feeling
- elimination of distractions (telephones, computers, loud noises etc.)

Employing active listening may be difficult if some of the following barriers are encountered:

- being unable to hear all the time
- not understanding the topic
- being confused
- a noisy or distracting environment
- having other things on your mind or IT equipment in your hand (e.g. iPhone or laptop)
- not liking what is being said
- finding the content boring
- the talker's tone of voice, or speed and manner of speech
- poor paraphrasing skills

Active listening may not come naturally and some practice may be needed. This may seem an odd statement, given that health professionals are commonly heavily involved in communication. Yet are we always listening actively? Here are some hints to help with your development of active listening (similar to the suggestions for the post-negotiation stage discussed earlier):

- Allow silences in the conversation.
- Notice body movements or indications that the person is forming a response and wait for them.
- Summarise accurately the meaning of what you have heard.
- If your paraphrasing statement was not well received, try again or ask for clarification.
- Give feedback feelings as well as content.
- Put the focus of your attention totally on the speaker.
- Position yourself so that you can see and hear the speaker clearly.

Consider these helpful hints and in your next conversation (at work or at home) make an attempt to employ active listening skills. It can feel a little strange at first (unless you do this already), but try to follow the advice here and really focus on what the other person is saying.

Self-talk

Managing conflict means, in many cases, managing ourselves. Grant (2003) suggests that we can choose not to be victims of our emotional reactions to events, and that we have a conscious reaction or process and a subconscious reaction or process. What we have been taught is that a particular

event leads to feelings and this has an impact on our communication. In this model we are potentially victims, controlled by what happens. Thus:

$$\textbf{Event} = \textbf{Feelings} = \textbf{Communication}$$

However, what really happens is that after an event we have the thought, belief, and interpretation of the event in our mind. This leads to an emotion and then we have a reaction seen as behaviour, and it is this that affects our communication. Thus:

$$\textbf{Event} + \left(\textbf{Interpretation} / \textbf{Thought} / \textbf{Belief}\right) + \textbf{Emotion} \\ = \textbf{Reaction} / \textbf{Behaviour} = \textbf{Communication}$$

If we can modify our reaction (our thinking) and behaviour, we can promote more effective communication by catching faulty thinking. Examples of faulty thinking are exaggeration, over-generalisation, should/must thoughts, having to be right, catastrophising, self-blaming, mind-reading and the misperception of being treated unfairly. These fuel negative thinking and result in miscommunication, which can lead to conflict. I can recall getting an email from a senior colleague indicating that they were taking over a project I had been running successfully. I felt upset, as I had invested heavily in the project and I felt as if they were just taking over at the project's conclusion to get the credit for it. This resulted in my feeling unfairly treated, and I sent a sharp and inappropriate email in response. My feelings had led to an assumption about the reason I was being taken off the project. I had acted without clarifying the reason and this led to conflict (not about the issue, but about my feelings), as my colleague could not understand my response.

Here is another example of this process in play:

- **The event is activated** – in this case giving a presentation in front of colleagues.
- **Belief** (in this case negative) – I must perform exceptionally well or my colleagues will think I am incompetent.
- **Consequences of this belief** – anxiety, poor concentration, defensiveness.
- **Disputing the self-limiting belief(s)** – just because I want to perform exceptionally well does not logically mean that I must. If I do not perform exceptionally well, will my colleagues really think that I am stupid?
- **Effective new beliefs** – there is no evidence that my colleagues think that I am stupid if I do not perform exceptionally well. I have given great presentations before. I have received positive feedback from peers in the past.
- **New feeling** – more confident, able to approach the presentation as a challenge rather than an ordeal.

The process outlined is really the process of self-talk or mindfulness. It is a concept that can be understood and developed and relates to an individual's capacity to become more competent by identifying negative thoughts and replacing them with positive self-talk, which in turn has a positive impact on communication. Eunson (2012) describes the concept of self-talk, recognising that leaders need to learn to analyse and manage three things: internal dialogue (self-talk), mental images (visualisation) and beliefs and assumptions. Eunson (2012) identifies that distinguishing between unhelpful or negative self-talk as opposed to helpful or positive self-talk can enable an individual to move away from patterns of self-talk that are limiting or damaging in some way. Once you engage in positive self-talk opportunities, you can focus on constructive ways of managing and dealing with change and challenging situations, including conflict. Once you have rethought and want to communicate effectively, another approach to developing clear communication is to use I-messages.

I-messages

I-messages mean speaking for yourself and not for others. At first this will sound odd, and if your first reaction to this is like mine, you will be thinking 'But I already speak for myself, who else do I speak for?' You may be surprised when you really consider it, but often our conversations are aimed at speaking for others, frequently to avoid conflict. Do you ever start a conversation with 'sorry'? I did so the other day in a restaurant when a waiter dropped a fork and I said 'Sorry, I'll get that,' as if it had been my fault.

I-messages use words like 'I, me, my, I think, I believe, I want to know that, I want to, I don't want you to.' The key is that they all start with 'I.' The communication is about what *you* want, feel or think. It is constructed so that you own what is being said and the listener is directed to how you feel, the behaviour of concern and its effect. As such, I-messages are structured as follows: 'I feel … (describe your feelings) when you … (describe a behaviour) because … (describe the effect).' For example, 'I feel upset when you don't fill up the car with petrol because it means I was late for work as I had to stop and do it.' Or 'I feel fed up when you say you are coming to bed and instead you stay up and watch television for another hour, because you wake me up coming to bed later.'

Relating to each other in this way all the time may make conversations sound a little fake or stilted, but in terms of addressing or stalling conflict it is a very effective way of demonstrating the impact of a set of actions and owning the feelings related to them. Practise some I-messages at home or at work and consider the results.

Conflict often sets people up on different sides of a discussion and leads to further division. Wheeler (2006) suggests that it is better to find common ground, and in many respects the proposed approach to dealing with conflict already set out is designed to help clinical leaders recognise their own conflict styles and search for common ground when they encounter conflict.

Reflection Point
Think about a conflict you have had recently at work. Was it resolved positively or could the outcome have been improved? If it could have been improved, how might I-messages, self-talk or active listening have affected the outcome?

Benefits of Conflict Management

There are a number of benefits for healthcare professionals and clients or patients if conflict is dealt with more effectively. Bearden (2009) emphasises that a reduction in conflict in the clinical area may lead to more culturally appropriate care, improved communication, greater staff satisfaction and increased nurse retention. For clinical leaders who can deal with their emotions and react in a collaborative style when faced with a conflict situation, the result can be more or more effective communication and better opportunities to proceed with practice improvements, innovation and change.

Case Study 12.1
Aung San Suu Kyi has faced conflict and opposition for most of her life. However, she has prevailed against one of the most oppressive authoritarian regimes in history. Read her story and consider the challenge that follows.

(Continued)

Case Study 12.1 (Continued)

Female Leaders: Aung San Suu Kyi

Aung Sang Suu Kyi was born in Burma (now Myanmar) in 1945. Her father was the prominent and inspirational politician and military leader General Aung San, who was partly responsible for negotiating Burma's independence from the UK in 1947. This was also the year he was assassinated, when Suu Kyi was just 2 years old. She left Burma as a teenager with her diplomat mother, Khin Kyi, and lived for a while in India before taking a degree at Oxford University and settling in the UK, where she married an English academic and gave birth to two children.

Suu Kyi returned to Burma in 1988 to care for her mother after she had suffered a stroke. At the time Burma was on the cusp of emerging from 26 years of oppressive dictatorship under Ne Win, but instead of the promised referendum and initiation of a parliamentary democracy, he instituted a military coup and reinforced further dictatorship. Following massacres of pro-democracy demonstrators, Suu Kyi began to speak up. Just a few months after her return she helped found the National League for Democracy (NLD) and in 1990 she was elected prime minister in a general election with 59% of the popular vote. Her party won 82% of the available seats. Tragically, the military junta refused to accept the result and persisted with its illegal dominance over the country, and the now opposition NLD party. Suu Kyi was arrested without charge in 1989 and remained a political prisoner, detained or imprisoned for 14 out of a total of 20 years. When under arrest she was denied access to her family and supporters and the junta even attempted to bribe or threaten her in to try to silence her influence on the people of Myanmar.

Detention did not prevent Suu Kyi from speaking out, though, and she carried on a difficult and determined fight for her people and her country's freedom. In 1989 she stood alone before an army unit while they trained their rifles on her. She refused all help from the military junta and endured hunger strikes that left her malnourished and ill. When her husband became seriously ill, the military government refused to allow him to travel to be by her side before his death in 1999, and her children grew up without their mother. Each time she was released from house arrest (in 1995 and 2002) she spoke out against the government, calling for liberty and democracy to be reinstated, and as a result was immediately placed back under house arrest, with her telephone lines cut and her letters vetted or intercepted. As a result of her courage, in 1990 she was awarded the Rafto Prize and the Sakharov Prize for Freedom of Thought, and in 1991 the Nobel Peace Prize, with the committee chairman describing her as an outstanding example of the power of powerlessness. In 1992 she was awarded the Jawaharlal Nehru Award for International Understanding by the government of India.

The military government in what is now Myanmar has tried to bribe Suu Kyi with offers of freedom in return for her permanent departure from the country, but she has refused to be moved in the hope of drawing international attention and aid to her country's plight. Her writings show her as an 'ordinary person fighting for the freedom of the ordinary people of her country'. She did not see herself as a martyr or hero or as exceptional, although she has maintained an optimistic and undiminished passion for her cause in the face of persistent, lengthy and cruel treatment at the hands of the military junta.

In November 2010 Suu Kyi was granted what Barack Obama has called her 'long overdue' release from house arrest, and joined thousands of joyful supporters outside her home in Rangoon, where she immediately spoke out against the dictatorship. The release came six days after the country's first election in 20 years, in which the political party supported by the military junta won in what is widely regarded as a sham election. However, progress is being made, and Suu Kyi has called for the people of Myanmar to work for unity. In 2012 she was successfully elected to the Myanmar Parliament's lower house and in 2015 her NLD party won 86% of the seats in the Assembly of Union, opening the door for Aung San Suu Kyi to remain in a political leadership position for some years. She continues to work for the development and growth of Myanmar.

Challenge: Suu Kyi has sacrificed much of her own personal freedom and family life in a struggle to gain recognition for the plight of the people in Myanmar and to have democracy brought to life. She has faced serious and real personal dangers and risked much to stand up for her beliefs and convictions. Fearless in the face of a harsh and compassionless dictatorship, she has remained active and vocal in the pursuit of her own and her country's fight for liberation. When have you found the courage to stand up and fight or struggle for the things you believed in or that are important to you?

Summary

- Conflict is part of life.
- Clinical leaders are in an ideal position to recognise and deal with conflict in the clinical environment.
- It is vital that clinical leaders understand what conflict means and how it can be recognised and managed.
- There are a number of ways in which people tend to respond when faced with conflict: they can withdraw, compete, become accommodating, compromise or collaborate.
- Clinical leaders who use a collaborative approach to conflict resolution deal more effectively with conflict.
- Conflict at work is often the result of unclear expectations, poor communication, unclear boundaries, conflicting interpersonal styles, conflicts of interest or change within an organisation.
- To reach a collaborative solution, clinical leaders are encouraged to define the problem, establish the goals, separate emotion from the problem or solution, brainstorm options for mutual benefit, find objective criteria to evaluate the solutions proposed and reach a mutually acceptable solution.
- Clinical leaders seeking a collaborative approach to conflict resolution should also employ integrity, honesty and superior listening skills.
- These approaches should reduce non-productive behaviours such as negativity, talkativeness, attention seeking, arrogance, arguing, withdrawal, aggression and complaining.
- These behaviours can also be reduced with the use of active listening, self-talk and I-messages.

Mind Press-ups

Exercise 12.1

How was conflict resolved in your family when you were growing up? What lessons have you learnt about conflict resolution from your experiences with family, friends and co-workers?

Exercise 12.2

When you have a conflict with someone, how do you prefer to handle it? What approaches to dealing with conflict are you less comfortable with or would rather not use?

Exercise 12.3

Think of someone with whom you often find yourself in conflict. What is the behavioural style or conflict strategy that you often notice them using? How can understanding this help with the conflict in future?

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13

Motivation and Inspiration

David Stanley

If your actions inspire others to dream more, learn more, do more and become more, you are a leader.
John Quincy Adams, 6th President of the USA, 1767–1848

Introduction: Inspiring Others

To be effective, clinical leaders need to be able to motivate and inspire others. As many clinical leaders are not in positions of 'power' over others (indeed, controlling others is strongly seen as a trait of non-clinical leaders), they need to consider other more appropriate and effective motivational approaches. In the research that underpins this book, most participants described clinical leaders as guides and teachers, indicating that they should be open, approachable and help people to feel part of a team (Stanley 2006a, b, 2008, 2010, 2011, 2012; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton, & McDonald 2015). Many suggested that leaders should provide support and motivation, and be individuals they could look up to or admire, even be inspired by. One participant in Stanley's (2006a) study said 'you need to be motivated I think to be a leader'. The researcher then asked 'And do you need to motivate others?' to which the research participant responded 'Definitely'.

In light of this vital aspect of clinical leadership, approaches to motivating and inspiring others are considered in this chapter. The key to motivating others, from a clinical leader's standpoint, is to allow them to see and be inspired by the leader's values and beliefs about care and patient health management. In this way, followers who identify with the clinical leader's values and beliefs will be prompted to align themselves with those values and be motivated to support and follow the clinical leader.

This chapter will also consider something more significant than motivation for the clinical leader. It will briefly explore the issue of inspiration and how clinical leaders might inspire others to follow and engage with steps to improve patient care and the health service.

What is Motivation?

Motivation is that extra, often intangible element that gets us up in the morning, the fire in the belly, the joy of getting 'stuck into something'. Daft and Pirola-Merlo (2009, p. 230) refer to motivation as 'the forces, either internal or external to a person, that arouse enthusiasm and persistence to pursue

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a certain course of action'. Heller (1998) supports this and describes motivation simply as the will to act. Clinical leaders are responsible for enabling a culture where motivation can flourish. Goleman, Boyatzis and McKee (2002, p. 41) link motivation with emotional intelligence and self-awareness (see Chapter 15), and explain that motivation is guided by values that are represented in emotionally toned thoughts, which can either appeal to us or repel us. The appealing elements can translate into motivators that drive us to do and achieve what we want.

Motivation is closely aligned to values. If you work in an environment where your own values resonate with that of the health agency, then there is an increased likelihood that you will display the behaviours of motivation. So what are these behaviours and what do they look like? Examining some models and theories of motivation may help explain this.

Models and Theories of Motivation

Motivation theory has been around since the 1940s, although it is only in recent times that its relationship to the work environment, and specifically leadership, has been recognised. Therefore, it will be useful to gain an overview of several theories of motivation. The earliest theories were Maslow's hierarchy of needs, theory X and theory Y and the two-factor theory, and more contemporary models include expectancy theory, the job characteristics model (JCM), McClelland's theory of need, cognitive evaluation theory, goal-setting theory and equity theory. Only three of these will be discussed here, so for more detailed information, see the explanations of various motivation models on ChangingMinds (http://changingminds.org/explanations/theories/a_motivation.htm).

Maslow's Hierarchy of Needs

One of the best-known and earliest theories of motivation is Abraham Maslow's hierarchy of needs. Maslow believed that there are five main needs that drive our motivation: psychological security, safety, belonging, self-esteem and self-realisation (Rouse 2004, p. 27; see Table 13.1). Within these stages are intrinsic (internal) and extrinsic (external) aspects of motivation. Amabile (1993, p. 185) examines intrinsic and extrinsic motivation in the workplace, and suggests that 'unmotivated employees are likely to expend little effort in their jobs [and] avoid the workplace as much as possible'. The upside is that motivated employees are creative, persistent and productive.

Motivation and creativity are closely attuned. Giugni (2004, p. 69) comments that 'creative individuals also demonstrate some degree of self-satisfaction' and that 'they are enthusiastic, attracted by the challenge and feel that they are working on something important'. Intrinsic motivational factors tend also to be more linked with creativity, as extrinsic factors are with task achievement. Both are important; however, intrinsic factors are driven from within and are therefore aligned with the individual's personal values. MacKenzie (2004, p. 143) describes Maslow's hierarchy of needs as well suited to the workplace environment, highlighting for example that primary needs are met in the form of remuneration (the safety stage) and more complex needs in areas such as knowledge, morality and creativity (the self-actualisation stage). For leaders it is noteworthy to appreciate what sits beneath motivation, how powerful it can be and why it can influence how someone behaves and performs in the workplace.

Expectancy Theory

Expectancy theory is one of the most widely accepted contemporary models of motivation. Developed by Vroom in the 1960s (Holdford & Lovelace-Elmore 2001), it is focused on outcomes rather than need, and consists of three factors: the strength to act in a certain way depends on the expectation of

Table 13.1 Maslow's model adapted for motivating workers.

Maslow's model	Motivating through
Basic needs	Remuneration – they will go where the pay is good Safe workplace and appealing environment Incentive schemes for employees Treated as individuals
Relatedness needs	Show respect Give responsibility and autonomy Recognise good work – for example, publicly acknowledge and minute this at staff meeting; privately send a 'well done on a good job' note or email Communicate – when things are going well and not so well Decision making – involve others Encourage ideas – open engagement, healthy debate Praise people Get to know the team – address people by name; genuine 'small talk' is just as important as talking 'work' Team-building events – not just something only managers do Celebrate – announce publicly, reward and acknowledge
Growth needs	Support to complete new tasks Present challenges, invite debate Encourage people to think for themselves Avoid predictable routines Ask people what motivates them Opportunities for self-development Reward good work

Source: Adapted from PRLog 2008.

the reward or the attractiveness of the motivator. Robbins, Millet and Waters-March (2004, p. 184) support this with an example: 'An employee will be motivated to exert a high level of effort when he or she believes that effort will lead to a good performance appraisal.'

Job Characteristics Model

The job characteristics model (JCM) is a framework developed by Hackman and Oldman (1976) for defining job characteristics that are important to employee motivation (see the description in Daft and Pirola-Merlo 2009, p. 176). The framework is divided into five core dimensions: skill variety, task identity, task significance, autonomy and feedback. Examples of the JCM from a fictitious ward setting are offered in Table 13.2. All the dimensions have a low value and a high value, and motivation results from a high level of satisfaction.

The first three dimensions merge to become purposeful work, when the work is more meaningful to the worker. As the person's autonomy is increased, so too is their level of personal responsibility and satisfaction. Job characteristics act more widely to influence the individual's critical psychological state (meaningfulness, responsibility and knowledge of outcomes) and outcome (high motivation).

Reflection Point

Who motivates you? Take a moment to consider people whom you find motivational or inspirational. This can be someone you know personally or someone you know about. Consider at length what attributes or behaviours they display that you find appealing. What can you learn from this?

Table 13.2 JCM: Examples of high- and low-level job characteristics.

Job characteristics	Level	Examples
Skill variety	High	Community mental health nurse, providing services to a range of clients, designing client interventions, collaborating with health professionals and families providing a mobile, flexible service.
	Low	Taking temperature and blood pressure only.
Task identity	High	Identifying an improvement activity and implementing a change in a health setting, for example identifying a need for an orientation package for graduate nurses working in the emergency department. Forming a project team, running a pilot project and leading the project to its conclusion, including evaluation of the effectiveness.
	Low	Completing an audit by ticking boxes on a form without knowledge of the subsequent improvement activity.
Task significance	High	Coordinating an intensive care unit or managing a residential aged care facility.
	Low	Collecting meal trays.
Autonomy	High	Community nurse who manages own workload based on client need. Ability to be flexible without asking permission. Outcomes-based approach.
	Low	A nurse who cannot be flexible with client needs unless permission is given.
Feedback	High	Wound care specialist nurse adjusting wound care interventions and evaluating effectiveness through evidence via observation, data and patient feedback.
	Low	A nurse applying a dressing, while a wound care specialist evaluates its effectiveness and discusses with the patient.

Source: Johns, G & Saks, AM, *Organizational behaviour: understanding and managing life at work*, 7th edn, © 2008. Printed and electronically reproduced by permission of Pearson Education, Inc., Upper Saddle River, New Jersey.

How to Motivate Others

Toode, Routasalo and Suominen (2010) conducted a literature review on nurses and motivation and found that motivated nurses have reported stronger empowerment in behaviour, words and outcomes than unmotivated nurses. They also go on to say that this attitude is positively reflected in patient health outcomes, which is a good argument for harnessing motivational attributes in the workplace.

The research that supports this book also reinforces the importance of motivation in leadership and identifies motivation and inspiration as key features of congruent leadership. A number of other studies have searched for the motivational factors that drive nurses and other health professionals (Bengtsson & Ohlsson 2010; Lambrou, Kontodimpoulos & Niakas 2010; Sung 2010; Kudo et al. 2011; Rose 2011; Moghimian & Karimi 2012). As a clinical leader, it is important to recognise that different things motivate different people, with nurses mainly motivated by autonomy, positive relationships and access to resources (Germain & Cummings 2010), while for other health professionals it is about money (Kudo et al. 2011). For others it is the satisfaction of connecting with others or accomplishing something complex. Motivation is not a 'one size fits all' approach. Blanchard et al. (2003) and Toode, Routasalo and Suominen (2010) support this view, indicating that one should never assume what motivates someone else. They add that establishing motivation relies on building trust, focusing on the positive and redirecting energy when mistakes occur.

In the past, organisations have been dependent on a command-and-control approach to motivation, with reward or punishment used as the dominant motivational tool. However, partly in response to generational workforce issues (Stanley 2010), organisations have moved more towards advise-and-consent cultures or approaches. These are based on the premise that rewarding 'good' work is more effective than threatening punitive measures for 'poor' work (Handy 1999). Toode, Routasalo and Suominen (2010) also identified five themes that affect work motivation: workplace characteristics, working conditions, personal characteristics, individual priorities and internal psychological states. These are useful strategies to consider when motivating others and are summarised in Box 13.1.

Another motivation dynamic has been promulgated by author and analyst Daniel Pink (2009), who examined the traditional approach of businesses and compared it to the science of motivation. Pink (2009) found that the business world traditionally used extrinsic rewards as motivators to increase performance, such as bonuses, increased leave and share percentage. His research discovered that intrinsic rewards are far more motivating, suggesting that basically people do things they like if they

Box 13.1 Five themes of work motivation

1) In terms of **workplace characteristics**, nurses and other health professionals are motivated by:
   - good collaboration between members of the healthcare team
   - social support inside the team
   - positive team spirit on the ward or in the clinical area
   - each health professional having equal status as a valued health professional in a team
   - high level of autonomy, especially in regard to decision making
   - variety of skills and combination of different talents
   - performing 'whole care' rather than 'part care'
   - opportunities to learn
2) **In terms of working conditions**, nurses and other health professionals are motivated by:
   - the coordinator's ability to manage changing demands on a ward or clinical area
   - suitable working hours and the possibility of combining work and private matters
   - appropriate remuneration and job security
3) **Personal characteristics** that are attributed to motivated nurses and other health professionals include:
   - a variety of correlations with age and work environment
   - high levels of motivation and awareness of professional knowledge and ability among tertiary qualified professionals, who are internally motivated
4) **Individual priorities** for motivation of health professionals include:
   - whether their work meets certain individual needs and values that are important to them
   - the ability to meet their own needs and have control over their use of time
   - the opportunity to help others
   - positive opinions on ethical factors in the work environment
5) **Internal psychological states** influencing motivation include:
   - knowledge of actual results of work and experiencing outcomes of work
   - perception of work as being meaningful

align with their values and if they have meaning for that individual. Pink (2009) suggests that there are three core elements of motivation: autonomy, mastery and purpose:

- **Autonomy** – the ability to decide and control what you do, when you do it and how you do it
- **Mastery** – the thrill at becoming better at something and increasing one's knowledge through engagement
- **Purpose** – the yearning to do something bigger than ourselves

Building these elements into clinical roles may enable motivation to occur. A motivated individual and team are far more effective and efficient and can provide better patient outcomes than a demotivated team (Pink 2009).

Another approach to motivating people is offered by Lundin, Paul and Christensen (2000), who describe the four principles of the FISH! philosophy. The motivational approach of FISH! originated in the Pike Place fish market in Seattle, and has grown into an international motivational movement. The FISH! philosophy is about producing a constant flow of positive energy that motivates and empowers people at work. The four principles are:

- **Play** – a way to have fun, creating energy and engaging people's playful and creative sides.
- **Be present** – engaging with clients, patients, customers and colleagues in a way that focuses on their needs in each moment.
- **Make their day** – again focusing on the needs of clients, patients, customers and colleagues in a way that energises them and creates feelings of involvement, belonging and support.
- **Choose your attitude** – a reminder that whatever you are doing it is important to be conscious of your attitude and that this is at the control of your will. We can choose to be sad, or upset or miserable, or happy. The circumstances in which we find ourselves at work may be sad, or disappointing or happy, but we all have a choice about how we respond. We can choose to be 'world famous' or to be down. It is up to us.

Signs that People are Demotivated

As a clinical leader it is important to recognise potential signs of reduced motivation among ourselves and others in order to respond to them, or prevent them from occurring. For example, the workplace culture may not be an ideal one where motivation and inspiration are valued or flourish. The clinical leader will need to be not only an expert clinician, but also an astute detective of motivation. The signs, reasons for and costs of demotivation are summarised in Box 13.2.

The Motivational Power of Failure

Failure is not something that people aim for, but when it occurs it need not always be seen as negative. There is a Chinese proverb, 'Failure is the mother of success', and Cantwell (2015 p. 19) states simply that teams 'learn from their mistakes', adding that in 'rapidly changing situations, they will respond more effectively to, and recover better from, setbacks'. Moreover, Japanese engineer Soichiro Honda is known to have said that 'success is 99 percent failure'. Failure, then, can be regarded as a motivational force, if it is viewed as an experience that can be learned from. Martin Seligman (2006) suggests that setbacks can be viewed optimistically, depending on our capacity to recognise them as remote from ourselves. If people feel that setbacks are due to their own inadequacies and cannot be

Box 13.2 Demotivation uncovered

Signs of demotivation:

- increased sick leave
- increased absenteeism
- lateness
- decreased work quality
- decreased communication
- sloppy attire or poor attention to presentation
- change in attitude from positive to negative

Why staff become demotivated:

- lack of recognition
- lack of job stimulation and involvement
- inadequate education and training at work
- work overload
- being micro-managed
- lack of autonomy
- lack of decision-making ability
- high workload with limited support

Costs of demotivation in the workplace can be:

- staff replacement, such as retraining, readvertising
- emotional contagion of working where motivation is low – negativity spreads quickly
- interruption to job routines, for example through frequent orientation of new staff to a ward, unit or department
- the word gets out, 'please don't send me to ward 93G' and so on
- a knowledge drain as the repository of intellectual information leaves

overcome, then those setbacks become a genuine barrier to progress. However, if failures are seen as being related to individual or specific circumstances, or as temporary in nature and able eventually to be overcome by greater effort and more application, then the response may be to effect a solution or do better next time (Tan 2013)

Taking an optimistic view of failure can be learnt, with the result being that even failure can be seen as a motivational force. Some of the greatest medical advances have come about because of apparent failure (e.g. the discovery of Viagra as a potent treatment for erectile dysfunction when the drug was being tested for its impact on heart problems such as angina). Furthermore, humans have a greater tendency to pay more attention to negative than positive occurrences (Tan 2013), since such failures can be used to help us learn not just what did not work well, but what might be best avoided in future. In the health service mistakes and errors are (sadly) not uncommon, but the lesson to take from them is to recognise them, acknowledge them and use them to learn. Clinical leaders are not perfect, but the mark of a great clinical leader is likely to be their capacity to see setbacks optimistically and to use them to try harder and not give up. Recognise that sometimes to find new and innovative paths you need to get lost first, if not most of the time.

Inspiration

Inspiration is described as the arousal of the mind to a special or unusual activity or creativity, or the arousal of a particular emotion or action. In my opinion it holds a key place in the role of a clinical leader. Goleman (2013) is of the view that leaders who inspire can articulate a shared set of values that resonate with and motivate the group. Inspiration and motivation are closely related, but there is something about inspiration that takes people to a higher plane. In terms of emotional intelligence (see Chapter 15), it is the application of empathy, active listening and self-awareness that leads to relationship effectiveness and setting people apart as inspirational (Goleman, Boyatzis & McKee 2002). People who do this are the ones you love to work with or want to work with. They speak to us from their heart with their values on show (Goleman 2013). Motivation can be associated with managerial steps to exercise control or support people to perform in their work environment, but inspiration is something that can lift people to achieve, or create or contribute to an exceptional degree. Cleary, Thomas and Hungerford (2015, p. 317) suggest that it is 'moments of inspiration that keep us from becoming cynical about our professional lives' and help us focus on what is important to us.

Inspiration can come from anything (a person, a thing, nature, a song) and the impact will be different for different people. The key message here is that the actions of a clinical leader are often inspiring as well as motivational for people affected by or witness to their actions. Part of the power of congruent leadership is that people are drawn to follow leaders who stand by their beliefs, values and principles and this alone can support inspirational acts. Cleary, Thomas and Hungerford (2015) suggest that inspiration can come from even routine or standard activities such as clinical supervision, and from strong professional and supportive collegial networks. Therefore, focusing on our values of care can sometimes be a beacon for others to follow (Hungerford 2014).

I suspect that 'inspiration' is rarely the intent of any particular action, but clinical leaders should be aware that inspiration of their colleagues may indeed be the result of their engagement with congruent leadership and the embodiment of emotional intelligence (Goleman 2013). This supports the claim that demonstrating our values in our actions carries significant influence and may even negate the need to resort to titles, hierarchical positions and roles with control features in order to have an influence, motivate or genuinely inspire others.

Case Study 13.1

Boudica had her lands seized, she was flogged and she was forced to witness her daughters being raped. However, she used these insults and injustice as the motivational force to rise up against the Roman Empire. Read Boudica's story and consider the challenge that follows.

Female Leaders: Boudica

As a child I learnt about Queen Boadicea of the Iceni tribe, now more commonly known as Boudica (also spelt Boudicca). The Iceni tribe resided in what is now East Anglia in England and had the misfortune to be an indigenous tribal group under the occupation of the Roman Empire.

Boudica's husband, King Prasutagus, had managed to remain allied and in good favour with the Roman administration, but when he died the Roman governor ignored his will (which left his kingdom jointly to Rome and his daughters) and annexed the Iceni lands. On Prasutagus's death, his subjects also became liable for his debts. Boudica was flogged and her daughters were raped as an example to other tribes, and under Governor Gaius Suetonius Paulinus Rome took the Iceni lands and began to enslave the people.

Queen Boudica, her tribe and some other local tribes were outraged, and rebelled against the Romans in the immediate vicinity. At first the Iceni and their allies had great success. They captured the Roman settlement of Camulodunum (now Colchester), killing many and routing the Roman garrison of elements of the IX Legion. Boudica then planned the next stage of the rebellion, raiding and sacking both Londinium (now London) and Verulamium (now St Albans). Governor Suetonius was away fighting other British rebels when he heard of Boudica's rebellion and he hurried back to eastern Britain. He concluded that he did not have the strength to assault the rebels directly, so he withdrew to what is now the West Midlands. The enraged tribes were successfully rampaging through the captured towns, murdering, raping and pillaging. They even went as far as desecrating Roman cemeteries and burning towns to the ground. All the while Boudica rallied the tribesmen by riding about in her war chariot with her daughters.

Suetonius regrouped in the vicinity of the Roman road Watling Street. He gathered together as many men as he could, mostly from the XIV Legion and a number of auxiliary troops, but his force numbered less than 10,000. Boudica had a massive force, put at 230,000; although that is unlikely (given that the only source for the number is Roman and likely to be exaggerated), the rebel force was still huge.

Roman historian Tacitus suggests that Boudica, with her daughters in her chariot, motivated her army by presenting herself not as a wealthy landowner who had been robbed, but as a woman who had been abused, who had witnessed her daughters being raped and who had a just cause. She was set on a victory (the name Boudica is thought to derive from the Celtic word for victory) and moved into the West Midlands for a final conflict.

The Romans had the better ground, were well disciplined and well equipped, and in the final battle the Iceni and their allies rushed on, crashing into the solid Roman force. The fight was brutal, but the Romans had the upper hand and slaughtered the tribesmen. Tacitus reported that 80,000 Britons died while only 400 Roman infantry were killed. Boudica and her daughters, seeing their army defeated, reportedly poisoned themselves, and while a lavish burial is hinted at from other sources, no record of her grave exists.

The times when Boudica lived were violent and treacherous, and atrocities were committed by both sides during and before the rebellion. However, Boudica is a notable female leader because she rose to lead in a time of great conflict. She successfully motivated her tribe and others to fight and die against an invading and imperial force. Had she been successful it may have prompted Nero (the then Roman Emperor) to abandon Britain, and she may have gone on to rule over an independent country.

Boudica motivated others because she fought battles as a true warrior, leading from the front while maintaining a strategic focus. Visible in her chariot, her leadership behaviour was evident to those who followed her. Also she behaved in a courageous manner and was inspirational in her conviction, and the tribespeople followed her loyally.

Challenge: Boudica used frankly horrendous, negative personal experiences as a motivational tool. Although she ultimately failed, how can this type of motivation be applied in the health service? How can failure or insult be used as a force to generate a more positive result? Have you encountered setbacks that only made you want to try harder? Have you been challenged or taken to task by managers or colleagues and been left feeling bullied or belittled? Look back to Chapter 12 for advice about dealing with conflict (in more productive ways than Boudica), where the suggestion is that it is possible for negative personal experiences to be used in positive or productive ways to build stronger networks or better outcomes. This follows the maxim 'That which does not kill me makes me stronger'. Have you been challenged to come back from a setback? If so, how have you done so and have you achieved this in a way that builds and enhances relationships rather than damages them? Why is a positive (emotionally intelligent) approach likely to be more productive than the path that Boudica took?

Summary

- Understand what sits underneath motivation, or a lack of motivation, and the impact it can have on the workplace and the individual. Recall that intrinsic factors (from within) often hold greater meaning than extrinsic factors (from outside).
- Consider models or concepts of motivation to support the development of motivation. Explore beyond the models offered.
- Self-awareness is vital, so understand what motivates you. Be prepared to examine your own performance and make changes.
- As a clinical leader, in order to facilitate the inspiration and motivation of colleagues, you need to demonstrate the desired behaviour yourself. You do not need to hold a managerial role to influence, inspire and motivate or lead others.
- Failure can be a motivational force, as long as it is seen as something that can be learnt from and responded to optimistically.
- Inspiration is that something that can lift people to achieve, create or contribute to an exceptional degree and it is very much associated with congruent leadership.
- Positive behaviour can be contagious. As a clinical leader, learn to let go a little, be prepared to be wrong, allow ideas to be tested and encourage and enable colleagues to try them out, and take a step away so that others can step forward. Find ways to renew your energy so that you can be motivational and inspirational to others.

Mind Press-ups

Exercise 13.1

Answer the following questions – and be honest with yourself. Take 15 minutes to complete this then discuss your answers with another person.

- Describe your level of autonomy now in the workplace.
- If you could make changes to increase your level of autonomy, what would they be?
- What would you like to gain greater mastery at?
- What steps would you need to take to achieve this mastery?
- How does your current purpose at work align with your values?
- What steps could you take to ensure your values do align?

Exercise 13.2

Visual motivation: select a picture or photograph (magazines can be useful or your own photo collection) and create an inspirational statement to accompany your image. If the result really resonates with you, place it somewhere you can see it so that you can be regularly inspired and motivated.

Exercise 13.3

Think of a time you have failed. How did you respond? Did you give up? Why? What might have happened if you had regrouped and tried again or tried a new approach to the issue? Can you see that failure is not a full stop but a comma? It is a pause and an opportunity to have a new go, a chance to learn! Think of a failure that you have learnt from. Why did you think differently about this failure?

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14

Creating a Spirit of Enquiry

David Stanley and Judith Anderson

Facts do not cease to exist because they are ignored.
Aldous Huxley, English critic and novelist, 1894–1963, in 'Note on dogma', 1928

Introduction: Is the Spirit with you?

The provision of evidence-based clinical care is now an essential aspect of modern healthcare (Hopp 2012; Kaper et al. 2015). The idea of evidence-based practice (EBP) feels intuitively sound: both professional intuition and clinical experience suggest that the client or patient is more likely to receive good-quality care if that care is based on sound evidence. Melnyk and Williamson (2011) have proposed that 'many' healthcare and policy decisions are based on isolated, ritualistic and unsystematic forms of clinical practice. This chapter attempts to address this issue by discussing what constitutes EBP and how nurses and other health professionals can develop a spirit of enquiry. It also considers how clinical leaders can use evidence to support change and strengthen their practice by developing a nexus between research, clinical evidence, practice and education to create a workplace that promotes critical thinking and new knowledge.

Two Keys

As with effective team working, there are two key strategies that will initiate a spirit of enquiry within a healthcare environment: support and challenge. A spirit of enquiry and critical thinking can be initiated by offering the challenge of a good question that makes health professionals think. Support is also vital, as it allows clinicians to take a chance and ask awkward, difficult or challenging questions. Nothing supports like being listened to and helping health professionals feel comfortable at bringing questions, issues and challenges to the leader or manager's door. Both support and challenge are central to creating a clinical environment where critical thinking, EBP and innovation can be fostered.

Wilson (2014) indicates that nurses, especially those from later generational groups (Gen Y+), appreciate being shown evidence before they will accept changes. The 'Google Generation' have grown up with their hands on data and they are connected to the point where they are taught to question, research and confirm the information they are given. Yet does the healthcare workplace welcome this and enhance their skills – or contrive to suppress their enthusiasm for knowing more?

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Increasing the research capacity and spirit of enquiry in the healthcare environment requires strong leadership that generates a habit of enquiry and a strategic approach (Mitchell, Baillie & Phillips 2015). Furthermore, the recognition of evidence that informs practice is captured under the umbrella of EBP, so it is wise to start by exploring this concept.

Evidence-based Practice

Evidence-based practice (in the form of evidence-based medicine) has its philosophical origins in early or mid-19th century Paris. It has not always been enthusiastically received, with criticisms terming it 'old hat', that it facilitates 'dangerous innovation', is a service to bean counters or that it is used as a tool to 'suppress clinical freedom' (Sackett et al. 1996, p. 71). However, today EBP has come to represent the pinnacle of practice, with Kaper et al. (2015, p. 1261) defining it as 'a problem solving approach intended to improve the quality of health care by informing clinical decision making in patient care by the current best evidence'. Systematic reviews (SR) use rigorous methods to identify, appraise and synthesise the information from several studies that are all attempting to answer the same research questions to inform best practice (Melnyk & Williamson 2011).

The Cochrane Collection was the first attempt to pull together international evidence of primary sources of research in order to inform practice. The Joanna Briggs Institute focuses on nursing research to synthesise and disseminate systematic reviews of evidence (Hopp 2012). Williamson and Kretschman (2010) indicate that EBP is implemented by integrating research, clinical expertise and patient preferences and values. Hopp (2012) adds another component of 'resources' to indicate that these also have an impact on the implementation of EBP. Together this results in a four-part formula for EBP:

EBP = research evidence + clinical expertise + patient preference + resources

The fundamental principle that supports EBP is the belief in a hierarchy of the reliability of evidence, based on research designs that minimise the effect of bias on the results obtained. Best research evidence is considered to be that which is derived from well-conducted randomised controlled trials (RCTs; McNamara & Scales 2011; Melnyk & Williamson 2011) and lends itself to the development of criterion-referenced best-practice guidelines. As RCTs represent the so-called gold standard for biomedical research, there is an implicit assumption that guidelines derived from such studies carry greater validity than other studies (e.g. qualitative studies; McNamara & Scales 2011).

One of the criticisms that has been levelled against EBP is that it encourages a 'recipe' approach to care, or care devoid of its containing context (Banfield 2011). Furthermore, the narrow methodological perspective that RCTs represent limits the use and critical appraisal of research derived from other methodologies. However, part of the EBP formula, which includes clinical expertise, tacitly endorses the use of other sources of knowledge, such as personal experience, expert knowledge and reflective knowledge (Banfield 2011; Djulbegovic & Guyatt 2014).

In the context of an EBP formula, two components act to mitigate the limits of treatment guidelines derived from (so-called) context-free studies, supported solely by RCTs (McNamara & Scales 2011; Melnyk & Williamson 2011). These are clinical expertise and patient preference, since both – if given equal weight in the EBP equation – incorporate the contexts of the professional healthcare provided and the patient. As such, these components are free to interact with evidence-based guidelines in a manner that immediately contextualises a treatment regime and brings in issues of clinical leadership and clinical decision making (Hoffmann, Bennett & Del Mar 2013). Therefore, EBP refers

to a synergistic relationship between the patient, the healthcare professional/clinical leader and the research evidence, and it is this interplay of the three components of the formula that calls on the application of clinical leadership.

Therefore, the key issue in adopting and applying EBP is not the presence or absence of context-free research evidence, but rather the ability of the health professional to interpret the research evidence (qualitative or quantitative) in the context of their clinical expertise and the preferences of the patient, and to apply their spirit of enquiry to the critical questions they face.

Another question is: 'How do we know that the evidence is sound?' If we adopt evidence for practice that derives from SRs that incorporate RCTs the question becomes moot (or does it?), as RCTs are said to provide the strongest levels of evidence, an SR incorporating RCTs that have been undertaken in the area of study providing the strongest level of all (McNamara & Scales 2011). However, returning to the 'or does it' question, Keenan and Dillenburger (2011) caution against limiting research strategies to a single experimental paradigm, especially in light of the desire to provide individualised treatment. The focus of randomised control trials is on an average patient rather than an individual patient. From a percentage perspective, this means that a treatment that is effective for 80% of patients will not be effective for the remaining 20%. It is also possible that a statistically significant difference between a treatment and a control group does not actually indicate a clinically significant treatment. Even when the treatment is clinically significant, when variations in population are taken into account the significance can be negated (Keenan & Dillenburger 2011).

This has been a short review of the nature of EBP. Inevitably some issues have been omitted, as have some detail and further discussion regarding the issues and ideas that have been presented. However, to explore the complexities of EBP further, we offer the following historical lesson.

Scurvy: A Word of Warning about Evidence

In May 1747, ship's surgeon James Lind conducted one of the first controlled trials in history. As surgeon on the British ship HMS *Salisbury*, he faced a constant battle with the curse of scurvy. We now know that scurvy is the result of a deficiency of vitamin C, but in 1747 nothing was known of its cause or cure. Lind set out to discover at least a cure for this dreadful and deadly condition (Brown 2003).

The ship had a number of men suffering from scurvy and Lind took 12 of them, 'as similar as I could have them', so that he was starting with 12 men with about the same degree of illness. He described them as having 'putrid gums, the spots and lassitude, with weakness of the knees' (Brown 2003, p. 118), all signs of advancing scurvy.

After selection, Lind separated these men from the rest of the crew and placed them in hammocks in the forehold of the ship. He instructed that they should all receive the same diet. He then separated the men into six pairs and supplemented the diet of each pair with a different 'treatment'. He also had other scurvy sufferers housed in other parts of the ship who received no treatment. The treatments that Lind prescribed were as follows:

- One pair received one quart of 'cyder' per day. This was made from apples and was slightly alcoholic.
- Another pair received 25 'guts' (drops) of 'elixir of vitriol' three times a day (TDS), on an empty stomach, and they were to gargle with it too.
- Another received 'two spoonful's of vinegar' TDS on an empty stomach and to gargle with it, and have it added to their food.
- The fourth pair received 'a half pint of seawater every day'.
- The fifth pair were treated with two oranges and one lemon for six days (this was all the citrus fruit the ship had and the treatment stopped when supplies ran out).

- The final pair received 'the bigness of nutmeg' TDS of a paste consisting of garlic, mustard seed, dried radish root, balsam of Peru and gum myrrh washed down with barley water (Brown 2003).

Lind recorded that the pair given the fruit (oranges and lemon) recovered in less than a week. They were then appointed to 'nurse' the others, who remained ill apart from the two men who drank the cider who recovered a little, but after two weeks they were still too weak to resume their duties. Most of the others died (Brown 2003).

Lind would not have been granted ethical approval for this trial today, but for the time and with the limited resources at hand, he may be forgiven, given that he had stumbled on a potential cure for scurvy. Lind's methodology was sound, although not statistically significant. However, it was not until 1753 that he was able to publish the results of his findings. Nevertheless, seawater and blood-letting were still recommended as suitable treatments for scurvy, as was 'wort of malt' (an infusion of barley that is part of the beer brewing process). Lind republished his results in 1768 and between 1768 and 1771 Captain James Cook sailed to the Pacific and back, defeating scurvy in the process, but he was unable to say how. In 1772 Lind published his results and findings for a third time. Cook made another journey to the Pacific and endorsed wort of malt as the reason for the lack of scurvy in his crew. In 1794 an old sailor William Hutchinson claimed that salty food and a cup of tea were responsible for curing him of scurvy. This was the year James Lind died (Brown 2003).

In 1780 Sir Gilbert Blane (a wealthy gentleman) took a post as physician to the Admiral in the West Indies fleet. He read Lind's study (and reports from Cook's journeys) and initiated a number of recommendations; these included improving shipboard cleanliness, the regular washing of sailors' clothes and bedding, the removal of infectious sailors to hospital and the inclusion of wort of malt and citrus juice as daily dietary supplements. Blane then started collecting statistics from all the ships in the fleet asking ships' surgeons to report to him monthly on the state of their sailors' health. He presented his information to the Admiralty in 1881, but they remained unconvinced and failed to implement his recommendations, partly as citrus fruit was seen as an expensive option; partly because the greatest producer of citrus fruit at the time was Spain, with whom Britain was at war; and partly since the head of the Royal Society, Sir John Pringle, would not be moved in his lack of belief in citrus fruit as the cure (Brown 2003). Finally, in 1795 Blane was appointed head of the Sick and Hurt Board and, using his experience with the West Indies fleet, his reputation, social standing and intimate acquaintance with many of the Lords of the Admiralty, he was able to convince the board to issue lemon juice as a daily dietary supplement on all Royal Navy ships. This was 48 years after Lind's controlled trial and a year after Lind's death (Brown 2003).

As can be seen from this example, having the best evidence is not always enough. Evidence alone, even if collected well and methodologically sound, may fail to move colleagues and others who choose to ignore it. Black and Dawood (2014), Fry et al. (2011), Henderson et al. (2010) and Jennings et al. (2015) all suggest that there is ample evidence to show that the introduction of nurse practitioners (NPs) into emergency departments and other clinical environments facilitates more effective, more rapid patient care that is of a high standard. However, political forces driven by the powerful medical lobby and managers worried (incorrectly) about the perceived high costs of NPs negate the evidence and perpetuate an antiquated approach to care in the health service. The issues that affected Lind and his results from 1747 appear to be alive and well in the modern health service.

How to Create a Spirit of Enquiry

There are a number of initiatives that can be employed to generate a spirit of enquiry and facilitate the effective implementation of EBP in the clinical environment.

Role Modelling

One approach is for clinical leaders to role model the practice and use of EBP. An academic can also be employed in the clinical area to job share or establish a joint appointment (Mitchell, Baillie & Phillips 2015), so that clinical health professionals can be guided and led to develop critical clinical questions or establish quality initiatives or research projects. Support could be offered to clinical 'champions' who actively engage in research or quality initiatives and the successful achievement of those who undertake research or quality initiatives could be celebrated.

Mentorship

Like role modelling, a system of mentors to support and foster research or quality initiatives can be established (Mitchell, Baillie & Phillips 2015). In this way clinical leaders with research and enquiry skills can lead and guide novice practitioners and foster others to capture and practise with a spirit of enquiry.

Understanding the Value of a Nexus

A nexus is the coming together of teaching, research and practice. It adds up to a synergistic impact on the ward or unit culture, so that it is recognised that the clinical environment is not just a place for practice, but one where education, research, enquiry and practice all merge and generate growth and value in the others. Valuing the nexus will foster a strategic approach to the development of enquiry (Mitchell, Baillie & Phillips 2015).

Encouraging Quality Improvement Initiatives

Research can sometimes be a little daunting. Therefore, it may be more productive to encourage enquiry through smaller quality initiatives (see Chapter 16). These should be local, small, focused on your immediate client group, founded in passion and enthusiasm for making care or practice better, and may be based on the ideas of clinical leaders. Managers and leaders should feed these ideas, free the clinical leaders to think and challenge and not hold them back.

Fostering Innovation

Facilitate and educate staff and colleagues to recognise the value of enquiry and research skills. Support staff and colleagues to come forward with new ideas, to understand change management tools and processes and to apply them as the spirit of enquiry grows.

Rewards

Reward innovation and great ideas. Do not crush colleagues who see a new way or propose a change in practice. Think creatively about how staff ingenuity can be celebrated, such as with a poster competition (Mitchell, Baillie & Phillips 2015). Rewards do not have to cost money, with simple personal recognition of staff who foster a spirit of enquiry often being all that is needed for others to see its value and seek to engage. Set up awards for colleagues who have a genuine impact on the spirit of enquiry.

Professional Development (PD) Opportunities

One of the best rewards is support for ongoing professional development (PD; Black et al. 2015). Allow and encourage colleagues to learn research skills. One of the best motivators is to support people on their professional and personal journey. PD activities do this well, are not always expensive and can have knock-on effects when staff bring new skills back to the ward or unit to share with others.

Being Involved

There is no point just talking about research or enquiry generation. Clinical leaders need to be involved and at the forefront of studies and quality improvement initiatives. Even small studies will keep clinical leaders engaged with the spirit of enquiry. Being seen to be involved will allow greater role modelling, build more research skills, foster a sense of pride in the ward or unit and offer useful clinical data.

Collaboration

Collaboration with colleagues in other disciplines or wards may also help foster a wider range of research or quality improvement opportunities and expose clinical leaders to a broader set of other people with research skills. Collaboration can also lead to the establishment of 'research buddies' or 'critical friends' who can help support and encourage a deeper engagement with research practice. Each can raise the spirit of the other, bring different skill sets and share the work of building the research project.

Journal Clubs/Engagement

Clinical leaders can foster a spirit of enquiry by establishing journal clubs, tearoom talks or informal meetings about current research or practice trends. These informal activities can help raise the profile of enquiry and help colleagues focus on their ability to contribute to the spirit of enquiry. In addition, clinical leaders can join professional associations (such as the UK's Royal College of Nursing or the Australian College of Nursing) and take part in professional forums online or in areas of specialist practice.

Making it Relevant to Practice

The most effective studies or research are those that relate to the practice and clinical focus of the clinical leaders involved. Focus on improvements and enquiry in your own area of practice. Greater engagement will result if you are addressing the agenda of your personal spirit of enquiry. Start simple, start focused and start with a question from your own practice area.

Benefits of Evidence-based Practice and a Spirit of Enquiry for Nurses and Health Professionals

Evidence-based practice aims to improve outcomes for patients, providers and healthcare organisations (Burns & Grove 2011). From a nursing and healthcare perspective, there can be a number of benefits to the integration of EBP into clinical practice. These include:

- improved patient/client satisfaction with standards of care (Kaper et al. 2015; Staffileno & Carlson 2010)
- the opportunity for nurses to be more satisfied with their work (Staffileno & Carlson 2010)
- the development of more consistent patient/client care and a stronger focus on patient/client outcomes (Djulbegovic & Guyatt 2014; Kaper et al. 2015)
- a process by which poor or ineffective practices are no longer used and new ways are found to do old things (Jolley 2013; Kaper et al. 2015)
- more collegial collaboration with other health professionals to provide patient care (Staffileno & Carlson 2010)

- the initiation of more research or quality improvement projects
- a safer ward or clinical environment with fewer complaints and more empowered staff

Barriers to the Development of a Spirit of Enquiry and the Use of Evidence-based Practice

Implementation of EBP and a genuine spirit of enquiry remains variable. The major factors that have an impact on the implementation of EBP are related to the quality of the evidence itself, the individual's mindset, the group norms of the profession, competence in EBP, the balance between confidence and critical reflection and the collaboration received from management (Kaper et al. 2015).

Leung, Trevena and Waters (2014) acknowledge that nurses frequently welcome EBP but often do not have the knowledge and skills to implement it. This lack of skills is also supported by Jolley (2013). Positive attitudes towards EBP were more likely to lead to implementation, but time constraints, a high workload and a lack of organisational support were barriers to its implementation (Leung, Trevene & Waters 2014). Gerrish et al. (2011) particularly identify organisational constraints such as lack of autonomy to change practice, inadequate support from managers, insufficient resources and lack of time to devote to EBP as inhibiting its uptake by clinical nurses. Banfield (2011) particularly identifies that in order for research to meet the needs of practising nurses, the ideas for what should be researched need to come from them. This would make the research more valuable and more likely to be translated into practice. The barriers hindering nurses in the application of EBP (Retsas 2000; Brown et al. 2008; Williamson & Kretschman 2010; Burns & Grove 2011; Hopp 2012) are summarised as follows:

- a lack of skills in the use of EBP or a lack of insight into the benefits of enquiry
- fear/ignorance/insecurity
- a lack of time
- a lack of autonomy
- a lack of role models or facilitators
- a lack of resources
- organisational cultures that (continue) to fail in their recognition of the value of clinical-level professionals in the research/EBP process
- organisational cultures that (continue) to fail in their recognition of the value of learning environments to support the integration of clinical practice and EBP
- some professionals' resistance to adopting EBP practices
- poor reading habits, with few clinical staff reading research/EBP-focused journals (Retsas 2000)
- bullying or micro-managing managers or managers who are too controlling
- a lack of understanding of the difference between research and quality initiatives

Reflection Point

Speak to some senior colleagues. What are their attitudes to EBP in your clinical area or professional discipline? Repeat this with junior colleagues. Are their views about evidence different? Reflect on your own views on the use and accessibility of EBP. What is helping or stopping you from using more EBP in your clinical practice?

Applying Evidence-based Practice

Burns and Grove (2011) suggest that the process for applying EBP is first to generate evidence from research. This implies testing innovations, but it may also be wise to search the established literature for research that will support the proposed innovation without the need to re-create established research. Second, evidence should then be synthesised. It is at this step that Burns and Grove (2011) propose a systematic search through facilities such as the Cochrane Library (http://www.cochranelibrary.com) or the Joanna Briggs Institute (http://journals.lww.com/jbisrir/pages/default.aspx) websites. These and other resources do much of the work required when searching for clinical guidance, and can be the first stop on the journey of initiating EBP. The creation of evidence-based clinical guidelines can involve creating a clinically useful policy that balances the positive and negative aspects of the relevant research with the realities of the healthcare environment and the clinical setting.

The net result is guidelines that support practitioners within their scope of practice and within a team structure, so that evidence can be seen to support clinical expertise and patient preference. Getting this balance right is often one of the key barriers to the implementation of EBP. Evidence-based policy should also be applied to practice. This implies getting the right person to practise in the right way and at the right time. Many barriers may hamper this when inexperienced practitioners or people unsure or unfamiliar with policies or procedures persist with outdated or incorrect practices. Applying a new policy or practice necessitates a change that in itself may take time to institute.

It may even be that in relation to some patients, this new practice is not relevant. This implies Burns and Grove's (2011) final step, using clinical decision making to apply the policy or procedure in each patient's individual case. Applying the patient's values and rights to the clinical situation might mean abandoning what may appear to be the best clinical approach to the problem. Then, even if patients are offered the prescribed EBP option, they will still need to follow the treatment plan themselves.

Establishing EBP is fraught with difficulties, some relating to the practitioners, their resources or insights into research, and some to the organisation in which they are employed or to the patients themselves. The process of establishing EBP requires considerable effort (Dickinson & Mannion 2011). Successfully developing EBP or a procedure will not ensure that patients receive or accept optimal treatment. However, attempting to generate EBP in clinical decision making and policies will ensure that evidence finds its way into clinical practice and it is incumbent on clinical leaders to understand, promote and articulate the value of EBP.

Several authors (East 2013; Hoffmann, Bennett & Del Mar 2013; Melnyk & Williamson 2011) summarise these steps in evidence-based practice as (or similar to) the following:

- Ask a focused question
- Access the information available on the topic
- Appraise the evidence found
- Apply the evidence, taking into account the patient's values and preferences
- Audit the practice

Strategies for Breaching the Evidence/Practice Nexus

A number of models have been developed to support and facilitate the nexus between nursing/healthcare practice, clinical research and education. Some offer an overview of the research facilitation process from a practitioner's perspective: evidence-based practitioner models; some provide

general guides for research use: embedded models; and others describe efforts to implement research in practice with a focus on quality: organisational excellence models. Evidence-based practitioner models focus on the individual practitioner being responsible for access, appraisal and implementation of best practice. For instance, Gerrish et al. (2011) propose using advance practice nurses as knowledge brokers to promote EBP. Embedded models use policies, procedures, protocols, standards and guidelines to direct practice, removing the need for practitioners to engage with evidence themselves. Organisational excellence models are often cyclical, frequently reviewing practice, making incremental changes and adapting to different contexts.

Current evidence does not allow an effective comparison of these different types of models (much less the examples within each group), but it is suggested that different models work in different contexts (Wilkinson, Johnson & Wimpenny 2013). Many models have limitations: few adopt a holistic approach; they fail to consider all aspects of the process of research use and its impact on health outcomes; and not many help both researchers and clinicians. Moreover, most focus on uni-professional groups and fail to recognise the multi-professional/interdisciplinary focus of healthcare.

In contrast is the Ottawa Model of Research Use (OMRU), which was developed in 1995 although it has evolved since its inception (Campbell 2010; Kent & McCormack 2011; see Box 14.1). It was originally designed as a tool to support the nexus between researchers and practitioners in central Canada. It has since proved very useful as a guide to the integration of research, practice and education, although it offers limited usefulness as a recipe for connecting research and practice. The model identifies six key elements: evidence-based innovation, potential adopters, the practice environment, implementation of interventions, adoption of the innovation and outcomes resulting from that adoption. The first three elements involve assessing barriers and supports for the innovation (Kent & McCormack 2011).

Another model, the Critical Realism and Arts Research Utilization Model (CRARUM), is built on OMRU (Kontos & Poland 2009). However, this model focuses on the links between organisational culture, leadership, the critical reflection of adopters and the context of the change or innovation. Its ontological conviction is that reality is greater than the domain of the empirical (recognising that knowledge transfer is never just a matter of having the best evidence – remember the story of Lind

Box 14.1 The Ottawa Model of Research Use (OMRU)

Practice environment
(e.g. belief system, setting, resources, structure, decision-making processes, workloads, supplies, social factors, personalities, champions)

Potential adopters
(e.g. patients, wider stakeholders, staff and their attitudes, knowledge, motives, skills)
(Lions, sheep and donkeys)

Evidence-based innovation
(e.g. the innovation itself, risk/benefit, time saved, process of implementation, cost factors)

Strategies for transfer
(e.g. diffusion/ dissemination/ implementation)

Adoption
(e.g. use of the innovation)

Outcome
(e.g. audit, assess, evaluate, 'social validation', what is the 'true value' of the innovation?)

With the constant application of assessment, monitoring and evaluation

Source: Logan, J & Graham, ID 1998, 'Toward a comprehensive interdisciplinary model of health care research use', *Science Communication*, vol. 20, no. 2, pp. 229, copyright © 1998 by Sage Publications. Reprinted by Permission of SAGE Publications.

on the HMS *Salisbury* in 1747). The context is seen as fluid with social and power relationships that influence the construct of the model. The CRARUM uses an arts-based approach to support knowledge transfer, as well as adoption strategies offering some very interesting ideas about role play, drama and theatre as tools for influencing change and innovation. It is more complex than OMRU, but it builds links to a sophisticated understanding of context.

Both models offer guidance about strategies for dealing with the nexus between nursing/healthcare practice, clinical research and education. Rogers' (1995) decision-making process also supports practical approaches to addressing nexus issues. This simple model requires the use of knowledge (awareness of innovation), persuasion (development of positive attitudes), decision (a cognitive decision to adopt the innovation), implementation (use of the innovation) and confirmation (continued use of the innovation) as strategies to enhance the relationship or connections between research, clinical practice and education. However, more detailed strategies are offered that relate to the diffusion, dissemination and implementation of relevant research information to facilitate nexus success. Using the 'transfer strategy' headings offered by the Ottawa model (Logan & Graham 1998), the following strategies are considered to be effective.

Diffusion: A Simple Form of Nexus Development

This can be done via publication and access to journals, the web and textbooks.

Dissemination: More Involved with Wider Nexus Results

The aim here is to bring research from an abstract topic to a relevant practice-related concept. For instance:

- Share information at conferences
- Share with colleagues at meetings, e.g. curriculum development opportunities
- Send targeted information to specific colleagues, e.g. clinical leaders
- Place relevant research-related publications in course and professional development outlines/prospectuses
- Use relevant research papers in undergraduate and postgraduate programmes

Implementation: Key Nexus Activity Integration

The third approach is implementation. These strategies are seen as key to nexus activity integration and involve more collaboration:

- Put up posters, use postcards, advertise and promote the research/innovation (social marketing)
- Use workshops or staff development about the research/innovation
- employ group and individual instruction about the research/innovation
- Use product representatives and drug companies to support education
- Employ outreach activities (sponsorship at conferences, personal support with research proposals)
- Access and use opinion leaders or clinical leaders (use the lions in the stakeholder group)
- Support the need for change and innovation with patient and staff feedback, research findings, audit results
- Develop research- and initiative-promoting policies at a local level
- Support an organisational culture that promotes quality initiatives and supports staff in generating new ideas, the adoption of initiatives and innovation and engagement with research/EBP (e.g. role modelling, identification of champions, incentives and rewards)

- Access user groups, interest groups and lobby groups
- Gather audit data to support the need for change
- Develop skills in relation to change management models (to support the ‘how’ of change constructively)
- Employ specific incentives (e.g. promotion, study leave, financial rewards, gifts, conference attendance)
- Employ sanctions (this may be best avoided, but sanctions have been utilised where change is needed but resisted)
- Lobby for fairness in research funding access
- Access appropriate research funding (research cannot be done without funding)
- Consider the types of research proposed (nurses favour qualitative and phenomenological over quantitative or positivist research, so need to make research context specific)
- Integrate undergraduate student programmes with meaningful clinical practice
- Involve undergraduate students in clinical research activities (first-hand experience)
- Improve postgraduate students’ awareness of research approaches and ways of knowing (core units in research and participation in research activities)
- Integrate academic and clinical environments more effectively
- Base academic staff in practice areas to bring education, research and clinical practice back together (Hølge-Hazelton et al. 2016)
- Listen to patients (establish partnerships), listen to staff, focus on organisational goals and colleagues’ needs (this will drive research and the educational agenda, as research is not all about the researchers’ agenda or research goals)
- Support the creation of clinical chairs of nursing between universities and health service providers to cement research and clinical links (Hølge-Hazelton et al. 2016)
- Focus on developing clinical leadership capacity with skills around networking, negotiation, change management, conflict resolution, decision making, values, beliefs and team working
- Employ drama/film/theatre innovation adoption
- Avoid jargon and use language to make meanings clear – a nexus is impossible without clear understanding and communication
- Engage in ‘shared reciprocity’ (mutual search for meaning) with shared environment, language, humour, goals, perspectives, value for patients, critical thinking and knowledge transfer

Many people have struggled with the problems and challenges of building a successful approach to enhancing the relationship between nursing practice, education and clinical research. It is clear that all implementation strategies work at least some of the time, but none works all of the time. It is also evident that multiple strategies appear more effective than single ones. Strategies that are nearer to the end users and integrated into the process of care delivery are also more likely to be effective (Logan & Graham 1998).

The implementation of strategies to enhance research evidence in clinical practice is likely to be dependent on tailoring the transfer strategies to the environment, barriers, potential adopters, champions and supporters found in a particular setting. Transfer strategies are more likely to be successful when nursing practice determines the nursing knowledge and research to be undertaken (Banfield 2011).

The key may be to harness the skills, passions and enthusiasm of people, particularly clinical leaders, and facilitating them to lead change. This will bring the change and innovation into the domain of the clinical team, securing their investment in the nexus activity.

What can Clinical Leaders do to Promote Evidence-based Practice and a Spirit of Enquiry?

As well as the strategies offered earlier in the chapter, Burns and Grove (2011), Hopp (2012) and Williamson and Kretschman (2010) suggest that as the implementation of EBP and the generation of enquiry relate to the organisation, the environment and the individual, an approach that addresses each area, often in combination, should be used. For clinical leaders to have a positive influence on the development and implementation of EBP and a spirit of enquiry, they need to role model the application of these in their daily clinical activities, seeking out and using evidence or taking part where possible in clinical trials or other research activities. They should become mentors or guides for other health professionals. They should develop research as part of the organisation's strategic plan (including financial resources) and build a commitment to use EBP and sound clinical guidelines or clinical policies (Mitchell, Baillie & Phillips 2015). Clinical leaders can establish EBP and critical enquiry as genuine clinical competences and ensure that they are clinical skills that neophyte health professionals are exposed to and become proficient in. Managers can support clinical leaders by incorporating time for professional development in relation to EBP into the work life of the ward, unit or clinical environment (Staffileno & Carlson 2010) or enquiry can be initiated simply by reading more research-focused journals.

EBP and critical enquiry are about integrating individual clinical expertise with the best available evidence to influence and support best practice, but they (and the lessons from history) remind us that these alone are not enough. It is through the exercise of clinical leadership that evidence gains meaning and can be successfully applied in practice and with each individual client or patient. Barriers exist on many levels, but it is not enough simply to accept that the barriers are unassailable. If overcoming them in the short term proves difficult, it may be best if clinical leaders at least show a willingness to drive practice forward by using their initiative and acting to make care better based on the best available evidence (Jolley 2013). Recognising the problems hindering the implementation of EBP may be the first step, but effective clinical leaders need also to seek out and secure solutions that will foster more efficient use of evidence in clinical practice.

Case Study 14.1

Florence Nightingale is rightly remembered as a significant contributor to modern nursing. However, it was primarily her ability to gather and use statistics that helped her to influence and bring about change in the British military establishment in the 1800s. Read her story and consider the challenge offered at the end.

Female Leaders: Florence Nightingale

Florence Nightingale is the most famous of all nurses. Ironically, she did very little genuine nursing, and although she contributed significantly to the science of statistics and to the poor law and military reforms in Britain and India, it is for her pioneering work as the 'lady with the lamp' in the Crimean War for which she is predominantly remembered. She was born in 1820 in Florence (the city after which she was named) into a rich, upper-class, well-connected English family and lived there until August 1910. Her early years were spent between a number of stately homes and travelling across Europe. She was fortunate to have been well educated by her liberally minded father and she developed a powerful mind and sound literary skills.

In Rome in 1847 Florence met Sidney Herbert (who was to become the British Secretary of War during the Crimean War) and established a strong friendship. At this stage of her life she was struggling to find

direction and purpose that involved more than just marriage and the social circuit. She was courted by Richard Monckton Milnes, a politician and poet, but after a long holiday travelling through Greece and Egypt in 1850 with their family friends the Bracebridges, Florence rejected Milnes' marriage proposal (against her mother's wishes) to concentrate on working towards a 'career' caring for the sick and deprived.

She spent a few months at the Lutheran religious community at Kaiserswerth-am-Rhein in Germany in 1850, where she undertook some nursing training and participated in elements of nursing care. It was here that she found some direction and began the process of dedicating her life to her chosen career.

On her return from Germany, Florence faced opposition from her sister and mother, who both felt her career choice unwise and inappropriate for a young woman of her class. Undaunted, Florence finally secured a post as superintendent of the Institute for the Care of Sick Gentlewomen in London. It took some time to negotiate the terms of her contract and she only began work, principally as the organisation's manager, in 1853. Her father supplemented her salary and supported her career choice, albeit reluctantly.

The Crimean War broke out the following year and Florence and 38 other 'nurses' (many were nuns) travelled (at the request of Sidney Herbert) to support the military medical service already established in the theatre of war. She was based at Scutari Barracks Hospital (over 500 km from the fighting on the Crimean Peninsula) and after some time many other nurses followed (a fact that Florence resented at first), so that soon a number of other hospitals were under her managerial influence. From the outset she clashed with the military medical personnel and supply departments. Her advantage was that she had the support of the *Times* newspaper and a huge monetary fund raised in Britain to aid her work. Seeking to avoid disputes, she held her nurses back from involvement with care until she was asked to help, and only then did the 'Nightingale' nurses intervene.

It was assumed that the female nurses had a positive impact on the death rates at Scutari, but this is not the case. The cramped unsanitary conditions, poor diet and medical neglect meant that death rates rose into 1855, and only fell after the Sanitary Commission supervised the flushing of the sewers under the hospital. Following this and the onset of spring, the death rates dropped from 42% to 2% quite rapidly, data supported by Florence's own statistics.

Florence was, in effect, the manager of the women's medical service and – contrary to popular belief – did little or no actual nursing. Even her nightly rounds with her famous lamp were related more to catching nurses occupied in nocturnal shenanigans than offering care and comfort, although this may have been the net result.

Florence became very ill during her time in the Crimea, possibly as a result of brucellosis, which became a chronic condition limiting her activity, but not her influence and energy, for the rest of her life. She returned to Britain after the war (under an assumed name) and shunned publicity where she could. However, the legacy of her war work was a huge reputation and a considerable fund that was used to establish the Nightingale Nurse Training School at St Thomas' Hospital in London. This was established in 1860 and by 1865 Florence had supported other nursing endeavours, for example helping to set up the Liverpool Workhouse Infirmary. In 1859 she published the book *Notes on Nursing*, following an earlier publication *Notes on Hospitals*. She also worked hard to evaluate the impact of the Crimean War on the army and, although not its official author, laboured behind the scenes to produce a statistically stunning assessment of the military's treatment of enlisted men that was to have a profound impact on future military medical services. Mainly bedridden, Florence still found time to influence Britain's foreign policy on India.

Nurses trained in Nightingale schools spread around the world to America, Japan and Australia. In 1883, Florence was awarded the Royal Red Cross by Queen Victoria and in 1907 she became the first woman to be honoured with the Order of Merit. In 1908 she was given the freedom of the city of London and her birthday (12 May) is celebrated around the world as International Nurses Day.

(Continued)

Case Study 14.1 (Continued)

She remained active in influencing nursing training throughout the remaining years of her life and contributed greatly to issues of social and welfare reform with her prodigious writing. Although well known for her contribution to nursing, she should be equally well known for her passion for statistics. From an early age she is said to have excelled at mathematics and later in life she used this knowledge to expand her use of statistics. In 1869 she was the first female member of the Royal Statistical Society. However, she did not consider research and statistics to be the same, and when she heard that a legacy she planned to leave to the University of Oxford for applied statistics might also be used to support research, she withdrew the gift.

Florence is less well known for her involvement in the women's movement, mainly because she shunned publicity and because in reality it was not her aim to change the place of women in society, only to decry the over-feminisation of women of the upper-middle and upper classes.

Any acknowledgement of female leaders cannot ignore Florence Nightingale's place as a truly remarkable, pioneering woman. Her influence on nursing was profound and her writing and contributions to social welfare helped advance Victorian society and improve the plight of the poor and the military rank and file. Hospitals around the world are named after her, as are numerous nursing research foundations. In many respects her lamp still burns (although in reality she carried a lantern), mainly because of her contribution to the care of the sick and injured soldiers during the Crimean War and her legacy within the nursing world. While her achievements in the Crimea were remarkable, it was not nursing that she did there, and to a significant degree her influence can be attributed to very effective propaganda back in Britain. What she achieved in the 50 years before her death in 1910, even though ill and often bedridden, is also testament to her influence and determination to make a difference and follow her life's path.

Challenge: Are you sure that you know the real Florence Nightingale? This challenge is twofold.

1) Find out as much as you can about Florence Nightingale's involvement with statistics and how she used to them to record issues, gather evidence and change practice.
2) Think about how you use evidence. What do you do or who or what do you consult or refer to before you buy a new mobile phone, a new washing machine or a new car? You are likely to make a large investment in these items or depend on them to work effectively and efficiently, so you will want the best or the one that suits you best. Is healthcare any different? How do you (or indeed your clients) use evidence or statistics, or how do you or they access knowledge that will help inform decision making and practice?

Summary

- Evidence-based practice (EBP) is based on a combination of research evidence, clinical experience and patient preference.
- Clinical expertise tacitly endorses the use of other sources of knowledge, such as personal experience, expert knowledge and reflective knowledge.
- The key issue in adopting and applying EBP is the ability of health professionals to interpret the research evidence in the context of their clinical expertise and the preferences of the patient. This application can be described as a function of a clinical leader.
- Evidence alone is often not enough to change practice habits.

- There are many barriers to the application of EBP. These should be considered and assessed carefully when seeking to implement clinical practice changes. Some relate to the practitioners, their resources or insights into research, some to the organisation in which they are employed and others to the patients themselves.

Mind Press-ups

Exercise 14.1

Are you able to define EBP? Try to put it in your own words. Imagine that you are explaining it to a neophyte health professional in your area. What will you say?

Exercise 14.2

Can you name three areas of your practice that are supported by EBP? Can you name any areas that are not?

Exercise 14.3

What might be the barriers to the successful implementation of EBP in your clinical area or area of professional practice? Are the barriers and issues likely to be resolved? If they have been, how was this achieved where you work?

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15

Reflection and Emotional Intelligence

Karen Stanley

By three methods we may learn wisdom: first, by reflection, which is the noblest; second, by imitation, which is the easiest; and third, by experience, which is the bitterest.

Confucius, Chinese philosopher and politician, 551–479 BCE

Introduction: The Noblest Way to Wisdom

This chapter discusses how clinical leaders can develop emotional intelligence and reflective practice skills to support leadership, innovation and the development of values. It will address the concepts of emotional intelligence and reflection, what they are and when they can be used. Finally, it will explore how emotional intelligence and reflection can be used as strategies to sustain clinical leaders and assist them with personal and professional development and learning. Kahraman and Hicdurmaz (2016) indicated, in a study of Turkish clinical nurses, that while age, gender or other sociodemographic factors had limited impact on the demonstration or application of emotional intelligence, higher emotional intelligence was associated with longer exposure to clinical practice and greater professional development. This both makes emotional intelligence a feature of how clinical leaders may be recognised and points to the importance of clinical leaders understanding and applying emotionally intelligent techniques and reflection.

What is Reflection?

Reflection invites us to look in the mirror and remove our individual mask, so that we can look beneath what we see on the surface. This is achieved by exploring our previous thoughts, emotions and behaviours, which leads to useful insights for future experiences and increases the potential for congruence in leadership. According to Johns (2006, p. 3), 'reflection is being mindful of self, either within or after experience, as if a window through which the practitioner can view and focus self within the context of a particular experience'. Johns (2006) further suggests that reflection enables us to confront, understand and move towards resolving a contradiction between our vision or values and those of our actual practice. This means that we are not only able to learn through reflection, we are also able to meet our objectives by linking theory to our everyday behaviour.

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Reflection and Learning

Dewey first introduced the idea of reflective practice in 1933. His belief was that reflection involved the whole person, in an open-minded and wholehearted endeavour, and that it was a rational, intellectual act (Ruth-Sahd 2003). Reflective thinking can be purposeful, encouraging the individual to confront their values and beliefs, which includes examining their emotions as a holistic activity (Horton-Deutsch & Sherwood 2008).

Brockbank and McGill's (2000) exploration suggests that our learning activity is very much influenced by our values and philosophies; it is because of this that reflecting on our practice can indeed close the gap between theory and practice. Chang and Daly (2012) add that being reflective also encourages us to think critically and to problem solve. They contend that critical thinkers are autonomous, because they are able to analyse issues and challenge beliefs. Critical reflection, as with critical thinking, assists us in thinking about and distinguishing between our beliefs, as well as in questioning our existing assumptions and perspectives. Therefore, combining critical thinking with critical reflection enables us to learn through our experiences, which helps create the opportunity for us to form new knowledge and insights and change our behaviours appropriately (Jarvis 2013). Acquiring the ability to analyse assumptions and become more critically aware could certainly assist individuals, as well as leaders, by enabling each to speculate more imaginatively (Bishop 2009).

Reflection is therefore about:

- describing an experience
- understanding your reactions to the experience
- critically analysing situations
- developing new perspectives
- evaluating the learning process

Benefits of Reflection for Clinical Leaders

There are a number of benefits to be found from the application and use of reflection, outlined in the following discussion.

Better Self-knowledge

Socrates is reported to have said, 'To find yourself, think for yourself'. As a philosopher, he clearly knew the value of reflection, because he believed that it would help individuals move towards understanding themselves more fully. According to Bishop (2009), understanding the 'self' is an attribute that enables leaders to become more transformational, especially through their actions, and through those actions they are capable of inspiring and motivating others to achieve desirable outcomes and develop innovative practices.

Identification of Your Values

Individuals tend to align themselves with others they view as like-minded and who demonstrate the same values and beliefs as they hold. The application of these values and beliefs is something that leaders share with others because they work closely and frequently with their team. According to Stanley (2011), they are role models who provide direction and guidance for the quality of care and the interactions that take place between individuals and teams. Congruent leaders in particular are followed in the main for their values and beliefs. This is because they are viewed as having specific clinical knowledge, and therefore in the eyes of the follower this makes the leader a credible individual.

Connection to Caring

Reflection, according to Benner and Wrubel (1989), can also assist the individual in reconnecting to caring, especially when there is a loss of caring due to burnout. Clinical leaders may have a better understanding of this phenomenon because they are linked more closely with the values of caring than are managers, who may be more interested in the outcomes of care delivery rather than the process of care.

Empowerment

Chang and Daly (2012) state that reflection can be both emancipatory and empowering, because it can be used as a tool to assist with self-knowledge, thereby freeing leaders to explore future scenarios that support others while improving clinical practice. Although it can be common for leaders to hold power, congruent leaders do not necessarily use this power to inspire and empower others. This is because there is a shared understanding and alignment of a congruent leader's values and beliefs with regard to therapy or care that is visible through the leader's consistent actions (Stanley 2011).

Learning from Mistakes

There is strong evidence to suggest that nurses who make mistakes rarely repeat the same mistake following a period of reflection. This is because the process of introspection and analysis enables them to critically examine what was right and wrong in a particular situation and to take responsibility for the choices they made. Mistakes are part of the human experience, and this is no different for leaders. However, the way in which leaders deal with their mistakes gives others an insight into their integrity. If leaders want to gain respect and loyalty, they must be trustworthy. Trust comes before loyalty, and once loyalty is established commitment follows (Chang & Daly 2012).

Models to Support Reflection

A multitude of models have been developed over the years to support reflective thinking. These include models by the following, among many others:

- Mezirow (1981)
- Boud, Keogh and Walker (1985)
- Schon (1987)
- Gibbs (1988)
- Atkins and Murphy (1993)
- Johns (2006)

None is highlighted over any others, and readers are encouraged to seek out or consider all them and identify one or a combination of reflective models that best supports their application of reflection. As the next sections indicate, the application of reflective models is very much a personal choice.

Using Reflective Models

Reflection can have many layers (Johns & Freshwater 2005) and key theorists such as Mezirow (1981), Boud, Keogh and Walker (1985), Casement (1985), Schon (1987) and Freshwater, Rolfe and Jasper (2001) all discuss the different levels of reflection, viewing it as more of an intuitive, holistic way to view the self from within. Mezirow's (1981) model can be used for promoting critical reflection (Freshwater, Rolfe & Jasper 2001), whereas other models such as those of Gibbs (1988) and Schon (1987) offer a more linear approach, with prompts to guide the reflector through the reflective

process. However, contemporary thought is that reflective models can be combined to provide deeper reflection. The value of combining models and modifying them is that this type of layering approach can maximise reflection and facilitate greater learning, so that the reflector can explore a situation more fully.

Reflection Point
Think back to a significant personal or professional situation that you found challenging. Identify a reflective model with which you feel comfortable and explore this situation using the model's prompts. While reflecting on the events that took place, think about the emotions associated with them and how this affected your reactions and the outcome to the situation.

Approaches to Reflection

There are a range of views about reflective writing, with a common question being whether the reflection needs to follow a prescriptive, structured or formal approach. All of the models already discussed offer a systematic, structured approach to reflection; however, some reflective writing techniques can provide the individual with the intellectual space to 'stop and think', without structuring the reflection. Two approaches in particular can be used:

- **Reflective diaries journals and portfolios**: Horton-Deutsch and Sherwood (2008) discuss the value of reflective diaries as a way to retain an account and historical record of our own developments, whether they are personal or professional. Maintaining a diary, journal or portfolio enables us to undertake personal reflection and keep our thoughts private.
- **Clinical supervision**: Some reflection can be more beneficial if undertaken verbally, as this may provide the opportunity to seek clarification and advice on specific issues. Clinical supervision offers an individual space to reflect with a supervisor/mentor who can be an expert or clinical guide. In group supervision individuals may also benefit from the reflections shared by others, as this provides additional insights and support when they are a group of professionals reflecting on their practices (Chang & Daly 2012). In clinical supervision the supervisor/mentor is able to assist the supervisee(s) to recall events and guide them through the process of reflection, which can be achieved by utilising a reflective model or a combination of models to promote deeper levels of reflection (Latimer 2007; Jarvis 2013).

Utilising either of these approaches can be beneficial, as reflection can be viewed as a learning strategy that assists with the development of economically competent leaders (Horton-Deutsch & Sherwood 2008; Jarvis 2013).

What is Emotional Intelligence?

Emotional intelligence is described as the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions (Salovey & Mayer 1990). Goleman (1998) describes emotional intelligence as the capacity for recognising our own feelings and those of others, for motivating ourselves and for effectively dealing with our own and others' emotions.

Goleman (1998) reminds us that our emotions are instrumental in our lives, and goes as far as saying that they are elemental in our development on a personal and professional level. Emotions are

a human factor and are also an essential part of who we are. Expressing emotions at the right time and in the right place is a concern for most of us. Emotional intelligence means judging when to deal with emotions or when, as Brockbank and McGill (2000) state, to 'park' them. Many people react to life events with their emotions, claiming that they are not able to control them adequately. Anger, fear, jealousy, regret, feelings of betrayal or of hurt at being let down are some of the common emotions we experience, as well as the more positive ones of joy and relief. Emotional intelligence is about exercising control over these emotions so that our response is tempered by a conscious acknowledgement of the feelings we are experiencing.

The Five Building Blocks of Emotional Intelligence

According to Goleman (2005), the five building blocks of emotional intelligence are:

- **Self-awareness (of your own feelings)**: This is the ability to gauge and understand your emotions and recognise how they will influence your work performance and relationships. It is also about recognising and being realistic regarding your strengths and weaknesses.
- **Self-management or self-regulation (of your emotions)**: This is self-control. It involves the ability to keep disruptive emotions and impulses in check. It requires you to be conscious of your emotions.
- **Social awareness or empathy (to recognise the feelings of others)**: This is about recognising and sensing the emotions of others, understanding their perspective and employing empathy. It is an essential skill for networking and navigating through relationships.
- **Social skills (to manage emotions in others)**: This is a set of skills that build on communication, listening and conflict management. These are skills that build bonds and cooperation.
- **Motivation**: This is the drive to go beyond superficial motivations (money or status) and see the 'bigger picture' in building successful and meaningful personal and professional relationships. It captures ideas of optimism and a willingness to be committed to more than just yourself.

So emotional intelligence is about exercising self-control and applying zeal and persistence in motivating ourselves in the face of frustrations. It is also connected to delaying gratification, monitoring and regulating our mood and keeping distress away from our ability to think. Emotions are essential aspects of the human condition, but they are meant to serve us and not control us, so emotional intelligence helps us recognise that emotions can promote our well-being, but only if they are employed appropriately or in a controlled way. Instead of trying to avoid emotions, especially at work, leaders have an important role in regulating emotions within groups and within themselves by providing support and guidance that harness the energy of emotional interactions positively (Rajah, Song & Arvey 2011; Taylor, Roberts & Smyth 2015). Goleman, Boyatzis and McKee (2013) suggest that when it comes to shaping our decisions and actions, feelings count every bit as much as our thoughts, if not more so.

Self-awareness is key to the development of emotional intelligence, as it allows us to recognise the feelings we have and become aware of our mood and the thoughts that are driving our mood. Being attuned to our emotions also helps us recognise the emotions of others. This leads to the next key in the development of emotional intelligence: the development of empathy and our ability to recognise the often subtle social signals that help us understand another person's needs or wants. Once developed, emotional intelligence can help us to manage relationships well, which leads to more effective interpersonal and professional relationships, more effective leadership and a greater ability to manage conflict successfully (Antonakis, Ashkanasy & Dasborough 2009; Taylor, Roberts & Smyth 2015).

Developing and employing an emotionally intelligent approach in your work and personal life can have the following benefits:

- Knowing your feelings and using them to make life decisions you can accept
- Being better informed about your level of self-awareness
- Knowing what triggers or 'pushes' your buttons
- Not being overwhelmed by worry or anger
- Persisting in pursuing your academic, professional and personal goals despite occasional setbacks (Por et al. 2011)
- Handling feelings and relationships with skill and maturity (Taylor, Roberts & Smyth 2015)
- Moderating the impact of stressful situations on your mental health (Benson, Ploeg & Brown 2010)
- Fostering effective interprofessional communication that influences the quality of care and patient safety (Bulmer Smith, Profetto-McGrath & Cummings, 2009)
- Managing clear communication in a crisis, which may be central to clarifying and resolving disputes –remaining calm and in control will have immediate effects!
- Improving your communication and conflict management styles, helping you build rapport and get the job done better (Taylor, Roberts & Smyth 2015)

Chang and Daly (2012) indicate that emotional intelligence can be critical even when an individual is not in a leadership role, as it assists with identifying and developing skills of self-regulation, empathy, social skills and motivation across the five building blocks. This can lead to the effective management of emotions in a variety of situations. No person is an island, and emotional intelligence does not concern being nice to ourselves and others, it concerns making choices about how we feel, identifying emotions in others and providing the support they need. This can have a dramatic impact on the success of our work and personal relationships and ultimately on our ability to advance in our career or grow as a person (Taylor, Roberts & Smyth 2015). It is often said that a great resume will get you the job, but it is effective emotional intelligence that will keep you in the job. The good news is that emotional intelligence can be learnt and developed over time (Goleman 2005).

Reflection on Reflection and Emotional Intelligence

Chang and Daly (2012) assert that the ability to reflect on evidence – and more importantly to reflect critically – has become an essential skill for the clinician of the future. Clinical leaders can benefit from this process by challenging their thoughts, feelings and behaviours and therefore creating new realities (Jarvis 2013). Boud and Walker (1991) say that if professionals accept positions of responsibility, they need to learn from experience. Reflection on experience helps us understand and gain insights into previous situations. While critical thinking is important to support decision making, reflection enables us to view situations from different perspectives and can be transformative (Schutz 2007; Beauvais et al. 2011; Jarvis 2013). The benefits of emotional intelligence are also optimal when we willingly engage purposefully in the self-awareness process. Reflection can be a vital tool for bringing our values and beliefs to consciousness, which enables us to respond and behave in ways that are ethical and professional. Reflection is one way in which we can access preconceived ideas, by challenging ourselves in an emotionally safe capacity and applying new knowledge and insights to the next interaction or situation. The outcome of this new knowledge and insight is facilitation of our own learning and maximising of personal and professional development (Chang & Daly 2012; Jarvis 2013).

A final note on the link between congruent leaders and emotional intelligence is the concept that a leader's values and beliefs are deemed to be more visible when they are demonstrated in practice.

Leaders who are congruent in their actions foster constructive emotional responses that are conducive and effective in a variety of interactions and situations. Emotionally competent leaders are able to regulate their emotions confidently and can motivate others by sharing collective values and beliefs that have positive impacts in all environments (Bulmer Smith, Profetto-McGrath & Cummings, 2009; Heckemann, Schols & Halfens 2015). Goleman, Boyatzis and McKee (2013) refer to this as the 'primal' emotional task of a leader, because it is both original and the most important act of leadership. Congruent leaders are therefore capable through their actions of inspiring and motivating others to achieve desirable outcomes and develop innovative practices.

Case Study 15.1

Anne Frank is one of the most famous reflective writers and her harrowing experiences are told almost innocently in the form of a diary. Read Anne's story and consider the challenge that follows.

Female Leaders: Anne Frank

Many people suffered and recorded their suffering during the dark and terrible days of World War II. However, one of the most remarkable stories of the triumph of humanity and hope in the face of great ordeal and despair comes from an energetic and extroverted young Jewish girl, Annelies Marie Frank.

Anne was born in 1929, in Frankfurt am Main, Germany. The Franks were Jewish and, fearing the growing anti-Semitic policies of the Nazi party, emigrated to the Netherlands, where Otto Frank, Anne's father, set up a number of companies in Amsterdam. In May 1940 the Germans invaded and then occupied the Netherlands and began to impose the anti-Semitic policies from which the Franks had fled. Jewish people had to register with the 'government', their children were segregated into 'Jewish schools' and, like other Jews across occupied Europe, they had to wear a yellow star to distinguish them from other citizens. In 1941 Anne began attending the Jewish Lyceum School in Amsterdam, leaving many of her friends behind. In June 1942, when she was 13, her father gave her a blue, red and white plaid autograph book, which she decided to use as a diary. Her first entry was 'to Kitty' and began, 'I shall be able to confide in you completely, as I have never been able to do in anyone before, and I hope that you will be a great comfort and support to me.'

The anti-Semitic policies and sanctions of the German occupying force were becoming more severe and a few weeks after Anne was given her diary, Margot, her older sister, received orders to report for transportation to a work camp. Determined to prevent this, the next day Otto led his family into hiding in a secret annexe he had been preparing in the premises of one of his companies. From July 1942, the Franks and four other people lived in a tiny space behind a false bookcase at the top of a set of stairs behind Otto's office. When Anne moved in she recorded in her diary that she had to put on two vests, three pairs of pants, a dress, a skirt, a jacket, a summer coat, two pairs of stockings, lace-up shoes, a woolly cap and a scarf, because leaving their house with suitcases would look suspicious.

Anne wrote in her diary almost daily until her last entry on 1 August 1944. She recorded the most intimate details of the small group's everyday lives and the interplay of their relationships. She was a gifted writer, with a quick wit and a critical eye. The diary reveals the thoughts, hopes and fears of a normal teenager, showing her to be bright, imaginative, moody and impatient. She struggled, too, with her 'good Anne' and 'bad Anne' sides and, in spite of the monotony of life in the annexe, offered insights into their plight that were wise beyond her years, perceptive and innocently honest.

(Continued)

Case Study 15.1 (Continued)

She wrote in 1944, shortly before the annexe was discovered, that 'it really is a wonder that I haven't dropped all my ideals, because they seem so absurd and impossible to carry out … yet I keep them, because in spite of everything I still believe that people are really good at heart'. Three weeks later the German police stormed their hiding place after their secret was betrayed and Anne and Margot were transferred to Bergen-Belsen concentration camp, where they both died of typhus within days of each other in March 1945. Of those in hiding, only Otto Frank survived the war.

Anne Frank's diary provides an honest glimpse into her hopes and fears, and her refusal to be broken and torn by the persecution and despair of the dark days she lived through. It was a comfort to her in the isolation and confinement of the annexe, and remains a record and warning for others about the vigilance needed by everyone to heed the lessons of history and keep an open heart to their inner thoughts.

Challenge: We hear about reflection and reflective practice frequently today, but what does it mean on a day-to-day basis for active clinicians? When do you stop and reflect? Do you even need to stop and reflect? Anne was forced into an attic and had both the time and the means to capture her thoughts and ponderings. When are you able to take time to look back over your practice? This may require a mindful approach to care, where you consciously undertake a period of active or guided reflection. When you are next at work, take a moment – take a few – to stop and consider what you have done, what you could do better and the implications for you or for your clients. Try to capture your thoughts by writing them down or recording them. Constant 'doing' will get things done, but reflection might mean that you find new ways to do things or have an opportunity to do things better.

Summary

- Reflection encourages and supports critical thinking, problem-solving and decision-making skills.
- Reflection assists with linking theory to practice.
- Both reflection and emotional intelligence help with the development of insight and self-awareness.
- Models of reflection can be utilised to provide a framework for more critical reflective practice.
- Clinical supervision, reflective diaries, journals, portfolios or a reflective companion can support the reflective process.
- Emotional intelligence may be developed through emotional awareness and can promote personal and professional growth.
- Emotional intelligence is more evident as professionals grow and develop in their clinical role, linking effective clinical leaders with the application of emotional intelligence.

Mind Press-ups

Exercise 15.1

Decide on two methods of reflection, such as writing a journal or verbalising your thoughts with a reflective companion, and compare them to assess what the more effective reflective method is for you.

Exercise 15.2

Watch the animated film *Inside Out*. What does it say about emotional intelligence and about the emotional internal dialogue that might be going on inside all of us?

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16

Quality Initiatives and Project Management

David Stanley

> *Young men [and women] are fitter to invent than to judge; fitter for execution than for counsel; and fitter for new projects than for settled business.*
>
> Francis Bacon, English philosopher, statesman and empiricist, 1561–1626, in 'Of youth and age', 1625

Introduction: Influencing Change at a Local Level

This chapter addresses two concerns central to the effectiveness of clinical leaders and how they can have a positive impact on the health service. It is in the domain of quality initiatives that clinical leaders can and do often shine. Organisational leaders have long known that in order to build successful businesses attuned to the needs of their clients and customers, products and services need to be of the highest quality and flexible enough to respond to market demands (Griffiths & Walker 2012). When initiating and following up on quality initiatives, clinical leaders can have a dramatic influence on quality, innovation and change in the health service. Part of taking quality initiatives forward involves planning for change so that it has the greatest opportunity to succeed. The most effective way to initiate change is with a clear plan of how the quality project can be developed accompanied by the application of knowledge, skills, tools and techniques to meet the project requirements. This chapter therefore focuses on the relationship of clinical leaders to quality initiatives and project management.

The Quality Improvement Process

It is possible to outline a process that may be followed to have a positive impact on clinical quality improvement. The American Hospital Association (AHA 2012) suggests that there are five steps in improving patient care quality (www.aha.org/research/reports/tw/12oct-tw-quality.pdf). These are:

1) Identify target areas for improvement.
2) Determine what processes can be modified to improve outcomes.
3) Develop and execute effective strategies to improve quality.
4) Track performance and outcomes.
5) Disseminate results to spur broad quality improvement.

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There are other models that can be applied, such as LEAN, Six Sigma (Langabeer et al. 2009) and the Plan–Do–Study–Act approach to quality improvement. Clearly, the employment of a model can help structure approaches to changing practice and implementing quality initiatives in a structured and planned way. Hospitals employ quality assurance departments, undertake audits and collect data on a wide range of quality indicators. They also seek to comply with government or industry-driven standards and institute key performance indicators (KPIs; Abujudeh et al. 2010) and others for measuring performance and quality (Mendiratta-Lala et al. 2011). However, as the Francis Report (Francis 2013) found, even with these processes in place quality care is not guaranteed (Ryan, Brahmajee & Justin 2012; Rafferty et al. 2015). Although these wider approaches to quality maintenance are vital, they often fail to address quality initiatives at a local level or reach into individual clinical areas to ensure not just that standards are being met, but that change for the better is taking place.

Opportunities and Challenges for Quality Initiatives

There are a number of activities that healthcare organisations can undertake to push or drive change and implement quality initiatives (Abdallah 2014). These may include one of more of the following:

- An organisational culture that values quality and change
- Effective team working
- Recognition of the value of clinical leader contributions
- General facilitation for cultures that support quality and change by middle-level managers
- Choosing an appropriate approach to dealing with change
- Choosing an appropriate quality initiative to address
- Effective staff training about quality initiatives and change management or project management
- Respectful engagement between colleagues and interdisciplinary teams
- Effective strategies for dealing with conflict
- Effective strategies for delegation
- Recognition of all staff members' ability and responsibility to contribute to quality initiatives
- Recognition of the special place clinical leaders have in helping identify and drive change and quality initiatives that are client and service focused

There are also a number of challenges that healthcare organisations face when attempting to bring about change and implement quality initiatives. These may take various forms:

- An inappropriate model or approach to bringing about a quality initiative
- An organisational culture that fails to value quality and change or plays only superficial lip service to quality processes
- Ineffective team working
- Managers and staff who are poorly education about quality initiatives and the role of all staff in helping identify poor-quality care and proposing change
- General resistance in the organisation to change, or to new ideas and practices
- Low employee empowerment, confidence or poor morale
- A perception that only medical staff can lead in the clinical domain
- Complexity or bureaucracy
- Lack of communication within the organisational hierarchy

In general, quality improvement stems from the implementation of effective quality initiatives. These are commonly led by clinically focused health professional leaders working in clinical teams or in multidisciplinary collaborations (AHA 2012; Pexton 2016).

While measuring quality activity is important, it is more important to accept the proposition that it is clinically focused health professionals who often come up with fresh ideas and new ways to solve clinical and client-focused problems. Managers can support these, but frequently they are too removed from the actual patient/client interface to see what quality initiatives are required.

Improving quality also starts with the patient, client and 'customer' by focusing on their needs and positioning the health service, ward or clinic to be flexible enough to adapt to individual client needs. While health industry managers, ward managers and health service administrative staff are often responsible for driving and maintaining quality initiatives, their success is very much dependent on working with clinically focused health professionals and clients, patients and their relatives. They all need to work as partners in terms of initiating, maintaining and bringing change, innovation and quality to fruition at the coalface (Pexton 2016).

The key issue is to ensure that everyone in the health service realises that they are accountable for the quality of their part in the service. Clinical leaders who demonstrate congruent leadership do know this. They already have their values and beliefs about high-quality care on show. In fact, one of the clinical leader's frustrations is that management or health service administrators sometimes seem to act in ways that run counter to the clinical leader's values about supporting clients, being compassionate towards patients or making the care they offer the best it can be.

Quality Initiative Stories

So clinical leaders have been and continue to be involved in copious quality initiatives. It is in these local, often apparently insignificant modifications or changes in how services are delivered that the greatest changes to quality patient care can take place. Numerous publications offer stories from clinical practice that describe the implementation of successful quality initiatives, such as Brook et al. (2010), Steele, Jones and Ninan (2012) and Unützer et al. (2012), all of which offer examples from the allied health and behavioural healthcare environments. These quality initiatives include initiating strict handwashing practices before and after any client intervention; disinfecting the skin with appropriate antiseptic solutions before a central line insertion; or the implementation of strategies to reduce radiation doses without sacrificing diagnostic quality in the use of computerised tomography (Tamm et al. 2011). These are actions that have come about because clinical leaders have acted on evidence-based data and clinical observations (Schulman et al. 2011; AHA 2012). One of the best examples of a clinical leader challenging and then changing practice was the Hungarian doctor Ignaz Semmelweis, who advocated and recommended the practice of handwashing (Chassin & Loeb 2011). He was ridiculed for his proposal, yet it was a clinically driven intervention aimed at improving client care and patient outcomes. Today handwashing is part of accepted quality hygiene care in all healthcare environments. Boxes 16.1 and 16.2 are two other examples of quality initiatives led by clinical leaders.

There is a veritable raft of other examples that could be offered. However, these few will serve to highlight this chapter's point: that clinical leaders can and do make a real and tangible difference to the quality of care and the quality of life of clients and patients every day by suggesting, inventing and initiating new ways to do things. Indeed, a key feature of the literature on quality initiatives is that it

Box 16.1 Toilet bell

A physiotherapist on a cardiac rehabilitation ward noted that patients were usually assisted to the ward toilet and then left there. They were given a bell and told to ring it when they had finished. Then a nurse or physiotherapist would help them off the toilet and walk them back to their bed. Apart from taking considerable time on the busy ward, this whole process did not seem to be supporting the features of effective cardiac rehabilitation and helped foster greater client dependence on nursing and therapy staff. This practice had been in place for years and years and was described as part of the 'ward culture'.

The physiotherapist and a registered nurse suggested to the ward manager that if bars were placed in front of the toilet, patients could hold onto these and help themselves to stand, before walking slowly back to their bed unaided. The bell would only be used for emergencies and busy clinical staff could focus on more pressing client needs. True rehabilitation and a focus on patient independence could also be encouraged. When they took the idea to the ward manager, she had no idea about the practice of ringing the bell, the clinical time being wasted or the missed opportunity for rehabilitation on her ward – as it was not her job, she had never answered the bell or helped anyone off the toilet and back to their bed.

Ironically, there were bars in the toilet area, but they had been attached to the wall behind the toilet, well out of anyone's reach. Indeed, it looked as though they had always been there and yet were never used. It cost nothing to ask a hospital maintenance man to remove and reattach the bars where they could be reached, in front of the toilet.

The net result of this clinically driven initiative was that patients engaged in more positive cardiac rehabilitation activities and developed a greater sense of their role in their rehabilitation journey. The toilet bell was only used in emergencies, nurses and the physiotherapist were less distracted by frequent calls to answer the bell, and other patients benefited from greater attention to their needs afforded by the time saved. The physiotherapist and nurse were in my view clinical leaders and this quality initiative, which cost nothing to initiate, is an example of the value of engaging and fostering clinical leaders in addressing client-focused change.

Box 16.2 Bedside diary in ICU

Having read about the idea of placing a diary at the bedside of unconscious patients in the intensive care unit (ICU), one of the registered nurses doing a clinical leadership course I was running undertook to make this initiative her 'change project'. As such, she sought permission to run a trial where each unconscious patients in the ICU where she worked was provided with a spiral-bound notebook. This was placed on the bedside locker, and relatives and visitors, nurses and medical staff were encouraged to make notes, draw pictures and record their thoughts about the client's situation, care and progress.

The idea came about originally because ICU nurses were aware that when they recovered from their serious medical or surgical condition, clients often awoke with no recollection of what had happened to them when ventilated or unconscious. Many described a gap in their life and memory. The idea of the bedside diary was to help fill the gap. The patient could read it once they recovered and at least part of their story would be available to them.

The quality initiative required some preparation, with consent and ethical hurdles to be overcome, including devising clear guidelines about how the diary was to be used and by whom. The purchase of the notebooks also needed to be arranged. A force-field analysis was conducted that demonstrated the benefits of the activity and the ward manager was persuaded to fund a pilot project. The results were evaluated and the viability and effectiveness of the project were soon proved.

The clients' relatives quickly took to the idea and a range of health professionals soon felt comfortable adding short diary entries. There was an issue with taking photos that sat outside the ethical parameters of the project and photos were initially not permitted to be used. However, relatives saw them as valuable and soon further ethical permission was sought so that they could be added with the consent of the patient's immediate relative.

The patients who survived their ICU experience, and had diaries to take with them, provided feedback that they were very grateful for the notebooks and often added that they wished these offered even more information.

Even though this initiative came about because the registered nurse had found an article on the practice in another country, this is still an example of a clinical leader, operating from a clinically driven focus, using her knowledge of change tools to institute and follow through a change and quality initiative. The pilot soon became a formal programme on this ICU and was part of the activities that helped others see this unit as a progressive and quality-driven clinical area and the registered nurse as a practitioner driven by a focus on quality.

is leadership and clinically focused leaders who make the most significant difference in influencing the success or failure of quality initiatives (Kaplan et al. 2010; Kelloway & Barling 2010; Liechty 2010; Perla, Bradbury & Gunther-Murphy 2011; Abdallah 2014; Pexton 2016). Juran (1993, p. 38) goes as far as stating that 'the most decisive element' in the success or failure of a quality initiative relates to leadership.

Reflection Point

Can you think of any quality initiatives that you have been involved in, suggested, proposed or seen in action? What were they? Did they work? Was there any resistance? How was this overcome? What sort of response was there from clients or patients to the initiative?

I would really like to hear about any quality initiatives you were involved in, so please feel free to email your example to me (dstanle5@une.edu.au).

Project Management

This part of the chapter explores project management, what it is and how using the stages of project management *correctly* can have a positive impact on change and innovation in health services, while enhancing effective quality and change.

Nurses and other health professionals are not usually instructed in the formal practice of project management, despite being expected to act as change agents and managers of both small and large projects. The processes for making changes in health services are no different from such processes in any industry. If managed correctly, a change follows a process and this is often known as 'project management' (Kloppenborg 2015). However, nurses and other health professionals not specifically trained to recognise the stages of change in this way. Not being aware of project management strategies can lead to a misperception that the processes in which health professionals, including nurses, are often involved are not activities that sit within the domain of project management.

Project Management Explored

What is a Project?

A project is defined as 'a temporary endeavour undertaken to create a unique product, service or result' (Project Management Institute 2013, p. 553). As such, every project has a beginning and an end. The end is when the project is terminated, when the objectives of the project have been reached or it is clear that they never will be. In the definition here, 'temporary' does not mean of short duration, since some projects can span many years. Each project is characteristically unique because even if projects appear similar, they are all different in some way (Kloppenborg 2015), in terms of factors such as time frame, location, budget, suppliers and so on. Even the presence of repetitive elements does not change the reality that each project is unique.

A key attribute of a project is that it is progressive; that is, it advances in steps. Projects are commonly a means of handling activities that cannot be addressed within an organisation's normal operating limits.

What is Project Management?

Project management is the application of knowledge, skills, tools and techniques to project activities to meet the project's requirements (Project Management Institute 2013). Most project management is applied though the integration of the steps of initiating, planning, executing, monitoring and controlling, then closing the project (Kloppenborg 2015). Project management is often closely associated with engineering projects, which typically have a complex set of components that need to be completed and assembled in a set fashion in order to create a functioning product (Project Management Institute 2013; Kloppenborg 2015). It is a methodical approach to planning and guiding project processes from start to finish through five stages: definition, initiation (or selecting), planning, executing (or controlling) and closing (Project Management Institute 2013). Project management can be applied to almost any type of project and is widely used to control or manage the complex processes involved in any developmental project.

Another view is that project management is an endeavour in which human/machine/material or financial resources are arranged in a unique way, to undertake a novel set of work, of a given specification, within constraints of cost, time or resources, so as to deliver beneficial change defined by quantitative and qualitative methods (Pilarski 2013; Kloppenborg 2015). Project management uses specific techniques to plan and control the scope of the work in order to deliver a product to satisfy the clients' and stakeholders' needs and expectations. As such, project management involves planning and arrangement of an organisation's resources in order to move a specific task, event or duty towards completion (Project Management Institute 2013). It typically involves a one-time project rather than an ongoing activity and the resources managed include both human and financial capital.

Reflection Point
Given this description, have you ever been involved in project management? If so, what was your role and how was the project managed? Was what you were involved with seen in the same way that project management is described here?

What is the Role of a Project Manager?

A project manager will help define the goals and objectives of the project, determine when the various project components are to be completed and by whom, and create quality control checks to ensure that completed components meet a certain standard (Crowe 2006). Project managers use tools including visual representations of workflow, such as Gantt and Program Evaluation Review Technique (PERT) charts, to determine which tasks are to be completed by which departments and people. These tools are not restricted to business, engineering or construction and they fit well with health projects and processes.

The project manager is the person who holds responsibility for managing the project, identifying resources, establishing clear lines of communication and distinct objectives, as well as balancing the competing demands for quality, scope, time and cost, the needs of various stakeholders and adapting the plans as required. These responsibilities may be shared with a project team, but it is essential that within the team clear responsibilities are identified (Kloppenborg 2015). As project management is a methodical approach to planning and guiding project processes from start to finish, it is the project manager who leads and monitors the overall process.

Reflection Point
Have you had a project manager role? If so, what did you do? How did it feel and what was your experience? Did things go well? How did you set the project up? Where you ever trained in project management principles, or were you just left to get on with things? Talk to others who may have led projects. What was their experience of leading projects to fruition?

How is Project Management Structured?

The information in this section outlines how change projects using a project management approach are structured. Figure 16.1 outlines the general structure employed to take a project from initiation to product delivery, often referred to as 'phases' (Kloppenborg 2015). All projects, regardless of their scope and size, have a similar profile.

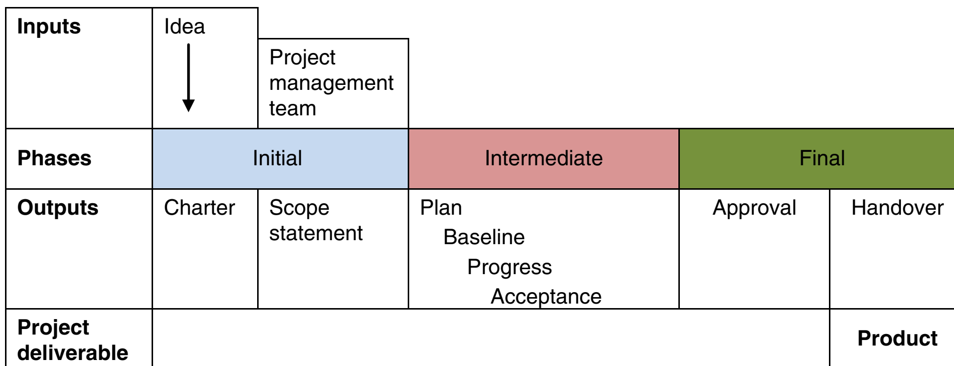

Figure 16.1 Phases of a project plan.

Phase 1: The Initial Phase

A project's life cycle begins with an idea. This could be anything, such as a plan to change a handover system, a new staffing model, a new workload plan, the initiation of a new clinical service, or the building of a new hospital. The initial phase starts with 'inputs' or a general outline that something needs to be developed, built or changed. Developing the inputs requires the establishment of the project team. The initial phase also requires a number of 'outputs'. These require the consideration of a number of critical components: time, money, scope and the creation of the project charter as a scoping exercise.

Project Management Team

The project management team can be one person, but usually includes a number of people led by the project manager. Having the right team and team membership can enhance the overall competence of the team, improve team engagement and heighten project performance (Daft 2010; Stanley 2011; Project Management Institute 2013). Team building should start with establishing team ground rules, encouraging participation, maintaining team cohesion and ensuring confidentiality. Managing misunderstandings and handling conflict appropriately so that trust is built and maintained are also vital (Stanley & Anderson 2015). In addition, project managers need to manage meetings well, establish team roles, maintain time lines and team focus and, crucially, make decisions promptly. These actions make up the inputs for the initial phase of the project.

Time, Money and Scope

Frequently project management is referred to as having three components: time, money and scope (Shenhar & Dvir 2007). Reducing or increasing any one of the three will have an impact on the other two. If a health service reduces the amount of time it can spend on a project, that will affect the scope (what can be included in the project) as well as the cost (since additional people or resources may be required to meet the abbreviated schedule). All these have an impact on the initial phase of the project (Kloppenborg 2015).

Charter

The charter is the formal agreement of project responsibilities. This is where the business case is set up and links are established between the project and the work of the organisation and the parties involved. It sets out contracts if required, works out a project statement and defines organisational or individual responsibilities (Project Management Institute 2013).

Scope Statement

The scope statement outlines the project's deliverable requirements; in other words, what will be achieved or delivered and when. It could involve the boundaries of the project, methods to be used and, if various multi-level projects are involved, how they will relate to each other and the scope of each level of the project. Issues about the general scope of the project need to be discussed and agreed from the outset (Project Management Institute 2013; Kloppenborg 2015). Once the idea is established and the project management team set up, they meet to work out the charter and the scope statement for the project. Project teams commonly use a SMART framework (S = Specific, M = Manageable, A = Achievable, R = Realistic and T = Time framed) to help establish what the specific goals are (general goals may also be important at this stage, but the objectives are more focused and specific). Developing the scope statement for, say, the introduction of a new waste disposal system will require the involvement of the project leader, project team and significant stakeholders and should result in a set of clear objectives for each stage of the project. Having achieved these steps, the project can move on to the next phase.

Phase 2: The Intermediate Phase

This phase is made up only of outputs and it represents the principal and most significant part of the project. It is here that the project is brought to life and eventually to fruition. The outputs involve a plan of action, baseline, progress and acceptance (Kloppenborg 2015).

Planning the Project

The project manager defines what the project is and what the users hope to achieve by undertaking it. It also includes a list of project deliverables; that is, the proposed outcome of a specific set of activities. The project manager works with the business sponsor or nurse manager who wants to have the project implemented and with other stakeholders, who are those with a vested interest in the outcome (Phillips & Simmonds 2012). If the project is setting up a new mobile public health service, for example, the project manager would need to be clear what is to be achieved, by when and with what resources, and specific outcomes would need to be established by the project team. It is also at this time that all the project's activities are defined. The project manager lists all activities or tasks, how the tasks are related, how long each task will take and how each task is tied to a specific deadline.

Models exist that are used to design and execute the project effectively and to guide the project management process from initial feasibility study through to maintenance of the complete application. Examples include the Systems Development Life Cycle (SDLC); the Waterfall Model, which was the original SDLC method; Rapid Application Development (RAD); Joint Application Development (JAD); the Fountain Model; the Spiral Model; the Build and Fix Model; and the Synchronize-and-Stabilize approach (Project Management Institute 2013). Applying one of these models in this phase allows the project manager to define the relationships between tasks, so that, for example, if one task is *x* number of days late, the project tasks related to it will also reflect a comparable delay. Likewise, the project manager can set 'milestones' or dates by which important aspects of the project need to be met.

Baseline

Here the minimum requirements for completing the project are defined and the project manager identifies how many people (often referred to as 'resources') and how much expense ('cost') are involved in the project, as well as any other requirements that are necessary for project completion. The project manager will manage assumptions and risks related to the project and will identify project constraints, typically relating to schedule, resources, budget and scope. A change in one constraint will typically affect the other constraints; for example, if the project involves supporting or planning a new ward, or new staffing structures or staffing levels in an emergency department, and this implies that additional resources will be needed, these features are added as part of the project scope, which will have possible impacts on scheduling, other resources and the budget.

Progress or Executing the Project

Once the project team is established and the project manager knows what resources are available and how much is in the budget, those resources and budget are then allocated to various tasks in the project. Key to this is the act of delegation and the manager's communication skills (Stanley 2011). For example, if the project involves the introduction of new medical or nursing equipment, the project manager might allocate the testing or training required to others in the project team. This phase is about doing what is planned and putting the plan into practice (Kloppenborg 2015).

Acceptance or Controlling the Project

The project manager is in charge of updating the project plans to reflect the actual time elapsed for each task. By keeping up with the details of progress, the project manager is able to understand how well the project is progressing overall. Gone are the days of pen-and-paper mapping exercises, and with the advent of greater information technology and computer software, nurse managers and other health professionals are able to lead projects of increasing size and complexity (Pilarski 2013). Specific products (such as Microsoft Project®) can be used to facilitate the administrative aspects of project management. However, basic Excel® spreadsheets can offer a suitable tool for less complex projects.

Phase 3: The Final Phase

This phase is where the project is concluded and, if required, the product or service is handed over. Prior to final handover, formal approval, sometimes called the 'signoff', has to be implemented. Reports are exchanged, responsibilities are handed over and the project team is closed down.

Closure of the Project

The project manager and business owner (or other levels of management) bring together the project team and those who had an interest in the outcome of the project (stakeholders) to analyse its final outcome and successes, and consider whether things could have been improved or done differently (Minoja 2012).

Key Issues

The key features of project management include making sure that there are predetermined start and finish dates, a planned potential life cycle and an assigned budget (Kloppenborg 2015). It is important that non-repetitive (unique) tasks, resources from various allocations, a single point of responsibility and team roles and relationships are established from the outset. In addition, no matter what the type of project, project management typically follows the same pattern of definition, planning, execution, control and closure (Shenhar & Dvir 2007).

The Components of Project Management

The following is a summary of the key components of project management. Underpinning all of these should be consideration of the particular organisational culture you are working within.

- **Scope**: What does the project cover? How is it going to be conducted? Why is it necessary? What work needs to be done?
- **Objectives**: Use a SMART framework. What specifically are your goals? (General goals may also be important at this stage but the objectives are more focused and specific.)
- **Strategy**: This is your master plan. How will you meet your objectives?
- **Budget**: What can you spend? What might be your costs?
- **Schedule**: What is the time line? What are the milestones for the project?
- **Customer or client**: Who are you working for?
- **Stakeholders**: Who else is involved in this project or will be affected by it?
- **Methodologies**: What project management methodology and/or charting methods are you planning to use?
- **Quality**: What are your standards? What are the criteria for success?
- **Environment**: What impact will the environment (internal and external) have on your project?

- **Risks**: What could go wrong? How will you foresee such events happening and plan to avoid them?
- **Resources**: What can you lay your hands on? What is available? What do you need? Can you afford it?
- **The end**: How will you measure success?

Final Project Management Issues

Recent trends in project management include project portfolio management (PPM), which is a move by organisations to maintain control over numerous projects by evaluating how well each project aligns with the overall strategic goals and quantifying its value (Project Management Institute 2013). An organisation will typically be working on multiple projects, each resulting in potentially differing amounts of return or value. The company or agency may decide to eliminate those projects with a lower return in order to dedicate greater resources to the remaining projects or in order to preserve those with the highest return or value.

Implications for Clinical Leaders

Project management is a valid and well-known approach to dealing with change in a structured way, yet it remains peripheral to nursing and health professional education (Sockolow & Bowles 2008). Few nurses or health professionals are aware of what project management is, or are prepared for the phases required to initiate and successfully implement it (Morris et al. 2006). Gaining greater understanding of project management in health services may streamline or facilitate more effective change management at all levels of nursing and healthcare and have positively impacts on health service quality. This may allow nurses and clinically focused health professionals to play a greater part in initiating or managing change projects at a range of levels across the health services and to manage them with confidence and competence.

Therefore, instruction in the use and application of project management, and tools to support effective project management, should be introduced into nursing education programmes. A specific recommendation is to include project management as a fundamental component of nurse manager education and instruction. This may help bring the voice and values of clinically focused health professionals to a greater range of projects, innovative change activities and healthcare initiatives.

Case Study 16.1

Sahar Hashemi is best known as the co-founder of the coffee shop chain Coffee Republic and the confectionery brand Skinny Candy in the UK. The book she wrote with her brother Bobby, called *Anyone Can Do It: Building Coffee Republic from our Kitchen Table*, outlines how their coffee shop project moved from an idea to a high-street brand that for a time rivalled the big US coffee chains. Read this brief biography and consider the challenge that follows.

Female Leaders: Sahar Hashemi

Sahar attended the City of London School for Girls and then studied law in Bristol. She worked for a very successful law firm for a few years before in 1995 she and her brother Bobby set out plans to open a US-style coffee shop in London. The brand proved very successful and by 2001 there were 108 stores across the UK. This was the year Sahar left Coffee Republic to focus on other ventures.

(Continued)

Case Study 16.1 (Continued)

The coffee shop soon went into decline and by 2009, after a number of shops had been closed, the business was sold to an Arab investment firm and now operates under the name Coffee Republic Trading.

Sahar went on to write two books about her business management style and became more involved in charity work, including with The Prince's Trust, the National Society for the Prevention of Cruelty to Children (NSPCC) Corporate Development Board and as a patron of the charity Child Bereavement UK. In 2005 she started a new business, Skinny Candy, which offers low-fat sweets and chocolates, although in 2007 she sold 50% of the business to a partner. She has been a strong advocate for women in business and frequently speaks about innovation, entrepreneurship and women's business issues. In 2012 she was appointed an Officer of the Order of the British Empire (OBE) and has received a number of other awards.

Challenge: Can 'anyone do it', as Sahar's book suggests? Do you have to go to a privileged school, win a scholarship or have an elite career path? Is success about being 'switched on', as she suggests in her second book? Sahar's view is that we all have the capacity to do great things, we just need to turn on our risk-taking switch and have a go. What do you think about these ideas? Are you 'just a nurse' or 'just a physio' or 'just a whatever'? Is what we are or who we are important in terms of us dreaming or trying for our dreams? Could mastery of project management skills help in terms of making a smoother transition for us all in terms of realising our dreams or reaching our career goals? Reflect on these questions as you consider what Sahar Hashemi achieved 'from her kitchen table'.

Summary

- A key role of clinical leaders is to change things for the better in clinical practice and this is often best achieved through quality initiatives.
- Change can best be achieved through a structured approach, such as following the patterns of project management.
- Project management allows clinical leaders to initiate change in a controlled, measured and systematic way.
- Success in implementing a project will be dependent on good planning, effective communication with all people involved, understanding and anticipating the risks and putting plans in place to manage them.
- Once the project has been implemented and is complete, celebrating success and acknowledging people who have contributed to it will encourage them to participate in future projects you may have planned.

Mind Press-ups

Exercise 16.1

Now that you have an idea of what constitutes project management, imagine you have a birthday party to deliver. Undertake the following task:

- **Plan a birthday party**: Budget $2000.
- **Customer specifications:** The party should be in your community.

Think about drinks, gifts, food, entertainment, music, dancing, guests and all the aspects of a really good party. Consider all the information offered in this chapter as you plan your project.

Exercise 16.2

Does managing a project mean taking total control? What are the other skills (some are outlined in this book) that you think might be used to support the job of managing a project successfully?

Exercise 16.3

Can clinical leaders really change the quality on offer to clients in the health service? Have you seen it happen? Look around your clinical area. What can you see in practice that has come about because of the initiative, courage and involvement of clinically focused health professionals?

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Part III

Clinical Leadership Issues: The Context of Values in Action

In politics if you want anything said, ask a man; if you want anything done, ask a woman.
Margaret Thatcher 1925–2013, prime minister of the UK 1979–90

The final part of this book places clinical leadership issues in context. Part I dealt with who clinical leaders are, their characteristics and the theories and details of leadership, in order to support an understanding of how health professionals can be seen as leaders in the clinical arena. Part II offered a range of tools that offer insights into how health professionals can effectively manage values to help bring about innovation, change and improvements in quality. Part III considers matters that affect the context within which nurses and other health professionals work.

Chapter 17 outlines the impact of gender and generational differences on how leadership is perceived and applied. How these two factors are viewed within organisations and by health practitioners can have a significant influence on the clinically focused leader's ability to express their values and may indeed affect the expression of their values.

Chapter 18 discusses the impact of power and politics on how health professionals lead. Power, influence and politics are defined, the types and styles of power are outlined and critical social theory is used as a vehicle to explore the impact of politics on healthcare. The chapter also offers some practical advice about dealing with the media and becoming politically active or being 'influenced'.

Chapter 19 addresses issues of empowerment and oppression. These are defined and explored in relation to their impact on nursing in particular, and health professional activity in general. A number of personal reflections are offered as examples throughout the chapter, and empowerment is explained as 'the walk and the choice about which path to take'. The characteristics of an oppressed group are outlined and strategies for dealing with oppression are offered.

Finally, Chapter 20 offers a summary of the main points covered in the book through a discussion of congruent leadership and clinical leadership. It offers further examples of congruent leadership and how this leadership theory influences a clinical leader's values and capacity to initiate change and promote innovation and quality in clinical practice.

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17

Gender, Generational Groups and Leadership

David Stanley

We are here to claim our right as women, not only to be free, but to fight for freedom. That it is our right as well as our duty.
Christabel Pankhurst, 1880–1958, British suffragette, in 'Votes for Women', 31 March 1911

Introduction: The Impact of Gender and Generations

This chapter addresses the issues of gender and its relationship to leadership for health professionals, as well as how different generational groups may or may not influence leadership. It begins by asking whether there is a difference between the leadership styles of men and women. The challenges that women face in achieving leadership recognition are outlined, together with some factors that hinder women in attaining leadership roles. The chapter also considers the potential causes of gender differences and the barriers that women may face in reaching their leadership potential, offering a number of recommendations to help women overcome the challenges. The theory of congruent leadership is linked to a female perspective on leadership to demonstrate that clinical leaders (male or female) may hold an advantage by applying a congruent leadership approach to their clinical leadership role. The discussion then moves to the issue of generational difference and considers whether such differences affect how health service leaders lead or manage. The chapter concludes by exploring what can be done to address the impact of generational differences.

Is there a Difference?

There remains considerable debate about whether men and women behave differently in leadership roles or exhibit different leadership styles (Vinnicombe 1999; O'Reilly 2015).

The Case for a Difference

Vinnicombe (1999) and Sandberg (2015) support the idea that both male and female managers agree that gender-based differences in management styles exist. Nielsen and Huse (2010) undertook research that supported this notion and proposed that while men and women do not differ in their ability to perform operational tasks, there is a difference in their perspectives on strategic

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decision making, because of their different sensitivity to the needs of others. Women's leadership competences are superior in the areas of taking initiative, self-development, integrity, honesty and driving for results (Zenger & Folkman 2012; O'Reilly 2015). In terms of leadership styles, Eagly and Johnson's (1990) study and another by Eagly and Carli (2007) suggested that there were statistical differences in the perceived leadership roles and effectiveness of male and female leaders. These studies demonstrated that female leaders had a preference for a more democratic/participative style and were less directive/autocratic (Sahoo & Das 2012). Women leaders were also shown to be more transformational (Vinnicombe 1999) and to give rewards, whereas male leaders were more likely to show a preference for transactional reward and punishment and laissez-faire styles of leadership. Women were demonstrated to be less hierarchical, more cooperative and collaborative, to place more emphasis on communication affiliation and nurturing, and to be more attuned to the self-esteem of others (a feature of emotional intelligence; see Chapter 15).

McKinsey's (2009) study, which surveyed over 800 business leaders, supported these views and added that women showed styles that promoted expectations, rewards, inspiration and participative decision making. Sahoo and Das (2012) agreed, proposing that female entrepreneurs (leaders) in the 21st century were more successful because they gave more attention to intellectual capital, the creation of self-organising networks, clear organisational goals, transparency, consensus building and collaboration and demonstrated a more 'connected' style of leadership. As such, women's leadership can be described as people focused, role modelling, and focused on clear expectations and rewards. Appelbaum, Audet and Miller (2003) refer to these as 'feminine' values and see them as having traction in rebalancing the traditional masculine values of competitiveness and authoritarianism. They see the feminine values as heightened communication skills, advanced conflict resolution skills, well-developed interpersonal skills and a softer approach to handling people, including the use of empathy. They add that rebalancing values towards more feminine approaches is increasingly being seen as the key to business success.

The Case for no Difference

Kakabadse (1999) is of the view that gender in leadership terms is a 'red herring', citing other factors such as the organisational culture, the leadership style of the 'boss' and office attitudes as having a more powerful role. Gender is proposed as only one feature of the maze of issues that determine good or effective managers or leaders, and both men and women can be good and bad as leaders. This view, that it is more a case of individual attributes, is in fact supported by Appelbaum, Audet and Miller (2003), who claim that leadership style is a choice based on an analysis of the context or situation rather than an inherent gender-based predisposition.

Styles are driven by issues of socialisation and it is just that the dominant theme in leadership has been the masculine model. This is being rebalanced with a more flexible emotional approach used to offset the traditional rational approach to understanding leadership. As such, effective leadership is not the exclusive domain of either gender and both can learn from the other (Appelbaum, Audet & Miller 2003). Recent studies by Andersen and Hansson (2011) and Cliff (2005) found no or minimal evidence to support the notion that gender differences had an impact on leadership styles. Moran (1992) suggested that while some small differences may be found, these may be the result of differences in socialisation and that leaders are instead simply people with divergent abilities regardless of their gender. Moran (1992) also identified that male and female leaders can learn from each other, adding strength to their organisations and helping each other producing a win–win situation for both genders.

While there is thus no agreement on evidence to support gender differences in leadership styles, there are clear differences in the challenges that women face when seeking leadership or senior management positions. These are explored in the following section.

Challenges for Women in Leadership

Women leaders today face challenges from both a personal and a global perspective (Patel 2013). In Canada, for example, women account for 51% of the population and make up 46.5% of the labour force. However, in the health service women are more than half the available workforce, creating a compelling case for unlocking the full potential of women leaders. The first case in support of a proposition to include more women as leaders is that greater leadership diversity leads to greater competitive advantage, with a more flexible approach to products and services that ultimately leads organisations to being better able to meet service users' needs (Hanna 2012).

Evidence that women have a positive effect on corporate performance or on the business bottom line is offered by Catalyst (2004), an American non-profit organisation devoted to the advancement of women in business, who compared Fortune 500 companies on the representation of women on their boards and their corporate performance. They noted that companies with a higher representation of female leaders had a return on equity increase of 53%, a profit margin increase of 42% and an increase return on invested capital of 66%. Management consultancy McKinsey (2007) confirmed the relationship between high levels of female leadership by indicating that the greater the gender diversity at the higher levels of an organisation, the greater the returns on equity and the better the operating results, which led to stronger stock price growth of up to 70%. Wilson and Atlanter (2009) found that having at least one woman on the board of directors decreased bankruptcy by a full 20%, and Franke (1997) suggested that companies with women on their boards employed more ethical behaviour and better corporate governance.

In spite of these advantages, from a global perspective women do not seem to be advancing quickly into leadership or decision-making roles and even when they do, there is still a considerable disparity in salaries compared to men in similar management positions (Tsui 1998). Women do not seem to be receiving equal access to education and are not being employed at equal rates to their male counterparts, and in some countries women still face legislative barriers, have limited access to credit or mentorship and there may even be laws denying them access to collateral. Women are universally under-represented on business boards across the globe. In the USA women make up 15.7% of board members; in Australia and Canada female representation is at about 10%; in India female board members account for less than 5% (European Commission 2012); in the Asia-Pacific region female board members are at about 6.5%; and in the Middle East and North Africa female board members constitute only 3.2% of leadership teams (Corporate Women Directors International 2010).

Globally, women are also less represented in primary and secondary education, although more women are being educated at tertiary level. This is not reflected in the employment figures, though, as women in many parts of the world have lower participation in the workforce than men, with rates below 30% in India and Pakistan, 48% in Nigeria, 44% in South Africa and 56% in the UK (World Bank 2013).

Women also face personal issues not attributed to male workers, such as the 'double burden' where they retain a high proportion of responsibility for domestic and care-giving duties as well as searching for paid employment and professional opportunities. Also known as the 'double burden syndrome', this is more pronounced in Asian and African communities, although women in Europe and other developed parts of the world are also responsible for twice as many domestic duties as men (McKinsey 2007).

Furthermore, women face a crisis of confidence and in environments expected to be dominated by male behaviour, women tend to lack belief in their own abilities and the capacity to communicate confidence (Eagly 2003). Finally, women also suffer from gender bias and stereotyping, with many unfortunate assumptions being made about their ambitions and potential, and women having to work harder to be perceived as equally competent to men in many leadership and management areas (Lyness & Heilman 2006). All these factors have impacts on women's capacity to reach or take part in attaining higher-level leadership roles.

The Causes of Gender Differences in Leadership

There are a number of factors that may lead to perceptions that men and women lead differently because of their gender. Patel (2013) separates these into personal differences and professional differences.

Personal Differences

- **Confidence**: Generally men can be characterised as more confident than women (Bengtsson, Persson & Willenhag 2005).
- **Apologetic**: Women tend to be more apologetic than men (Schumann & Ross 2010).
- **Bluffing**: Guidice, Alder and Phelan (2009) found that men show a greater capacity to bluff, or at least that they believed that they were better at bluffing than women (Holm 2005). Holm's (2005) study also found that both genders were more likely to lie to women than to men.
- **Social risk**: While in general terms women are considered to be more risk averse than men, in social terms they have been found to be more risk ready, because they have greater social sensitivity and can handle social uncertainty better. As such, they are willing to take social risks (Harris, Jenkins & Glaser 2006).
- **Emotional and facial recognition**: Women are better at recognising subtle facial expressions (Hoffman et al. 2010), helping them more effectively 'read' someone else's intentions and state of mind (Enticott et al. 2008). This supports their capacity to take more social risks.
- **Communication styles**: Marquis and Huston (2009) uphold the view that men and women communicate differently, with men often focusing on business issues while women bring social and personal issues into the business domain.
- **Emotions and actions**: Cunningham and Roberts (2012) indicate that men and women differ in their impulsive base reaction, where women are more likely to respond through feelings and men to respond through action. Thus men's immediate reaction to a stimulus is to act or look for a solution, while women's tendency is to feel. Patel (2013, p. 15) concludes that men are generally 'more overconfident and optimistic, whereas women have a higher social sensitivity and react by feeling'.

Professional Differences

- **Risk aversion**: Generally women are more risk averse than men (Weber, Blais & Betz 2002; Eckel & Grossman 2008). Furthermore, higher levels of testosterone in men have been correlated with higher levels of risk taking (Sapienza, Zingales & Maestripieri 2009).
- **Competitive environments**: Niederle and Versterlund (2007) found that women have a lower preference for competitive environments and, as Appelbaum, Audet and Miller (2003) established, these environments make women feel less welcome and possibly even threatened.

- **Response to uncertainty**: Women respond to uncertainty with fear, while men tend to respond to it with anger (Grossman & Wood 1993). This is significant, as these emotions trigger quite different responses to risk perception and risk taking, with fear diminishing risk taking and anger increasing it (Lerner & Keltner 2001). When confronted with stress women make decisions more slowly and tend towards less risk taking, while men veer in the opposite direction (Lighthall et al. 2012).
- **Context**: Women tend to react to the environment in a more emotional manner and are generally more perceptive of the environment, being more likely to be affected by the context (Croson & Gneezy 2009).
- **Evolution**: From an evolutionary perspective, men were hunters and women were gatherers. These traditional roles have evolved into preferences for certain behaviours (Buss 2012), with hunting skills more associated with leadership roles. Risk taking is also thought to be associated with status: taking greater risks increases status and may lead to more opportunities for leadership.
- **Team relationships**: Grossman and Valiga (2012) suggest that men tend to see issues as black and white, while women see more grey issues; men also often deal with teams from a purely business focus, while women bring wider personal or social issues into their team relationships, possibly enabling women to establish more effective team relationships.

Professional differences focus on the different approaches that men and women have to risk taking. Patel (2013) also emphasises biological differences in the structure and function of the brain. It is claimed that men favour right-brain functions (logic, detail, linear tasks), whereas a women's brain does not favour the left brain (holistic, intuitive, abstract) but instead operates on a higher interconnectedness between the right and left hemispheres. This interconnectedness may explain women's greater social risk taking, better facial recognition skills and higher ability to process emotional information (Cunningham & Roberts 2012).

Potential Barriers that Female Leaders Face

There is considerable agreement that women face more barriers to becoming leaders and more pressure from their roles than men do, especially for leadership roles in male-dominated professions or industries (Eagly & Johannesen-Schmidt 2001; Gardiner & Tiggemann 1999). Women can exhibit styles that allow them to work effectively as leaders, but there nevertheless remain a number of barriers that are keeping them from fulfilling senior leadership or mid-level management roles.

- **Gender bias**: As outlined in the previous section, women are subject to bias based on their approach to leadership. Heilman and Parks-Stamm (2007) showed that female leaders were likely to be viewed negatively when adopting masculine leadership characteristics, although if female leaders demonstrate feminine traits but perform a 'male role', they are seen as too emotional and lacking in assertiveness (Eagly & Carli 2007). These stereotypical views of women as less capable leaders than men persist (Appelbaum, Audet & Miller 2003).
- **Confidence**: Women continue to under-rate their ability to perform effectively in senior or mid-level management or leadership positions (Eagly 2003). A lack of confidence is manifest in women leaders seeking or accepting less in terms of money, rewards and praise for their leadership skills (Appelbaum, Audet & Miller 2003).
- **Negotiation**: Cialdini (2001) found that while women are able to negotiate as well as men, they enter negotiations with lower expectations.

- **Work environment**: Some women experience work environments in which they feel less welcome and even threatened by what they may perceive as a self-serving or domineering organisational culture. Some organisations favour masculine values and masculine attributes propagated by traditional structures or the 'old boy network' and there may be a lack of value placed on 'feminine' characteristics (Appelbaum, Audet & Miller 2003).
- **Authority and leadership identity**: Women find it more difficult to claim authority over their leadership roles (Lagace 2003). Thus, when leadership roles are associated with decisiveness, assertiveness and independence, women, who are commonly assumed to be friendly, caring and selfless, suffer from a form of gender bias that interferes with the development of an appropriate leader identity. The leadership identity constructed is often overly masculine, causing women to avoid taking up leadership roles or feel that they fit better with men. This phenomenon may explain why although men make up a minority in the nursing workforce, they are more evident in higher numbers in the management and middle-management ranks.
- **Role models and mentors**: Successful and effective female leadership role models are few and far between. They do exist, but in relatively small numbers (Ely, Ibarra & Kolb 2011). Moreover, in order to avoid disapproval women will role model modest behaviours, seeking to avoid attention, and making it difficult for women aspiring to management or leadership positions to recognise or locate mentors or role models (see the Female Leader role models offered at the end of each chapter).
- **Career paths**: Women are more likely to have non-linear career paths. Taking time out with family commitments and avoiding jobs that feature travel led McKinsey (2007) to conclude that many organisations are intolerant of the career paths and needs of women.
- **Networking**: Although women are more skilled at social engagement, their networking skills are not as well honed as those of men in the workplace. Ely, Ibarra and Kolb (2011) have found that women are reluctant to use networking as it is perceived as inauthentic and embroiled in stereotypical male-orientated social activities. Forret and Dougherty (2004) recommend that women need to adopt different strategies to become more visible in the organisation in order to have their leadership skills recognised.
- **Scrutiny**: While female leaders are noted as adopting modest behaviours to avoid attention, once a female leader is identified they are commonly subjected to increased scrutiny, watched more closely and assessed with greater care than many of their male counterparts. The net effect of this may be an increase in risk aversion, preventing their performance from being as competent as it might otherwise be.

Reflection Point
Reflect on the topic of gender differences and then speak with a female colleague whom you see as an excellent leader. Ask them if they have felt they have been disadvantaged in any way because of their gender, or if they have found any advantages in being a woman as they sought to secure a leadership position? What advice could they offer to aspiring female leaders? Also reflect on any work or social gender bias you may have faced yourself.

Recommendations to Address Gender Differences

Women are becoming more prominent in senior leadership and middle management positions in a range of organisations. In order for this trend to continue, women need to take personal responsibility for their goals and enhance their own skills to overcome the challenges mentioned in this chapter.

Moreover, if both women and men are to become effective clinical leaders, they need to recognise and find solutions to overcome the challenges or barriers in their path and those facing their staff. The following points are offered as advice for female leaders to diminish gender differences and overcome the challenges that women may face when seeking leadership and management roles.

- **Become a role model**: If you are in a leadership position or aspire to one, be visible and approachable. Be there for others to come to and make time to share your own leadership journey with other women.
- **Join or start networks** (see Chapter 11): Professional and industry organisations offer many networking opportunities, although it may be that more local and specific networks can be established to support colleagues. Establish mixed-gender professional and business networks (even beyond your own professional group) in order to establish relationships, widen perspectives and create opportunities.
- **Build your skills**: Become talent ready. Learn skills that will enhance your leadership potential and push your comfort zone in terms of developing IT competence and people or communication skills. Take responsibility for growing your own career, skills and talents.
- **Find a mentor**: It is important to find a quality mentor. Do not be afraid to ask for advice and show gratitude for any help or advice that is offered. Make yourself available as a resource for others and seek out key individuals with whom you can build a trusting and symbiotic relationship (Rowe 2009).
- **Align your style with your values and beliefs**: Women's predominant leadership style may match well with congruent leadership as their values and beliefs are in line with or match their actions (Stanley 2011). This approach will build the leader's credibility and authenticity and foster trust within the team. Sahoo and Das (2012) also recommend a 'connective' leadership style that allows women to perceive common ground and possibilities for handling division and difference.
- **Build technical and cultural competence**: The modern workplace means that leaders (male and female) need to be at ease with modern technology, as this facilitates communication strategies and networks. The complexity of any work environment also results in a need for leaders to become competent in dealing with the work culture, employing cultural, social and emotional intelligence. A work culture based on a patriarchal model presents specific challenges for female leaders and investing in personal skills around emotional intelligence and social intelligence are vital to meeting your career goals.
- **Develop your confidence**: McKinsey (2007) supports the idea that for female leaders to be successful they need to develop their confidence. This means making your achievements visible and being assertive. This can be achieved by ensuring that your manager is aware of your achievements (by sending on reports, telling your manager about your work and presenting your team's results), seeking the credit for work you have done, looking for feedback on your performance and asking for promotion (Catalyst 2011). Recent research by Carney, Cuddy and Yap (2010) also recommends taking on a posture of confidence (called 'Power Poses') that will support your own confidence and show others your 'power'. These poses include physically taking up more space and keeping limbs open, or at least avoiding a subservient and powerless posture such as slumping and hunching your shoulders. Confidence is an attitude that you can own.
- **Communication**: Speak directly and do not apologise. Speak as though you know you will be believed (Feldt 2012). Remain authentic and find a communication style that maximises your feeling of being genuine and that will diminish any miscommunication or misunderstanding based on stereotypical bias.

- **Be yourself**: Many women are successful leaders and they often achieve great success without having to take on or infuse 'male' or masculine approaches to leadership. Do not adopt a leadership style that is unnatural or uncomfortable just to get ahead. It may be that the organisational culture is at fault or that an 'old boy network' dominates in that area. Just be yourself.

Gender and Congruent Leadership

All leaders are different and use different styles or approaches at different times depending on the situation, socialisation approach, relationships they have with their followers and their degree of power. Gender is one factor in establishing these differences, although it need not be a barrier to successful leadership in the health service. Deuskat (1994) feels that organisations based on traditional masculine approaches are less inclined to promote or value transformational leadership approaches common to the styles that women display.

As the health service seeks to promote change and leadership that drives a values-based change agenda, it is possible that this favours female leaders, who are more likely to demonstrate a transformational or congruent style. Nevertheless, as Moran (1992) suggests, the core differences between male and female leadership styles are small, and the similarities may well be stronger. Sharing or building on the styles and talents of both male and female leaders may provide a situation that allows both genders to flourish.

From a clinical leadership perspective, recent research supports the notion that clinical leaders show the same attributes regardless of gender (Stanley 2014). In the studies that support this book, male and female paramedics and nurses mentioned identical characteristics when asked to describe the attributes of clinical leaders. Both genders suggested that clinical leaders need to have integrity and to be approachable, clinically skilled, visible in practice, good communicators and supportive. Both groups suggested that they would be least likely to follow clinical leaders who were 'controlling' or who demonstrated strong 'management' skills, again linking the attributes of clinical leaders with a congruent approach to leadership. Both genders supported leaders who lived out their values and beliefs in their actions (Stanley 2011, 2014). Gender did not seem to be a feature that prevented clinical leaders from demonstrating effective congruent leadership skills.

Reflection Point
Men in nursing have been described as being on the 'glass elevator', while women seeking to advance have been disadvantaged by the 'glass ceiling'. Is this the case for other health professions where men are in the minority? If it is the case, how much of this phenomenon is down to gender, and how much is governed by other, non-gender-specific issues? What might these other issues be and how can they be overcome? Why does the elevator only carry men?

Generational Differences and Leadership

Significant life experiences have been proposed to be the root cause of why generational groups express different characteristics or are motivated and driven to express different values (De Meuse & Mlodzik 2010; Cahill & Cima 2016). Different generational groups are engaged in the workforce and it is widely acknowledged that generational issues may have an impact on how leaders emerge or are

followed (Kogan 2001), because different generational groups are motivated and follow leaders for varying reasons (Nelsey and Brownie 2012). There are a number of different generational groups to consider, described in the following sections.

Veterans

Also known as Traditionalists, the Silents, the Forgotten Generation and the War Generation, this includes people born before 1945. They make up few, if any, of the current workforce, although some will still be found in the ranks of volunteers serving generously in hospitals and community service organisations. They have a wealth of experience and continue to contribute because they believe in lifetime employment and they generally value hierarchies. They also appreciate dedication, rules and loyalty and believe that hard work will produce rewards. They tend to prefer command-and-control management/leadership structures. Their core values are hard work, respect for authority, law and order, duty, honour, dedication and sacrifice (McCrindle 2016).

Baby Boomers

This generations includes people born after World War II (between 1946 and 1964), who were raised in an era of optimism, opportunity and progress. Generally, 'Boomers' have secure jobs, access to good education and relative prosperity. As such they question the status quo, embrace the 'big picture' and recognise the world as a smaller place. They value optimism, personal growth, equal rights, health and wellness and involvement (Weingarten 2009; McCrindle 2016). Baby Boomers are still evident in the health professional workforce and can be found in many senior and leadership positions, making them ideal mentors and preceptors (Nelsey & Brownie 2012). Their work ethic tends to be strong. In this regard they value flexibility, they want to know that their ideas matter; for many their work or career matters greatly and often defines them (Cahill & Cima 2016; McCrindle 2016).

Generation X

People born between 1965 and 1980 entered an age of rapid change, with changing social and economic factors affecting their education and social development. Many grew up in two-career families, faced high divorce rates, industrial downsizing and rapid developments in technology and communication. Those in this generation focus on personal development and actively oppose authority, the status quo and the idea that job security is a given. They value thinking globally, work/life balance, technological and communication literacy and global diversity (Gursory, Maier & Chi 2008; Weingarten 2009; Cahill & Cima 2016). At work they want independence, informality, and time to pursue their own interests and to have fun (McCrindle 2016).

Generation Y

Also known as the 'nexters', 'internet generation' or 'Millennials', Generation Y includes people born between 1981 and 2000. They are more numerous, more affluent, better educated and more ethnically diverse than any previous generation. By 2020 they will make up over 50% of the workforce (Cran 2016). They display a range of positive social habits and are clear about the value of belonging to a group. They are generally technologically savvy and are masters of the video game, mobile phone, social media and the internet. They prefer to be tech savvy, are good at multitasking and are keen to participate or collaborate in decisions as much as possible. They like team-orientated workplaces, they expect to be treated with respect and they want to feel positive about

themselves (Cahill & Cima 2016; McCrindle 2016). Their core values are optimism, civic duty, confidence, diversity, modesty, achievement, morality and teamwork. The focus of Generation Y in the workforce is to find an employer for which they *want* to work, and not to work because they *need* to (Cran 2016).

Generation Z

While not yet a factor in health service employment or leadership issues, this generation is on the cusp of having an impact on the health service. Generation Z was born between 1995 and 2010. It is seen as a global, social, visual and technological generation (McCrindle 2012). Its members are well connected, well educated and sophisticated and are commonly described as early adopters, brand influencers, social media drivers and pop-culture leaders. It is said that those in Generation Z do not just represent the future, they are creating it (McCrindle 2012). This newest generational group is developing during a time of crisis, with recent and impending global recession, acts of global terrorism and, significantly, the impact of climate change. They are the students of today and the university graduates, employees and consumers of tomorrow.

It is worth adding that the peer-reviewed literature tends to conclude that there are very few meaningful differences between generational groups (De Meuse & Mlodzik 2010) and that leaders (and organisations) would be better served by focusing on individuals and their intrapersonal/interpersonal issues (Cahill & Cima 2016). However, health professionals, and nurses in particular, enter the workforce at a range of ages (Keepnews & Shin 2010), implying that the health workforce will be made up of a wide range of generational groups. While recognising that each person, leader or manager is an individual, it is still good to understand each generational group. This may allow leaders and managers in the health service to come to terms with what may drive or motivate each group and to work more collaboratively (Hayes, Bonner & Pryor 2010; Stanley 2010). Dealing with employees across the scope of the generational spectrum is vital if employers are to retain their workforce, motivate staff and find ways to lead or be led by professional colleagues. Engaging with multiple generational groups will help develop a more diverse workforce and support strategies for dealing with conflict based on generational differences or consequent differences in values. It may also allow employers to prepare for the impending shift as Baby Boomers leave the workforce and Generation X and Y move into more prominent positions (De Meuse & Mlodzik 2010).

Case Study 17.1

Oprah Winfrey has risen to a dominant position in American television and offers a powerful voice for women. Read her story and consider the challenge that follows.

Female Leaders: Oprah Winfrey

Oprah was in fact born Orpah, a name from the biblical book of Ruth, but her relatives usually transposed the *r* and the *p* so that she was soon known as Oprah and the name stuck. Her parents were unmarried teenagers: her mother was a housemaid called Vernita Lee and her father, who was in the military at the time of her conception, was called Vernon Winfrey. She was born on 29 January 1954 in the American state of Mississippi.

In her early years Oprah was brought up by her grandmother (Hattie Mae Lee) on a poor rural property. Described as a bright child, she soon learnt to read under instruction from her grandmother and

from the age of 3 she was reciting the Bible in church. She moved to Milwaukee with her mother at the age of 6 and was soon being subjected to sexual and physical abuse. She claims to have been raped at the age of 9 and became pregnant at the age of 14; her child died in infancy. Unhappy and discontent, Oprah ran away from home and ended up in a juvenile detention centre.

When she was released she went to live with her father in Nashville. Vernon, who was now a barber, insisted that his daughter be educated and imposed a strict set of rules that ensured she was well educated. Every week Oprah was required to read a book and write a report about it. In the seventh grade a teacher noticed her reading during the lunch break and recommended her for a scholarship to a better school. Regarded as extremely pretty, Oprah won a number of beauty competitions, prominent among them the title of Miss Black Tennessee, and at the age of 17 she secured a job reading the news on a local radio station. As well as her academic diligence, her talent for performing showed early and after leaving school she attended Tennessee State University to undertake a bachelor's degree in speech and performing arts, graduating in 1976. During her studies she gained a job with a Nashville television company and became their first black female news anchor.

After completing her degree, Oprah worked as a co-anchor on an early evening news show in Baltimore. Producers noticed that she occasionally became emotionally embroiled in the news she was reading and she was made co-host of a local television talk show. It was in this format that she shone and she was soon perfecting her talk show skills.

In 1983 she was hired to host a low-rated, half-hour morning talk show in Chicago called *AM Chicago*. Again she made the format her own and the show soon became a major success. It was expanded to an hour in length and renamed *The Oprah Winfrey Show*. It began as a traditional talk show, but gradually expanded into a format for the discussion and presentation of current issues and featured major stars, eventually ranking as the highest-rated talk show in history, running from 1986 to 2011. In 1986 the show began being broadcast nationally and Oprah's fame as a daytime television presenter of controversial topics was cemented. Much of the content focused on topics with specific relevance to women. Oprah also shared many of her personal issues, allowing women to identify with her struggles (particularly with weight loss). Her fan base grew and her ability to retain a 'common' or popular image kept her in the public eye. The show was soon transmitted internationally and won three Emmy awards.

Oprah also undertook a number of acting parts and in 1985 appeared in Steven Spielberg's film of Alice Walker's novel *The Color Purple*. Inexperienced at acting and intimidated by Spielberg, Oprah was slow to deal with her role, but as her confidence grew the part was expanded and her talents again shone. She was awarded other acting roles and appeared in the television mini-series *The Women of Brewster Place* in 1989. In 2013 she took a role in the film *The Butler*.

The power of Oprah's influence can be evidenced by the effect of her weekly book club, introduced into her talk show in the late 1990s. Any book reviewed or discussed on the book club shot to the top of the US bestseller list. She could have a negative impact too. After doing a show on mad cow disease she made an off-the-cuff comment that she would never eat beef again. This led to a national slump in beef prices and she was sued for business disparagement by a group of Texan cattle farmers. She was found not guilty.

Oprah is considered to be the richest African American of the 20th century and is currently North America's only black billionaire, with an estimated worth of $2.8 billion in 2012. Her wealth, media profile and personal support for Barack Obama are said to have delivered millions of votes to his two presidential election successes and in 2013 he awarded her the Presidential Medal of Freedom.

(Continued)

Case Study 17.1 (Continued)

In the early 1980s Oprah started working on a number of charity projects and this work continues. She began The Angel Network as a coordinating body for her numerous charity activities, with funds raised being used to support school scholarships and to build youth centres and homes or shelters for homeless women. She also manages the Oprah Winfrey Foundation, which offers grants to support education for women, children and families around the globe. In 2007 in South Africa she established the Oprah Winfrey Leadership Academy for Girls in partnership with the Ministry of Education as a tool for helping young girls in the country get a better education and thrive.

Oprah's media empire grew throughout the 1990s and 2000s with the establishment of *O – The Oprah Magazine* and *O at Home*, as well as a women's cable television network and her own production company, Harpo Productions (Oprah spelt backwards).

Oprah Winfrey is recognised internationally as a media personality and as a philanthropist and she retains a massive influence over popular culture. She is claimed to be one of the most influential women in the world and one of the top 100 most influential people of the 21st century. She retains a huge capacity to motivate and direct viewers and readers with the aim of improving their lives, and in particular the lives of women, helping them to care about the things she cares about. She is seen to be harder on male guests on her show than women, and has always favoured female-focused charitable endeavours. However, she stands solid as an example of someone who has risen from poverty and childhood disadvantage to achieve great personal wealth, international influence and benefit for society.

Challenge: Oprah's story is replete with clichés, but it reminds us that hard work and study can pay dividends. What are your study and development plans? Do you have a plan for how to advance your career or personal life? Oprah is clearly very talented, but she was also able to recognise her weaknesses and do things to address them or enhance her strengths. How can you identify your weaknesses and enhance your strengths? Chapter 15 on reflection and emotional intelligence offers a number of tools and advice to help with reflection. Or you could start with a simple list of 'strengths' and 'weaknesses' and then consider strategies to deal with each. How can you help yourself be a 'better version of yourself each day'? How can you bring what is most wonderful about you as a person to the fore?

Summary

- This chapter has addressed the issue of gender and leadership, asking whether there is a difference between the leadership styles of men and women.
- It has described a number of challenges that women face in achieving leadership recognition, including lower than average salaries, under-representation in leadership roles, gender bias and a lack of confidence.
- Greater leadership diversity has been identified as leading to greater competitive advantage, with a more flexible approach to products and services that ultimately leads organisations to be better able to meet service users' needs.
- This chapter has suggested that there are a number of reasons for the gender disparity in leadership roles, with women being seen as having a lack of confidence, to be more apologetic, poorer at bluffing, more risk averse, more emotional and to employ different communication skills, while they also have higher social sensitivity and react by feeling.
- Women face a number of barriers in reaching their leadership potential, which include gender bias, a lack of confidence, lower expectations in negotiation, being less comfortable in some work

environments, being less identified as leaders, a lack of role models and mentors, having career breaks, not networking as effectively as some men and being subjected to greater performance scrutiny.
- To overcome these barriers women could employ strategies of becoming or finding a role model, starting a network of their own, building their leadership skills, aligning their leadership style with their values and beliefs, building technical and cultural competence, and developing their confidence and communication skills.
- The chapter also links the theory of congruent leadership and a feminine perspective on leadership to demonstrate that clinical leaders (male or female) may hold an advantage by applying a congruent leadership approach to their clinical leadership role.
- The main generational groups are outlined: Veterans, Baby Boomers, Generation X, Generation Y and Generation Z.
- Leaders and managers within the health service need to recognise the motivators and drivers within each generation and incorporate these into their management and leadership approaches to make the most of the core values of each generational group.

Mind Press-ups

Exercise 17.1

There is a common perception that many men in nursing (or healthcare in general) are focused on seeking a career in management. Do male health professionals have any advantages over their female counterparts in progressing more effectively through to more senior levels? Why might this be?

Exercise 17.2

Do generational differences exist in your workplace? Talk to your colleagues about this question. Are the main differences generational or are there other, less 'global' issues that tend to cause conflict or sit between people? If there are generational issues, how do you plan to overcome them so that values can be more easily understood and shared?

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18

Power, Politics and Leadership

David Stanley

Nearly all men can stand adversity, but if you want to test a man's character, give him power.
Abraham Lincoln, 16th President of the USA, 1809–65

Introduction: Power and Politics

This chapter addresses the issues of power and politics as they relate to leadership for health professionals. Power and politics have some negative connotations and have been assigned limited relevance by many health professionals in the past (Bishop 2009; Picton 2010). Nevertheless, politics and power are central issues to health service delivery in every country and, as such, nurses and other health professionals need to develop an awareness of, interest in or – if possible – a commitment to political engagement (Kearney 2010; Picton 2010; Basaran & Duygulu 2015).

The chapter seeks to outline some definitions of power and politics and discusses what it means to exercise professional power as well as other types of power. It also considers the significance of a professional's capacity to influence, together with a number of types of influencing styles. Critical social theory is used to develop an argument for the role of professionals in relation to power and politics. The chapter concludes with a discussion of politics and offers some practical approaches for how health professionals can deal with the media and become politically active, within the context of their professional responsibilities.

A Beginning

Like most phenomena in our lives, we begin to develop a sense of the characteristics of power and politics at an early age. Indeed, Howard and Gill (2000) suggest that children's interpretations are social constructions that cannot be independent of adult thought. Therefore, children assimilate information about power and politics through their contact with adults, or through cultural artefacts such as television, radio and the internet (Howard & Gill 2000). So it is fair to assume that we come to the concepts of power and politics with a long history of pre-developed thoughts, ideas and expectations that shape our understanding of, and interaction with, all our social experiences.

Social experience suggests the involvement of people. As we all know, in the context of social relationships sometimes we have no power and sometimes we do; that is, according to social context,

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there are always differentials in power. Hence, as Backer et al. (1998) point out, any social relationship that includes a power differential is political. What this means is that politics is about using power to facilitate the achievement of particular social, ideological or material endpoints.

Braynion (2004) asserts that power can be a vexed and difficult concept to define and that the definition will very much depend on the lens through which the phenomenon of power is considered. Roberts and Vasquez (2004, p. 197) cite *Merriam-Webster*'s definition of power as 'the ability to act or produce an effect', and Huber (2000) adds that power can be perceived as the ability to exercise influence over others, either by coercion or persuasion. These views support the notion that power is exercised between people and is therefore specific to their relationship.

Professional Power

Throughout this book you have been offered ideas and thoughts about the nature of clinical leadership, as well as the skills that allow for its operation in the practice setting. In this regard, you have been given opportunities to reflect on and analyse the meaning of clinical leadership for you as a health professional.

The operative word in the last sentence is 'professional'; that is, clinical leadership occurs in the context of professional practice. Therefore, it represents an activity carried out by professionals, where a profession is an occupational group that enjoys varying amounts of freedom and power, traditionally granted by governments (Wilding 1982).

As such, there is a sense in which a number of different types of power are operating. For example, there is the power held by governments, which determines the type of power held by professions; and there is the power held by professions, which affects individuals (Basaran & Duygulu 2015) as the subjects of the professions, and professions themselves. Bishop (2009) identifies the concept of 'mastery' as central to an understanding of professional power, defining mastery (2009, p. 14) as an 'acquired set of competencies that provide a baseline of knowledge and expertise for a professional, incorporating a level of self-confidence'. However, professional mastery and self-confidence alone are not considered sufficient to facilitate professional leadership, since leadership also implies the capacity to communicate well, to remain visible and to act as a role model (particularly in a clinical context) for the values and beliefs relevant to the professional's role.

Power Base

Marquis and Huston (2012) and Bishop (2009) suggest that leadership cannot be effective without some measure of power to support it. French and Raven (1959), Bragg (1996), Braynion (2004), Bishop (2009) and Yoder-Wise (2015) propose that a number of sources exist for the exercise of power. They cite the following types or sources of power:

- **Reward power**: This is exercised by the ability to grant rewards or favours. It could include bonuses, special treats, time off or indeed anything of value.
- **Punishment, authoritarian or coercive power**: This type of power is derived from the capacity to generate fear. It may involve threats (real or implied) of transfer, work reassignment, lay-off, demotion or dismissal.
- **Legitimate power**: This is the power of authority and commonly accompanies titled positions. It implies feelings of obligation or responsibility and its legitimacy arises from the authority associated with a job title.

- **Expert power**: This power comes from knowledge, expertise or experience that others value. It exemplifies the phrase 'knowledge is power'. It is often limited to a specialised area and usually fails to extend beyond this.
- **Referent or charismatic power**: This is power that is referred to a leader because others recognise or identify with that leader, or with what they symbolise. It can be paralleled with charismatic power and involves feelings of personal approval and acceptance, or it may be that the power comes from the reflective glow of being associated or connected with others in authority.
- **Resource power**: Controlling a variety of resources will imply a degree of power. This may be the control of budgets, staff promotion opportunities or the drug keys on a medical ward. It can be anything that has a relative value or may be scarce. Basaran and Duygulu (2015) indicate that Turkish nurses saw themselves as having above-average personal and professional power, but limited resource power.
- **Information or informational power**: This is derived from having access to selected information or the means to control the information flow (Heineken & McCloskey 1985).

Reflection Point
If leadership cannot exist without some sort of power to support it, what sort of power do you feel you exercise in the course of your work duties? Does this matter? Talk to your colleagues. What sort of power do they think you have?

There are other types of power, such as connection power, where power is gained by having a connection with people perceived to be powerful. Marquis and Huston (2012) also identify self-power, where a person is able to gain power over their life so that with maturity, security and confidence they develop a degree of personal strength or resilience.

Recognising that there are different sources or types of power allows us to see that power in itself is not good or bad, positive or negative. Power is not about a balance between victory and loss. Instead, power is related to how it is used and to the purpose (good or evil) to which it is put (Marquis & Huston 2012). It is also significant to realise that power does not belong to any one group or individual and therefore it is not an issue of taking sides or being in the powerful or less powerful group; rather, it lies in recognising that we all operate within a power structure and that the key is to understand the strategic elements of power (Foucault 1969).

Realising that power need not be positional – legitimate and related to a capacity to reward or punish – but is also related to expert power, knowledge, information and charisma means that influencing others through the appropriate use of power can enhance a health professional's personal and professional power base.

Reflection Point
What do you understand by the word 'power'? Please do not look in the dictionary. Instead, think about how the word is used in your daily life and in clinical practice. How is power derived and how is it maintained? In your opinion, is there a connection between power and leadership? Jot your thoughts down. It is useful to start with the experiences you have had of power and power relationships. It may also be instructive to reflect on your feelings about power and powerlessness.

Influencing Styles

It is clear that power is related to influence (by what are called 'micropractices' by Gilson, Schneider & Orgill (2014). Exercising power often relies on a leader's capacity to use influence well. In turn, using influence well relies on a person's capacity to employ effective interpersonal and social skills to encourage others to change their attitudes, decisions or behaviours to comply with their requests (Bragg 1996). This often rests on the front-line leader's ability to manage power at a local level and to develop strategies to influence and 'empower' colleagues to support change, quality initiatives and impending innovations (Gilson, Schneider & Orgill 2014). The following discussion on influencing styles provides one model for reflecting on some of the preferred influencing practices. Use of any influencing strategy is dependent on your own style or preference, the nature of your existing relationship with others and the personal style or preference of the individual you are attempting to influence.

As you reflect on your style, remember that if something is working, keep doing it; if it is not, try something different. If for any reason flexibility of style is an issue for you personally, think about how you operate on a day-to-day basis, intuitively shifting your style to achieve the desired level of influence on those you want to do your bidding.

Influencing styles include the following:

- **Assertive persuasion** – an attempt to influence someone through sheer weight of argument and counter-argument. This is a logical, calculated approach that attempts to overcome objections and resistance by appeals to sound reasoning. People will agree or disagree with your proposal because it is more or less effective, accurate, correct or true.
- **Reward and punishment** – an attempt to influence someone by using pressure or incentives to control their behaviour. Many negotiating and bargaining behaviours fit under this heading. Rewards may be offered for compliance; punishment or deprivation may be threatened for non-compliance. The use of power can be direct and aggressive (naked power) or more indirect, with veiled pressure from the use of status, prestige or formal authority. Whether people will agree or disagree is not the issue: the judgement of right or wrong is an evaluation based on a moral, social or arbitrary performance standard. The person making the evaluation sets themselves up as the judge.
- **Participation and trust** – an influencing style that increases people's commitment to the task by actively listening to them and involving them. It works best with the personal disclosure of one's own limitations; others are encouraged to be open and can more easily see that their contribution is valued. People's ideas are encouraged and their commitment grows as more responsibility is delegated and communicated back to the participants. As this occurs, understanding and acceptance of their ideas are generated.
- **Common vision** – this influencing style tries to identify a common vision of the future for a group, and then group members have the vision strengthened so that through their collective or individual efforts the vision can become a reality. The power of this approach is in communicating the vision clearly, then in seeing the leader as trustworthy or dependable, and seeking others' (followers') commitment to working towards the vision.
- **Common values** – this form of influence can be overt or unconscious. It is closely aligned with congruent leadership and relates to the leader demonstrating their values and beliefs. Appeal is made to the values and emotions of the other(s) and images, metaphors and, more powerfully, actions are used to communicate enthusiasm and kindle excitement in a better future or a better way.

When attempting to influence others, it may be useful to follow a 'problem diagnosis' approach:

- **Step 1: Situation identification.** Begin by identifying a situation where it is important for you to increase your influence and power.
- **Step 2: Influence outcomes**. Now consider your desired outcome from this attempt at influence. Consider what your objective is (e.g. to sell an idea, change an attitude, elicit certain behaviour). Describe your influence objective in specific behavioural terms (e.g. what you want the other person to do or say).
- **Step 3: Influence target.** Be specific about who you are trying to influence in the situation. If it is more than one person, identify the key individual whom it would be critical to influence, or most difficult for you to deal with effectively. In addition, describe the style of your influence target. How do they react to your influence attempts? What is it about the person that makes them difficult for you to influence?
- **Step 4: Situational factors.** Also consider any other characteristics of the situation that might affect your influence efforts (e.g. what the environment is like).
- **Step 5: Description of past influence behaviour.** Consider any previous efforts to influence others. Do not evaluate your efforts, simply describe in detail how you tend to behave.
- **Step 6: Evaluation of past influence behaviour.** Now evaluate the effectiveness of your influencing attempts in this situation. What behaviour is effective or partially effective? Do you use influencing behaviour that is inappropriate? Do you use an appropriate style, but apply it poorly?
- **Step 7: Ideal influencing style.** Based on your analysis in Steps 1–6, describe what you believe to be the ideal influencing style or sequence of styles and behaviours to use. Do not be concerned at this time whether or not you can use the styles or behaviours that you identify. Describe what you believe would be the best strategy if you had an unlimited repertoire of influencing skills.
- **Step 8: Moderate your risk strategy.** Now decide on an influencing strategy – a combination or sequence of styles that takes your personal strengths into account. You may want to modify it somewhat to bring your risk down to a more acceptable level.
- **Step 9: Focus on the next contact.** What is the first step you plan to take with your influence target? Briefly describe the circumstances of this key meeting or contact. Then consider the single most important outcome you want from this crucial first step.

These steps are useful only if you understand strategies for increasing your influence. Some approaches to increasing your influence are outlined in Box 18.1.

The exercise of influence is how power is achieved. Power – any type of power, even positional power – is only potential until the user has mastered the ability to influence others and release the latent resource of that power (Bragg 1996). The key to releasing the potential resource of power is to unlock the process of influence. Some theoretical background may help, and this is addressed in the next section.

Critical Social Theory

Professional groups seeking to exert their own power do not always find it easy to maintain harmonious relationships (Willis & Parish 1997). Power politics is therefore not necessarily about mutuality or cooperation, but rather about achieving pre-determined endpoints. When professional groups engage it is commonly through the application of countervailing power (Frankford 1997). In this way power is

Box 18.1 Increasing your influence

Gain greater expertise

- Develop skills in new technologies
- Gain more knowledge (general or specific)
- Attain knowledge that is of a specialised nature (but remember that specialisms come and go)
- Develop interpersonal skills that are of value (emotional intelligence)

Improve personal attraction

- Be pleasant at work
- Behave agreeably
- Be seen as trustworthy and likeable
- Avoid lengthy unresolved conflicts
- Dress (and smell!) to impress

Gain legitimacy

- Can you articulate your values and beliefs?
- Are your values and beliefs consistent or compatible with those of the organisation or your colleagues?
- Are you seen to be demonstrating (living) your own or the organisation's values and beliefs?
- Can you articulate your vision?

Make an effort

- Does what you do help or hinder your 'boss' or colleagues?
- What do you need to do to increase your departmental/organisational knowledge?
- Remember that effort equates to dedication and commitment
- Contribute to organisational functions and be seen doing relevant and appropriate things
- Arrive early, leave late – it all helps

subject centred; that is, it flows from one actor (a subject) towards another actor. Consequently, if this process is taken to be the traditional discourse of power, we can say the following about power:

- Power is a force applied by a 'wilful, rational, and autonomous subject' (Frankford 1997, p. 193).
- A second subject of power exists who, although equally wilful, rational and autonomous, is limited by its 'subjection' to the power of the first subject.
- Power can be created, transferred or possessed.
- The primary force of power lies in its ability to take hold of subjects' minds.
- Power is most effective when its action is invisible, and when it is invisible it minimises autonomy and freedom.
- The strongest antidote to this kind of power is transparency, as it helps to restore autonomy and freedom (Frankford 1997).

It is important to recognise that the term 'wilful' refers to an individual who is able to reflect and act on the basis of those reflections. However, to operate wilfully an individual must be conscious (aware) of their social state. Therefore, in the traditional discourse of power, the application or use of (invisible) power would render the individual less able to be wilful.

Box 18.2 Handmaidens in healthcare

Imagine that the profession of medicine has a historical association with nursing, such that it is in the interests of medicine for nurses to carry out the orders of the doctors; that is, to support the practice of medicine (as I said, it is hypothetical).

Now, imagine that some nurses start to understand that the ways in which they care for individuals are limited by the subservient role they find themselves in towards medicine. Assume that this understanding develops, and as it develops it causes a great deal of suffering for those nurses who believe they could provide better care if they were not 'shackled' to medicine. These 'more aware' nurses are cognisant of their social state and believe that a crisis is looming, a crisis that could be resolved if only more nurses became aware of the need and potential for change.

However, these more enlightened nurses are unable to act because the majority of nurses remain ignorant of their 'handmaiden' state. Therefore, the suffering of the enlightened nurses is accentuated by the ignorance, or false consciousness, of some of their own group. Finally, assume that nursing represents the largest component of the healthcare workforce, and that if all nurses could have a different understanding of their social state, they would have the power to discard the shackles and alleviate their suffering by providing more effective (and autonomous) nursing care.

Critical social theory evolved as a way of examining, or thinking about, the oppressive effects of society (Giroux 1983). It is not one discrete concept, but rather a conglomeration of theories (Fay 1987). A critical theory would want to explain a social order in such a way that the theory becomes a catalyst for transformation or shifts in power. Box 18.2 is a hypothetical example.

In explaining this situation, critical social theory would focus on the crisis and explain it as a function of the false consciousness of some of the group members. If explained in the right way, such a critique could lead to a change in consciousness and the transformation of nurses as a group; that is, by raising the consciousness of the oppressed, the critical theory enables the social group to achieve enlightenment. Enlightenment can be viewed as the ability of the group to see themselves in a different way. However, enlightenment is not enough; to achieve liberation, the social group must take action by becoming empowered. So the aim of social action is emancipation.

Hence, the goal of critical social science is achieved through the instigation of a three-phase process: enlightenment, empowerment and emancipation (Fay 1987). According to Fay (1987), a fully formed critical theory would contain the following elements:

- **A theory of false consciousness**: This exemplifies how the self-understandings of a group (of people) are false. This is not to suggest that people are duped (although the earlier reference to power taking hold of subjects' minds implies this kind of process). Rather, false consciousness refers to a process whereby a group takes on the values and beliefs of a more dominant group, and thus becomes oppressed (this effect is commonly witnessed following imperial colonisation).
- **A theory of crisis**: This examines the level of dissatisfaction within a group and the ways in which the crisis produced threatens the cohesion of society.
- **A theory of education**: This provides an account of the conditions necessary to achieve enlightenment.
- **A theory of transformative action**: This identifies the aspects of a society that require alteration in order to resolve the social crisis and provides a plan of action.

Thus through enlightenment about their current position and their potential, the congruent leader can encourage the healthcare workforce to be empowered and to work towards reform.

Healthcare and Politics

Politics is defined as the 'process of human interaction within organisations' (Yoder-Wise 2015, p. 417) and can be seen working wherever people congregate (e.g. in families, in professional and interprofessional groups and in leisure activities). It is significant for clinical leaders to be aware of and consider, because politics is really about dealing with change (Missen 2009; Marquis & Huston 2012).

Healthcare and politics have always had a strange relationship, however. Commonly politics is seen to be beyond the scope of a professional's responsibilities, and nurses in particular have largely failed to exercise significant political clout (Antrobus, Macleod & Masterson 2009; Su, Jenkins & Liu 2011). As a result, the media, politicians, organised medicine and many healthcare executives or heads of departments of health have viewed nurses and nursing as powerless or irrelevant (Antrobus, Macleod & Masterson 2009; Su, Jenkins & Liu 2011; Yoder-Wise 2015). This is changing, however: we only have to look at the impact that nurses have had on the development of the recent US health reforms, with nurses and professional nursing organisations across the country mobilising to voice their needs and those of their patients to the Obama administration (Gardner 2009; Hahn 2009; Malloy 2009; Newland 2009; Tongue 2009). The same has been seen in the UK, where nurses and other professional groups spoke up to influence the outcome of the national election in mid-2010 (Dean 2010a, b; Staines 2010) and in the wake of the Francis Inquiry (Francis 2013). In Australia, health reforms are being influenced and orchestrated by powerful nursing lobby groups, such as nurse practitioners (NPs) and practice nurses, often with the support of professional organisations in an attempt to stimulate health reform and engage more actively in the politics of healthcare (Kearney 2010; Picton 2010; Thomas 2010). In reality medicine as a whole has long had a powerful political voice, often out of all proportion to the size of its professional groups, and with carefully practised and well-directed comments shows us the value of speaking up on 'political' issues.

Cohen et al. (1996) suggest that there are four stages to the political development of the profession of nursing, which also apply to other health professional disciplines. These are described as follows:

- **Buy-in** – where the importance of activism is realised
- **Self-interest** – where the significance of politics is realised and political acumen is developed
- **Political sophistication** – where self-interest is eclipsed and there is a recognition that wider (public) benefit can be achieved with activism
- **Leading the way** – where genuine leadership is forthcoming on a range of healthcare platforms

Recent political activity shows nurses worldwide engaging at the last level of political activism, although it is acknowledged that they have always been involved on some level (Rubotzky 2000). This also serves as a warning about the delicate nature of politics and power and reminds readers that everyone involved in the political landscape is seeking their own ends or serving their own agenda. Nothing gained will come easily and, once an objective has been gained, vigilance is needed to monitor policy development and political backsliding.

If nurses and other health professionals are to engage in the politics of healthcare, it is clinical leaders who may be best placed to bring clinical imperatives to the political debate (Gilson, Schneider & Orgill 2014). Antrobus (2003) feels that political leadership occurs at the macro level and that the clinical leader's main aim is to deliver improved patient outcomes at the micro (clinical) or meso (strategic/executive) levels. However, if health professionals are genuinely going to have an impact on policymaking at local or national levels, there needs to be a strong clinical voice speaking for practitioners and patients at the political table (Antrobus, Macleod & Masterson 2009; Missen 2009; Yoder-Wise 2015). Getting to the table requires clinical leaders to become politically astute, and to develop self-confidence and collaboration skills, as well as the capacity to work with a wide range of

other professionals and people in healthcare (Kramer & Schmalenberg 2003). Clinical leaders also need to learn that change takes time and that the path to change can sometimes be convoluted (Jasper & Jumaa 2005; Marquis & Huston 2012). Finally, clinical leaders need to remain humble, as staying at the table and engaging in politics require tact and focus.

Practical Politics

Dealing with the Media

I was at the 2007 Nurse Practitioner (NP) conference in Perth, Australia, where a keynote speaker, Linda Jones (an NP from Canada), spoke about the importance of NPs finding their voice and promoting themselves and their role. She suggested that the key to this was to use the media and media tools appropriately and effectively. I agree, and propose that this is in fact a message for all health professionals, nurses in particular. For if nurses and health professionals are to get the good news about their contribution to the health system out into the wider society, the nursing profession needs to deal with the media effectively. Man (2010) put this simply in explaining Genghis Khan's leadership secret number one: controlling the message. In many ways groups of nurses and key professional bodies have achieved this, but there is much that clinical leaders can do to harvest the bounty that media acumen can deliver.

This section presents practical tips and advice about dealing with the media and using media tools effectively and appropriately. It also offers advice about promoting the image of nursing and getting the nursing profession's message into the public domain.

Dealing with the media can be a minefield. My first piece of advice is, if you have had no specific training or if it is not an integral part of your role to liaise with the media, stick with a 'no comment' line. Most organisations have policies about dealing with the media and these should be consulted before any contact or comment is offered. However, if you are required to deal with the media, practical tips include:

- Always be honest.
- Be very cooperative (this does not mean offering information that was not sought, but it does mean not looking as if you have something to hide).
- Find key journalists and build a relationship with them, keep them up to date, and send them information and updates about key events or particular issues.
- Be available and be prepared with relevant information or considered views.
- Try not to tell half the story.
- Be a reliable source of information.
- If you are part of an organisation, have a spokesperson or a central point of contact so that if issues break quickly there is a ready source to contact.
- Be contactable, have a mobile number or email address.
- Keep on focus, do not confuse or dilute the message.

Part of dealing with the media is about building a relationship. This can be difficult to achieve, but try the following approaches:

- Find an angle, an area of specialist interest or a human interest approach.
- Remember that the relationship should be reciprocal (the media need us too).
- Recognise that it takes time to build a compatible relationship.
- The media like the 'big story', so if you have one, serve it up generously.
- Always be honest, fair, helpful, enthusiastic and reliable, offer information clearly, be patient and act with courtesy.

- If possible, send information to the media at least two weeks in advance of an event.
- If it is a feature event (such as a conference or special event), send information four to six weeks ahead.
- If contacting local media (radio or press), do so before noon as they get busy with deadlines after this.
- Contact weekly or monthly publications just after they have published.
- Think of the audience: is the story topical, sensational, quirky, high impact, emotive? It needs to be at least some of these to catch on.
- Big is best – as a guide, 'If it bleeds it leads'.
- Be informative and interesting.
- Think about what is different about what you are trying to say; if the media have had three 'child breaks leg' stories that week, another is less likely to be picked up.
- Photo opportunities are very useful and images do indeed paint a thousand words. Some images are unusable if the resolution is poor, so send only high-quality photos to accompany your stories.
- Most importantly, remember that nothing is ever 'off the record'.

It is worth noting that while the media are in the business of getting hold of news, it is possible through social media for every individual to 'be the media'. While this is effective, it is also fraught with dangers and risks. Most professional bodies have policies and guidelines for the use of social media, and for good reason. These guidelines should be considered and followed before the social media world of Twitter, Facebook and YouTube is used to 'spread the word'.

Becoming Politically Active

Becoming politically active does not mean handing out 'how to vote' leaflets on election day (although it could) or joining a political party (although that is an option). Here it simply means gathering yourself to stand up for what you value and believe, and joining in the discussion, debate or dialogue or taking action so that you gain a voice in your hospital, clinical environment, community, local area, city, state, country or even in the wider world. Becoming politically active does not mean becoming a 'radical' or 'extremist'. These approaches to politics often polarise debate and stifle collaboration, creativity and democratic discussion. Therefore, the following list offers information about how to become politically active in support of promoting the nurse's role and function without becoming a 'political radical'.

Becoming a politically active health professional can involve one of more of these strategies:

- Join a professional association (networking).
- Become involved in newsletter contributions (writing or distribution).
- Get involved in the committee structure and meetings of local or national professional associations.
- Recognise that if you are not looking to forward an opinion or view, someone else is. Someone is always listening – if it is not to you or your professional group, then they are hearing some other group's view.
- Write letters (not emails, as they are too easily deleted or ignored) to an individual member of parliament or local government official. Be clear and concise, and explain the changes that you want to see. Keep your letter short and avoid blaming or being critical. Be positive and productive, and provide your contact details so that they can reply; in fact, encourage a reply.
- Move issues from tactical to strategic by developing strategic objectives, identifying key stakeholders and constructing different messages for different stakeholders (Antrobus, Macleod & Masterson 2009).
- Identify what you can do (in your clinical area, in your community, locally or nationally), not just what you would like to do.
- Engage with broader professional issues and gain a voice as a professional in the wider health arena and in health-related topics.

- Contribute to articles, publish in other ways and use the internet to express your views (there are a wide range of websites that seek to promote the cause of nursing and other professional groups).
- Support and sign petitions that matter to you.
- Get informed: look on the internet, go to conferences, join in, become involved. You *can* make a difference.

Reflection Point

Do you see yourself as politically active? Why and in what way? Are you a member of a union or a professional body? Are you a member of a club or sporting organisation? Do these organisations have a political agenda? What impact do these activities have on your political views and on the way you express yourself politically at work? Is politics something you feel you just do not do? Speak with your work colleagues about what they think about the nexus (union) of politics and your workplace or your professional discipline.

It's How You Use It!

This exploration of the concepts of power, politics and leadership has introduced some ideas and posed some questions aimed at prompting your thoughts. One of the ideas is that all nurses and other health professionals use power and are subjected to power, and have the capacity to be political. What this suggests is the importance of being aware of the power dynamics operating in your practice area and in your own practice.

In the end, of course, the ways in which you use power, or support its use, will affect the care provided to individuals in your care. Therefore, it makes good sense to consider, and make rational choices about, the power relationships that you develop.

Case Study 18.1

Benazir Bhutto was a political leader with great managerial skill. Seen as a threat to many and a gift to others, she was driven by her values and demonstrated the attributes of a great leader. Read her story and consider the challenge that follows.

Female Leaders: Benazir Bhutto

Benazir Bhutto was born in 1953 in Karachi (now Islamabad). Her father was Zulfikar Ali Bhutto, who became president of Pakistan in 1971 and then prime minister in 1973. She completed her formative education in Pakistan before moving to the USA in 1969, where she attended Harvard University. She would later describe her time at Harvard as four of the happiest years of her life. Following this she moved to the UK and studied philosophy, politics, international law, diplomacy and economics at Oxford. In 1976 she was elected president of the Oxford Union, the first Asian woman to head this prestigious debating society.

She returned to Pakistan after completing her studies, but became embroiled in her father's political misfortunes. His prime ministership ended in a bloodless military coup in 1977 and he was accused of plotting a murder, sentenced to death by a martial law court and hanged in 1979. During this time Benazir was hounded with intermittent house arrest and forced relocation. In 1981 she was imprisoned in a desert cell in Sindhi province and endured shocking conditions that she outlined in her book *Daughter of Destiny*. She underwent horrific treatment and physical hardships before she was moved to hospital and then back into another jail, before returning to a further period of house arrest.

(Continued)

Case Study 18.1 (Continued)

Even under the harsh restrictions of the military junta, Benazir made progress with her political ambitions. She forged a union with the other opposition party and created the Movement for the Restoration of Democracy (MRD). However, after six years of house arrest and imprisonment, the junta allowed her to travel to the UK for 'medical reasons'. Following some surgery, she began to further expose the political injustice in Pakistan and to speak out about the human rights abuse against political prisoners. After the junta leader's death and increasing international pressure, Benazir returned to Pakistan to support and take part in open elections in 1988. Her party won the majority of seats in the National Assembly and she was sworn in as prime minister of a coalition government. At the age of 35, she was the youngest person and first woman to lead a government in a Muslim-majority country. Her leadership prompted a rapid modernisation of Pakistan that some sections of the country saw as 'westernisation', advancing a secular and liberal agenda.

During her term in office Benazir was a strong advocate for women's rights and she introduced legislation that addressed discrimination against women, social reforms and health issues. She was also pro-life, although often her election promises failed to be turned into reality.

In 1990, Benazir and her husband were accused of corruption and her government was dismissed. It is likely that the charges were politically motivated and they have never been substantiated. Then in opposition, she fought the charges and in 1993 won a second term as prime minister. Her reform agenda was reinstituted and again conservative elements of Pakistan's society worried about the liberalisation of the country. During this time Benazir was a supporter of the Taliban, thinking that they would bring stability to Afghanistan, and she also oversaw the development of missile technology and the build-up of Pakistan's nuclear capacity.

In 1996, corruption charges were again filed against Benazir and her family, and in early 2000 she fled Pakistan to live in exile again, this time in the United Arab Emirates. Here she cared for her three children and her mother, who had Alzheimer's disease. Her husband had been imprisoned for corruption and was not released until 2004.

After eight years of exile, agitation and political manoeuvring, Benazir made plans to return to Pakistan. Her aim was to support and potentially contest elections that were planned for 2008. She returned in 2007, but a month later a suicide bomber attempted her murder. He failed, although he killed 136 supporters gathered at a political rally. This prompted the ruling government to issue a 'state of emergency' and Benazir was again placed under house arrest, making political campaigning almost impossible.

The next day the arrest warrant was retracted and she set out her party's manifesto, claiming that it would focus on the 5 Es (employment, education, energy, environment and equality). In December a second attempt was made on her life when her car was fired on and a bomb was set off near the vehicle. She was critically injured and rushed to hospital, where she was pronounced dead a few hours later. Riots in Pakistan and international condemnation followed, and her husband and son, Bilawal, vowed to carry on her political work.

Benazir Bhutto was a skilled politician who managed the responsibilities of wife, mother and her country's needs. She suffered greatly at the loss of her father and her subsequent periods of imprisonment, yet refused to abandon her political and social responsibilities and forged a political career in the hotbed of Pakistan. The cost was high, and she must have known that her assassination was a very real danger when she returned to the country in 2007. At her funeral hundreds of thousands of mourners testified that she was arguably the most popular democratic leader in her nation's short history.

Challenge: Benazir Bhutto managed many responsibilities and competing demands. Given what has been covered earlier in the book, would you say she was more of a leader or a manager? Why? Would a manager driven by a wish to avoid conflict have placed themselves (literally as Benazir did) in the 'firing line'? What do you think is the reason(s) that drives leaders to do this? How important is courage as a leadership attribute? Is it also a requirement of a manager? If so, why? Have you ever met or been inspired by a courageous manager or leader? What did they do and why do you think they took this risk?

Summary

- Politics and power are central issues in health service delivery and health professionals should develop an awareness, interest and commitment to being politically engaged.
- Our social context influences our experience of power.
- Power is about the perceived ability to exercise influence over others.
- There are a number of different types of power: reward, punishment or coercive, legitimate, expert, charismatic, resource and informational power.
- Influence and power are related. There are different types of influence: assertive, reward and punishment, participation and trust, and common vision.
- Power, even professional power, is exercised within the context of the social 'theatre' in which the actors (subjects) operate. Critical social theory is used to explore catalysts for transformation or power shifts.
- Health professionals, and nurses in particular, are beginning to engage more effectively in the political side of healthcare. Clinical leaders may be best placed to bring clinical imperatives to the political debate.
- Dealing with the media can be difficult and great care and appropriate preparation are required.
- Becoming politically engaged is advisable in the modern healthcare environment and there are a number of options for doing this. It is about finding your 'professional voice' and taking a stand for your values and beliefs.

Mind Press-ups

Exercise 18.1

Consider two types of leadership: transformational leadership and congruent leadership. What sources of power would you identify as being associated with the the theories behind them, and why?

Exercise 18.2

What positive outcomes might be achieved for your future colleagues if, in the course of your work, you use your power and authority constructively?

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19

Empowerment and Oppression

David Stanley

Come to the edge.
We might fall.
Come to the edge.
It's too high!
Come to the edge.
And they came,
and he pushed,
and they flew.

'Come to the edge' by Christopher Logue, copyright © Christopher Logue, 1969

Introduction: The Voice Within

This chapter considers the issues of empowerment and oppression. They may seem odd topics for this book, but I believe that they are central to an understanding of clinical leadership and to gaining an insight into why and how nurses and other health professionals act in terms of their leadership potential.

If clinical leaders are a new breed of leader who 'can establish direction and purpose, inspire, motivate and empower teams around common goals and produce real improvements in clinical practice, quality and services' (DoH 1999, p. 52), then empowerment becomes a core element of the clinical leadership agenda and characteristics. In Australia, McMurray (2010, p. 117) reminds us that 'professions would be better empowered by the development of a more critical ideology, refinement of the way we articulate our position, and a commitment to culturally appropriate socially just actions'. Byers (2015) adds that empowering nurses (and other health professionals) who plan on leading quality improvement initiatives could be the key to unlocking healthcare improvements.

While the situation is changing, and is not as evident as in some professional disciplines, many authors feel that nurses display the characteristics of an oppressed group, showing signs that they lack self-esteem, autonomy, accountability or power (Friedson 1970; Greenleaf 1978; LeRoux 1978; Roberts 1983, 2000; Stein, Watts & Howell 1990; Fulton 1997; Freshwater 2000). Indeed, Freshwater (2000, p. 481) indicates that the 'cultural narration of nursing is for nurses to be subordinate'. Nurses

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may even display a lack of self-esteem and passive aggression that extends into behaviours as extreme as 'horizontal violence' (Meissner 1986, 1999a, b; Skillings 1992; Duffy 1995; McCall 1996; Randle 2011; Vessey, DeMarco & DiFazio 2011; McNamara 2012; Szutenback 2013; Riskin et al. 2015; Wing, Regan & Spence Laschinger 2015) (See Box 19.1, 19.2 and 19.3).

For a 'caring profession', nurses can be quite hostile towards each other at times, and many of the nurses interviewed for the clinical leadership research that underpins this book had horror stories about their managers or colleagues. The other professional disciplines involved in the additional research had their own stories of being oppressed. They described behaviour ranging from incivility to bullying. I have had my own negative experiences in a range of employment environments, as I am sure many readers have, and sadly figures from a Western Australian study exploring the employment directions of nursing and midwifery students after leaving university between 2005 and 2007 showed that 41% indicated that 'bullying of nurses by co-workers was (and remained) prevalent' (Nowak & Thomas 2009). A UK study suggested that 24% of nurses reported bullying as the most common reason for their work-related psychological problems (Lipley 2000).

I wonder, though, if clinical leaders could be the empowered few who have broken the oppressive bonds associated with a traditional view of nursing or healthcare? Perhaps they offer a view that nurses – or other health professionals – can look towards to lead their professional group to a more empowered position within the health service. By seeking the clinical nurse leader's 'voice within' and by exploring the experience of clinical leaders, an understanding can be gained of their place in relation to oppression, empowerment, disempowerment and leadership. Then genuine opportunities for change, improvements in patient care and clinical developments may be achieved.

This chapter defines empowerment and considers how it may be conceptualised to support its development in clinically focused health professionals. It also explores the issues of disempowerment and oppression in relation to health professionals and considers how caring professionals can establish empowering behaviours to counteract these.

Defining Empowerment: It's All about You

Grossman and Valiga (2012, p. 195) define empowerment as 'a process in which individuals feel strengthened, in control, and in possession of some degree of power'. Empowerment therefore can be seen as something that an individual may choose to deploy for themselves. Simmonds (1998) indicates that empowerment is associated with helping people develop a critical awareness of their situation and enabling or facilitating them to master their environment to achieve self-determination. Rogers (1979) also sees empowerment as developing from personal growth and the exercise of personal power. Yet in a health service steeped in traditional and hierarchical structures, power – both personal and organisational – appears to be held in place by position and authority. Studying clinical leadership offers an opportunity to explore the experience of health professionals who had – in spite of oppression by colleagues, managers and medical staff, gender bias, disempowerment, institutional structures and horizontal violence or incivility – found an opportunity to write their own script, liberate their practice and forge ahead.

Clinically focused health professionals and clinical leaders, it may be speculated, represent the empowered few who are able to motivate and inspire others and excel in clinical care. However, when defining empowerment, two significantly different perspectives can be presented: as a tool or as the result of personal choice. The decision to apply one or the other will reflect both the clinical leader's perspective on empowerment and their ability genuinely to lead change.

The First Perspective: Empowerment as a Tool

Box 19.1 A little horror story, Part 1
Once upon a time… a male student nurse, on his second placement, was taken aside by his assessor (the student's preceptor/mentor and a senior RN on the surgical ward) into the sluice room. This was the first day of this placement and needless to say, the student nurse was very nervous. This RN took it upon herself to welcome him to the ward. Her 'welcome', however, consisted of telling him that she did not like male nurses, that in her view they were lazy and had no place in nursing. The student nurse was not welcome and she would make sure that he had a difficult placement and would fail. Then she just left him to it. No handover, no guidance, no orientation… no hope. After this the student was always given the 'heavy' bays and the more 'difficult' patients, and the RN was consistently and persistently rude, snappy and curt. The student's colleagues and fellow students said she was 'just like that' and in fact she seemed to pick on everyone, but he found her negative attention particularly difficult and struggled to cope. (*To be continued*)

Yoder-Wise (2015, p. 420) defines empowerment as a tool, declaring that it is 'the process by which we facilitate the participation of others in decision-making and taking action within an environment where there is an equitable distribution of power'. Other authors take a similar line, with Kreitner and Kinicki (1998) indicating that empowerment is the decentralisation of power, while French and Raven (1959) consider that expert power is the ability to exert influence through the possession of knowledge or skills that are useful to others. Simmonds (1998) describes empowerment as helping people develop a critical awareness of their situation, enabling them to master their environment to achieve self-determination. Fullam et al. (1998) elaborated on what they called the 'triad of empowerment', in which leadership, the environment and professional traits are described as three parts of the process of empowerment that nursing organisations must master in order to empower their staff to deliver patient-focused care.

Esterhuizen and Kooyman (2001) and Jones et al. (2000) suggest that empowerment can be developed in others by external agents, almost as if empowerment can be bestowed on them. This view is supported by comments made by well-meaning senior health professionals and managers as they describe how they have 'empowered their staff', and ward managers who have hinted that through staff compliance with an appraisal process, they could 'make staff become more empowered'. To some extent these views have grown from Kanter's (1977) theory of structural empowerment, where empowering workplace structures are described as those that support employees to accomplish their work in meaningful ways. Kanter (1977) sees employees as human capital needed to achieve organisational goals, with structural empowerment offered as an approach that influences employees' attitudes and behaviours to either increase or decrease organisational effectiveness.

If clinical leaders are encouraged to 'empower teams' (DoH 1999, p. 52), this may reinforce the belief that empowerment grows from the actions of senior colleagues, and encourage health professionals to turn to others (external agents) to become empowered. Or it may support the clinical leader or manager's view that empowerment is something they can 'do' to others. The proliferation of programmes that aim to promote 'resilience' are another feature of the belief that empowerment can be granted. Resilience training and the development of greater resilience are important; Williams et al. (2016) found that nurses who displayed greater resilience were also seen to be more focused on

quality care. However, if empowerment and resilience are viewed as tools, as something that can be given, taught, imposed or transferred, consideration needs to be given to the depth of empowerment that will result – because from this perspective, how empowered are nurses or other health professionals ever really going to become? If empowerment can be 'given' by someone in a position of power or authority, it can also be 'taken' by someone in a position of authority.

The Second Perspective: Empower Walking

Another perspective is hinted at by Grossman and Valiga (2012, p. 195) when they define empowerment as 'a process in which individuals feel strengthened, in control, and in possession of some degree of power'. This second perspective is that empowerment is something that an individual may choose to deploy for themselves. To support this view on empowerment, Rogers (1979) suggests that personal growth leads to personal power, and so to empowerment. This perspective views empowerment as an action that an individual can take, rather than a tool used to impose empowerment on others. The second perspective can only be sustained if the first is rejected.

The book *Long Walk to Freedom* (Mandela 1994) about the life of Nelson Mandela can be used as an example of how empowerment is about personal growth, personal action and personal choice. Mandela's autobiography is a stark example of the life of a person who faced considerable personal obstacles and yet rose above the difficulties of living under an oppressive regime and imprisonment to lead his country. Even the title – where the word 'walk' is used in preference to 'road' or 'journey' – implies that the act of empowerment is about an individual's activity, choice and actions, and it is not a passive, not a 'given'.

The novel *The Power of One* by Bryce Courtenay (1989) is about a young English boy growing up in southern Africa, and also deals with the theme of empowerment. Peekay is not a big person, but he grows up to become a boxer. Early in his life he is taught the maxim that 'little beat big when little smart, first with the head then with the heart'. Peekay faced considerable difficulties as he grew up, isolated and an outsider. This fictional story and Mandela's real-life biography both imply that empowerment is something that comes from within, something that emerges from the individual and something that relies on the individual's choice. In both these examples empowerment was not dependent on a suitable environment, the person's authority, the beneficence of a senior colleague or favourable conditions.

The second perspective sees empowerment not as something that can be 'done' to others, but as something that remains in the domain of the individual, and is reliant on the individual's ability to choose. If clinical leaders demonstrate this approach, they will recognise that empowerment cannot be bestowed, given or imposed by them, or indeed be bestowed, given or imposed on them by others. The origin of the power to choose or to act is within the individual, and can only be achieved by conscious choice or direct action by the individual concerned. Empowerment is therefore about finding the courage to choose and act from within. In a sense, it is about finding the leader within us all. As such, the power to choose or act rests squarely with the individual practitioner, client or person, aligning itself with the concept of accountability.

Falk Rafael (1996) states that when empowerment is reconceptualised in this way, nurses (health professionals) have access to a power within themselves, and they are then able to set the conditions for empowerment in others. If nurses and other health professionals are able to tap into the centre of their being in this way, then the developmental process of empowerment can begin (Johns 1999). When clinical leaders are able to explore this perspective of empowerment, they may understand that empowerment can only be developed from within and it is there that they should look. Prestwood and Schumann (1997) support this position, declaring that knowing who you are is the beginning of the journey to becoming a leader.

Bower (2000, p. 2) calls this 'knowing self' and also advocates self-inspection and self-knowledge as a way to developing leadership skills and personal empowerment (linked here to reflection and emotional intelligence). Nevertheless, the process of self-discovery, vital to empowerment, is not an easy one, as Rinpoche (1992, p. 31) states in this Buddhist extract:

> Yet how hard it can be to turn our attention within! How easily we allow our old habits and set patterns to dominate us! Even though they bring us suffering, we accept them with almost fatalistic resignation, for we are so used to giving in to them. We may idealise freedom, but when it comes to our habits, we are completely enslaved.

Viewed from the first perspective, empowerment comes from someone with the power or authority to give it, implying that such empowerment will be limited and transitory. When viewed from the second perspective, empowerment becomes a liberating and personally uplifting prospect.

Unfortunately, much of the health service and management literature focuses on empowerment established from the first perspective. In a health service steeped in traditional, hierarchical structures, power – both personal and organisational – is held in place by position and authority. Clinical leaders (who may come from any level within the organisational structure) need to focus on empowerment from within and work on addressing the barriers that inhibit both themselves and others in their search for empowerment. Clinical leaders who employ congruent leadership (Stanley 2006a, b, 2008, 2011, 2014) engender a collaborative work approach that sees others following their lead as they live out their values and beliefs. These clinical leaders can demonstrate their professional traits or act out their core professional values in practice. Many have been able to engage in a choice to be empowered and are in a position to foster greater confidence among their colleagues and clients. These health professionals also benefit from improvements in healthcare environments, so they are more effectively supported in their progress and learning, and are encouraged to promote greater staff participation and client choice. In this way barriers to empowerment are reduced, so that individual and professional empowerment can be achieved, although such barrier-busting interventions are not in themselves empowering.

Ultimately, the choice to engage with a supportive work environment or genuinely to participate in continuous professional development or any other liberating, stimulating or role-enhancing activity rests with the individual. Recognising that the individual has the power to choose, to engage with the organisation or with the client, is equally important as accepting that seeing empowerment as a tool will provide a diminished return. Teaching, encouraging, facilitating and directing are doing exactly what those words suggest – in a sense showing a path to empowerment, but not actually empowering, because even if the barriers are down and even if the environment is the best it can be, it is still up to the individual to take that first step forward. If they do not choose self-empowerment, they will not cross the threshold.

> Empowerment isn't the path, it's the walk and the choice about which path to take.
>
> Taking that risk, taking a chance, going out on a limb or to the edge requires empowerment from within, and will happen independently of the state of the environment, professional position and leadership approach. If perfect conditions were the prerequisite for empowerment, nothing would ever get done.

Because power comes from within, you can facilitate it in others, but you cannot make it happen. Nelson Mandela was empowered and his will to act was a choice. He was not empowered by others: his countrymen, the government, his fellow prisoners or activists. His empowerment was not bestowed by others and the obstacles and barriers he had to overcome and resist were immense. Yet accepting that empowerment comes from within is in itself liberating, because it allows individuals to

focus on their own empowerment and to recognise the part they can play in taking down barriers for others. This is supported by Regan, Laschinger and Wong (2016), who identified that linking values-focused leadership and empowerment led to the possibility of improving interprofessional collaboration, as health professionals developed more confidence and greater trust between themselves.

The development of empowerment is pivotal to the success of the clinical leader and to the effective accomplishment of their responsibilities. In addition, it is vital to influence positive job satisfaction, staff retention and maybe even positive organisational and patient outcomes (Cicolini, Comparcini & Simonetti 2014). However, if real gains are going to be made by clinical leaders, it is their own empowerment that should be the focus of their efforts. They should tap into the centre of their being, reflect on their practice and ask themselves what their habits are. They should also talk to, engage with, challenge and react to their colleagues, clients and managers. They should read about other ways of working or doing work, and engage with, initiate and become open to research, reflection, best practice and evidence-based practice. They should open other doors and think about old things in new ways. They should explore their values and beliefs, look at their motives and explore the forces that drive them. Empowerment will not come to them and it will not be given to them, but from these steps they should be able to empower themselves and thus facilitate the journey of others.

Reflection Point

Che Guevara said, 'The revolution is made by man, but man must forge his revolutionary spirit day to day. Keeping the revolutionary spirit alive takes commitment and passion, belief and faith' (Knowles 2001, p. 354). What helps empower you? What are you committed to or passionate about? What do you believe in and what sustains your faith to keep going, day after day?

Box 19.2 A little horror story, Part 2

The student was struggling. The clinical work and adjusting to the pace and drama of surgical nursing were difficult enough, but the senior RN's sniping and criticism, ridicule and miscommunication were really affecting his confidence and ability to function. The student took a few 'sickies' to avoid having to work with her and even made an appointment with an educator to discuss the problem discreetly. The educator knew about the RN's behaviour, but declared that she was 'just like that' and other students had raised this problem in the past. What could she do? It was not an educational issue and the student was advised to discuss the matter with the hospital manager, the RN's boss, or to deal with it himself. The educator suggested that the student work harder and give the RN no reason to criticise or ridicule him.

The student did not want to go to the hospital manager, who by all accounts was a friend of the RN. So he reasoned he was just going to have to cope by rising above the matter. If the RN thought that male nurses were lazy, he would show her that they were not; in fact, she would see that this male nurse worked very hard. So the student began turning up a few minutes before work and leaving a few minutes later. He started helping other nurses with their patients and tried always to be one step ahead. If the RN came and said 'Have you taken out a wound drain?' or 'Have you done that set of obs?', he was more and more able to say 'Yes, done that', so giving her fewer faults to find and making her re-evaluate her stance. Other staff were also getting behind him and being supportive and were grateful for the help and effort he was making. Their support started to make the RN's ridicule and criticism seem petty or unfair and in time the sniping, nasty comments and ridicule began to subside. (*To be continued*)

Oppression: Bridging the Power Divide

It is my contention that clinical leaders are needed to act as catalysts to lead change, empowering themselves and others, motivating, inspiring and leading nursing and the health service forward. The research that supports this book indicates as much.

However, there is a raft of literature that claims that health professionals need to change because they may be disempowered and need inspiring, motivating and leading. This view is not new. Roberts (1983, 2000) – who is supported by Cleland (1971), Torres (1981), Clifford (1992), Oughtibridge (1998), Freshwater (2000), Watson and Shields (2009) and others – indicates that experts on nursing leadership have argued that the lack of nursing leaders is due to a lack of people with initiative, self-esteem and assertiveness in the nursing profession. They add that the style of leadership within nursing has evolved because nurses, like other groups throughout history, are oppressed.

Walsh and Ford (1994) also note that nurses have traditionally been oppressed because they are predominantly women in a patriarchal society and function in a profession dominated by the powerful (male-dominated) medical profession. It may be that this perspective can be applied to other health professional groups. Oughtibridge (1998) maintains that nurses are usually perceived as obedient, unselfish, caring and submissive, and that these factors support their subservience to the all-powerful, all-knowing medical profession. Nurses also describe themselves as being oppressed by managers, and McCall (1996) found that nurses felt devalued or that they continued to be viewed as 'handmaidens' as a result of medical and managerial domination. The oppressive state appears not to be waning, with Watson and Shields (2009, p. 51) noting that, in response to changes in the UK health service, nurses have become 'so disempowered that they do not object' to the negative changes affecting them and the patients for whom they care.

Nurses also display some of the characteristics of other oppressed groups, with Roberts (2000) reporting that nurses display a lack of self-esteem and show passive aggression that extends into behaviours such as the 'horizontal violence' already mentioned (Skillings 1992; Duffy 1995; McCall 1996; Randle 2011; Vessey, DeMarco & DiFazio 2011; McNamara 2012; Szutenback 2013; Riskin et al. 2015; Wing, Regan & Spence Laschinger 2015). Freshwater (2000) sees such behaviour as the unexpressed or repressed expression of conflict within an oppressed group. Indeed, conflict within the oppressed group that is directed towards other members of the oppressed group is a further characteristic of oppression. Powerless groups, who are unable to act against their oppressors or feel unable to change their circumstances, frequently vent their frustrations on the least powerful within their own group. Horizontal violence appears to be an expression of this characteristic.

Characteristics of oppressed groups can be summed up as follows:

- They look and act differently from the dominant group (who set the norms) and their actions and looks are valued negatively. The looks and actions of the dominant group are associated with power and control; oppressors have a non-uniform dress and they make the rules.
- Assimilation – they try to look like the oppressor, which can lead to marginalisation and to further self-hatred and low self-esteem.
- Dissociation from their own culture if it is perceived to be subordinate.

- Passive aggression in the face of being powerless against the oppressor. This can lead to self-destructive behaviour and aggression as oppressed people turn on their own group.
- Horizontal violence – the oppressed cannot attack the oppressor so they turn on themselves or their own kind.
- They are often viewed as inherently violent or uncooperative, rather than this being seen as a result of oppression.
- Submission to authority.
- Fear of authority.
- Fear of change, even though change in the oppressive circumstances is required.
- Lack of faith in their own ability to take responsibility.
- Lack of confidence in their ability to change the status quo, even if it were possible.

When studying oppression within Brazilian society, Freire (1971) found that oppressed groups learnt to hate themselves or their attributes (e.g. skin colour, language, clothing) because the dominant group set the norms for what was valued. Therefore, members of the oppressed group who attempted to succeed and escape their oppression could only do so by attempting to act and look as much as possible like the members of the dominant group; in effect denying their own characteristics. This led to what Lewin (1948) called marginalisation and resulted when members of the oppressed group tried to escape, but remained non-authentic members of the dominant group. This sort of behaviour often resulted in self-hatred, disapproval (from within their own group), frustration and conflict. Freire (1971) concluded that members of the oppressed group were then unable to unite against the dominant group and instead developed a passive-aggressive approach to dealing with the oppressor. Freire (1971) also proposed that the maintenance of oppression was supported by the educational system and by rewarding those in the oppressed group who supported the dominant views and values. Jobs, financial support and privileges were awarded to such people in the oppressed group, who worked to maintain the position of the dominant group and to subdue any potential revolt that might begin. As such, the subordinate group failed to establish any power base because its leadership was marginalised and fostered, rather than diminished, conflict and frustration. As Freire (1971, p. 29) commented, ‘it is the rare peasant who, if promoted to landowner, does not become the tyrant of the peasant’.

Within nursing and other health professional groups, leaders are commonly rewarded for maintaining the status quo (Cleland 1971; Torres 1981; Roberts 1983, 2000), even if it means the continued domination of the rest of the group. Roberts (2000) suggests that leaders within nursing have been viewed as an elite and marginal group who often view themselves as better than the other members of the oppressed group.

The leaders of oppressed groups can be described as having the following characteristics:

- Being controlling (not seen as a characteristic of a clinical leader)
- Coerciveness
- Rigidity
- Hatred of their own kind and desire to be like the oppressor
- Dependence
- Low self-esteem
- A tendency to be better educated, have higher incomes and possess values similar to the dominant group
- Are viewed by ‘their own kind’ with scepticism
- Hold the virtues and values of the dominant group and are often rewarded for maintaining the status quo

Liberated Leaders or Co-oppressors?

It is prudent to ask whether nurses and other health professionals are in fact marginalised in the health service. Roberts (2000) and Watson and Shields (2009) suggest that they are, since most nurses are women, as are the majority of other health professional disciplines, and women are still often considered an oppressed group, even in western society. It is also true to say that many nurses are from marginalised groups within western society (indigenous/racially marginalised groups), and many more are from countries where women are still treated with less respect than men. The UK has only recently introduced standard degree-level qualifications for registered nurse education, and while more nurses are seeking and securing degrees and higher educational qualifications (as they should), the entry standard and educational level of nurses are still generally lower than those of medical and some allied health professionals. It could also be suggested that traditional medical values remain dominant within the health service, and that while today few nurses are viewed as 'handmaidens', the nursing characteristics of warmth, care, empathy, self-sacrifice and sensitivity are commonly viewed negatively within the target-driven, outcome-focused, financially constrained health service.

It is also worth asking whether nursing (and any other clinically focused professional discipline) has a positive public voice, or if the public perception of health professionals remains positive. Is the general public's view of nurses still influenced by images of them as portrayed in the *Carry On* films, or more recent movies, media and television dramas such as *All Saints* (1998–2009), *Nurse Betty* (2000), *No Angels* (2004–06), *Nurse Jackie* (2009–15) and *Heartbeat* (2016)? Moreover, have recent and frequent negative press reports had an impact by diminishing the way in which nurses are perceived by the public?

There are perhaps two ways for health professionals to move forward. The first rests on viewing empowerment as an act from within, as a conscious choice made by free will, in spite of oppression, disempowerment, institutional structures, gender bias and horizontal violence. This approach offers all health professionals an opportunity to write their own script, find their own voice and forge ahead. Secondly, clinical leaders represent the empowered few who have overcome the odds in spite of the structures that surround them. They can therefore be the few to whom other professionals look to lead their professional discipline out of the oppressive, semi-professional mire in which some professional disciplines appear to be stuck.

However, it is vital to identify who the clinical leaders are, because if they are identified as the health professionals that foster (even unwittingly) the pattern of other nursing leaders, with the same characteristics as leaders of oppressed groups, then no progress is likely. If clinical leaders have broken free of oppression by accepting financial incentives, improved job status (e.g. nurse consultants, nurse practitioners or physician's assistants) and special privileges (prescribing rights/diagnostic privileges), simply to maintain the status quo or foster their own status and financial security, have they in fact merely become deluded, co-oppressors and highly paid frustrated conspirators? Have they instead moved into the marshland between their professional group and the oppressive, powerful manager and medical group, where they are now marginalised fringe-dwellers, no longer part of one group and still not accepted as part of the other? Media and nursing publications related to the development of the nurse consultant role in the UK in the early 1990s highlighted this danger when nurses voiced their concern over highly paid 'supernurses' who seemed to be developing roles beyond the scope and cultural norms of 'common' nurses (Caines 1998; Doyal 1998; Radcliffe 1998; Stephenson et al. 1998; Mulholland 2001).

Recalling that empowerment needs to be developed from within, simply inventing new titles or establishing new leadership positions will not foster empowerment. In fact, the introduction of consultant practitioners or NPs with potentially different values and agendas from the vast majority of

nurses or professionals within the same discipline may have a negative impact on the dynamics of the oppressed group.

While interviewing nurses for the research on clinical leadership that underpins this book, one nurse said of her newly appointed ward manager that she appeared to be 'just another stick to beat us with'. If nurse consultants and nurse practitioners are being directed towards being the new breed of clinical leader (DoH 1999), it is interesting to note how they will deal with groups they may be marginalised by, yet have a clear mandate to lead, motivate and inspire.

Personally, I am more optimistic. It is my view that the vast majority of nurse consultants and nurse practitioners are the clinical leaders we need. These clinical leaders are in a position to demonstrate that they have eclipsed their oppressed state and to offer a guiding light for all health professionals to follow. It is my opinion that nurses at any level can choose to become clinical leaders and transcend the traditional, usually negative, oppressive state in which nursing has found itself.

Box 19.3 A little horror story, Part 3

It would be delightful if I could support the theoretical perspectives offered in this chapter with a clear example of the power of the individual to rise above the oppressor and become truly empowered. However, this is a true story and while this student nurse had achieved that to some extent, he was still dependent on the RN's assessment of competence to 'pass' the placement.

Things had improved. The student had started to write his own script. He was less threatened and able actually to enjoy elements of his time on the ward. Mostly, though, this was when the senior RN was not there. When she was, she continued to pick on the student whenever she could (often when there was no one about) and although the student was doing well and knew that the RN would really have to be creative if she wanted to find a reason to fail him, he was still worried that she would try to do just that.

Then serendipity played a hand. As the student walked into the sluice room one day, quite near the end of his placement, he found the senior RN vomiting into the open sluice. She was pregnant and had a serious bout of morning sickness. He offered to help, showed real and fitting sympathy, but she was so embarrassed that all she cared about was that he left her alone and did not tell anyone what had happened. He kept it secret for many years until he told me the story. After this incident, the now embarrassed RN never picked on the student again. She was not nice or polite, but she left him alone and he passed the placement with flying colours.

Reflection Point

Reflect on this little horror story. Edmund Burke said, 'He that wrestles with us strengthens our nerves and sharpens our skill. Our antagonist is our helper' (Knowles 2001, p. 164). Have you ever had an antagonist that made you stronger? What made you strong and why?

How can Oppressed Groups Liberate Themselves?

While clinical leaders may be held up as examples of the liberated few, it is also important that the majority of health professionals recognise approaches they can take to foster empowerment and escape from oppression. Roberts (1983, 2000) suggests the following stages or steps that can lead to liberation:

- Expose
- Encounter
- Immersion–emersion
- Internalisation
- Commitment

or

- Passive acceptance
- Revelation
- Embeddedness–emancipation
- Synthesis
- Active commitment

In order to stop, suppress or limit oppression, health professionals and nurses can act to give themselves more opportunity to find their 'voice within' and take steps towards becoming empowered. Remember, though, that no one will do it for you. Empowerment only comes from within, yet this is both a strength and a weakness in escaping oppression. For empowerment to succeed it needs to be an individual choice. Escaping oppression as a group requires the stages suggested by Roberts (1983, 2000) to be deployed by the group members together, and it is here that nursing has traditionally come unstuck. However, here are a few activities and behaviours that can limit oppression and enhance empowerment:

- Expose the world of oppression as it relates to you. Talk about your oppression. If it is not recognised, described or acknowledged, then it cannot be changed, challenged or addressed. Recognise your circumstances. Are you oppressed? Are you able to make choices and influence your personal, professional, social or family life?
- Expose and destroy the myths associated with oppression. Oppressors would like you to think that being 'put down' and subservient is your natural state. It is not!
- Reject the negative images of your culture and replace them with pride and a sense of your ability to function autonomously. You will notice a number of famous women referred to throughout this book and a number of historical issues are discussed. As well as offering excellent examples of women with courage and drive, these are also an example of the use of the past to support and guide our journey into the future, so that we can avoid the mistakes and learn from the lessons of others.
- Autonomy must be acquired. Freedom is acquired by conquest, not by gift.
- Define yourself. Only you can do this. Reclaim your history and culture and create a sense of togetherness. In the 1960s the rallying cry for black Americans was 'Black is beautiful', and this worked as a focus for the civil rights movement in the USA. What might your rallying cry be?
- Empowered leaders must come from within the group, not from the elite or from another group. This is a 'grassroots' approach. In this regard, recognising and celebrating your own view of clinical leadership is vital.
- Get organised – in your personal, financial, social and work life.
- Know what you want to achieve and what you believe. Set out your aims and objectives and be clear about your values.
- Know what you like – in music, literature, the arts, friends, hobbies, food, drinks – and avoid what you do not like.
- Exercise your right to say 'no' if what you are being asked is not in your best interests, within your job responsibilities or will not enrich your own life or others' lives.

- Celebrate your accomplishments and the attainment of your dreams.
- Recognize and understand that nurses (and/or other health professional groups) are not inherently inferior.
- Develop leaders and leadership from the grassroots and avoid the elite leadership approaches of the past. They have not served nursing or the health professions well.
- Foster personal and professional pride in your work and your achievements.
- Examine your 'voice within'. Develop a positive voice and eliminate the negative 'put down' voice.
- Rediscover the great cultural heritage of your professional discipline. What is nursing about, what is the history of physiotherapy, what is it that occupational therapists believe about their professional role and history? Share this in writing and with your colleagues.
- Take and make your own way.

Reflection Point

Considering the information given here on oppression, in your view are nurses or other health professionals oppressed? Discuss this question with your colleagues. What are their views? Could it be that there are pecking orders within health? If so, how do you see them being structured?

Case Study 19.1

Germaine Greer is a female activist, academic and author who has never lost sight of her power to act and speak on controversial issues. Read her story and consider the challenge that follows.

Female Leaders: Germaine Greer

Germaine was born in 1939, in Melbourne, Australia. She attended a private convent school, Star of the Sea College, before continuing her education at Melbourne and then Sydney universities. She taught at the University of Sydney and was active with the 'Push' (a libertarian group) before gaining a scholarship to attend Cambridge. In 1964 she left Australia for the UK, where she studied at the all-women's Newnham College. She gained her PhD in 1968. She joined the Cambridge Footlights, which acted as a link with London's arts and media scene, and she started to write for publications such as *Private Eye* and *Oz* and was the editor of the Amsterdam underground magazine *Suck*.

In 1968 Germaine took a post as a lecturer at the University of Warwick. The same year she married an Australian journalist, Paul de Feu, but the marriage only lasted three weeks, during which she later admitted she was unfaithful several times. The marriage ended in divorce in 1973. In 1970 Germaine had success with the publication of *The Female Eunuch*, a book on the subject of female sexuality and the subjugation of women. It claimed that women were indoctrinated into western society, with girls feminised from childhood, and women forced to embrace stereotypical roles and develop a sense of shame about their bodies, lose their political autonomy and end up powerless, isolated, with diminished sexuality and lives lacking in joy.

The book won critical and popular acclaim and in 1972 Germaine resigned from Warwick to travel the world speaking about and promoting the book. She also presented the comedy show *Nice Time* with Kenny Everett and Jonathan Routh. She was arrested in New Zealand for using obscene language in a speech and was controversially fined.

In 1989 she moved back to the UK and took a post as a special lecturer and fellow at Newnham College, Cambridge. However, she resigned in 1996 after a conflict about her opposition to the appointment of a transsexual person to the fellowship of the college.

Germaine has been active in the media for much of her life and continues to appear on television and in print.She has written a number of other books, including *The Obstacle Race: Fortunes of Women Painters and Their Work* (1979) and *Sex and Destiny: The Politics of Human Fertility* (1984), which offers a critique of the western world's attitudes to sexuality, family and fertility. In 1986 she published *Shakespeare*, then *The Madwoman's Underclothes: Essays and Occasional Writings*, and in 1989 she produced a book about her father, *Daddy, We Hardly Knew You*. In *The Change: Women, Ageing and the Menopause* (1991) she suggested that women are frightened into using hormone replacement therapy by predictions of crumbling bones, heart disease, loss of libido, depression, despair, disease and death if they let nature take its course. The book concluded that fear makes women comply with schemes, treatments and politics that work against their interests. In 1999 she published *The Whole Woman* as a follow-up to *The Female Eunuch*. *The Beautiful Boy* (2003) is a controversial art history book about teenage boys, in an attempt to advance women's reclamation of their capacity for – and right to – visual pleasure. In 2007 she published *Shakespeare's Wife*, about Anne Hathaway.

Germaine has been outspoken on many issues, including the plight of Aboriginal Australians, transsexual and intersex people and their sexual orientation, the death of wildlife expert and conservationist Steve Irwin, suburban Australia and reality television. In spite of negative comments about shows such as *Big Brother*, she appeared for five days on the UK programme *Celebrity Big Brother* and some spin-off programmes in 2005.

Germaine Greer's writing has had a profound impact on women's rights and women's liberation and has kept a focus on feminist issues into the 21st century. Recently she was included in the *Prospect* magazine list of the 'World's top 100 thinkers'. She is now retired, but maintains a presence in print and television media and continues to advocate on feminist issues.

Challenge: Germaine Greer has courted and flirted with controversy most of her academic and adult life. Was this necessary for her to gain a voice in the public debate about women's place in society and how women are perceived? How do you make your voice heard? Are there other ways to be heard?

Summary

- This chapter is about the relevance of empowerment and oppression to clinical leadership.
- Empowerment is not the path, but the walk, and the choice about which path to take. This perspective of empowerment implies that nurses and other health professionals can liberate themselves and move forward in spite of the barriers and obstacles that may be acting against them.
- Empowerment can be defined as a tool, to be used to support or develop the empowerment of others, or as a choice, made by an individual to seize empowerment and take control over their life, both personal and professional.
- If nurses and other health professionals are able to access the power within themselves, then they will be able to empower themselves and set the conditions for empowerment in others.
- Clinical leaders may be the empowered few who have overcome some of the barriers in the health service to forge ahead and overturn the oppressive structures that impede their progress and success.
- Oppression remains an issue in the healthcare arena. Many nurses and other health professionals are still oppressed and display many of the signs of an oppressed group.

Mind Press-ups

Exercise 19.1

Do you think that nurses or other health professionals have inherited the values of the medical profession? Discuss this question with your colleagues. What are their views?

Exercise 19.2

In your experience have you ever encountered times when you have felt oppressed or been exposed to horizontal violence? Think about when this occurred and why it might have happened.

Exercise 19.3

Consider the characteristics of leaders of oppressed groups. Do any of these put you in mind of people you have worked for or with? In what way?

Exercise 19.4

Does nursing still suffer from negative stereotypes? How do negative stereotypes affect nursing's ability to influence the direction and quality of care and the health service? If nursing leaders are to make a difference in terms of care and the quality of the health service, how can nurses overcome the negative stereotypes that may remain evident?

Exercise 19.5

If nurses and some other clinically focused health professionals are oppressed, then taking steps to be liberated is vital. How can you take steps to liberate yourself (if you see the need) or to exercise your own empowerment?

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Clinical Leaders and Congruent Leadership

David Stanley

He that would govern others, first should be the master of himself.

Philip Massinger, English dramatist, 1583–1640, in *The Bondman*, 1624

Introduction: Clinical Heroes

I see clinical leaders as practitioners who have gone to the edge and flown. Or perhaps they are the clinicians who have taken their strides clearly and decisively in the direction of their values and beliefs. Or those who have simply stood by those beliefs, working not because they wanted to change the world, but because they knew that what they were doing was right and that their actions were making a difference – maybe not to the whole ward or unit or hospital or world, but for the person they were with, at that moment. When acting out or role modelling their values and beliefs (even unconsciously), something was happening in their relationship with the client, patient or colleague that gave a clear signal about what they believed or what their values were.

Responding to these values and beliefs has seen others view clinicians as clinical leaders: not because of their creativity, or because they were visionaries, in powerful positions or wielded great authority, but because they are open and approachable, clinically knowledgeable and competent. They are visible in practice, role models for the practice they espouse and good communicators. They are supportive, empowered, can motivate others, inspire confidence, are honest, cope well with change and their actions are evident or match their values and beliefs.

These clinical leaders capture what it means to be a congruent leader, standing by their values in the execution and drive of their actions, putting their hands where their heart is, acting out and following through what they believe to be right. These leaders are not selling a vision or communicating a path for others to follow, they are living their vision and walking the path, role modelling with courage, commitment, conviction and determination what they believe is the right thing to do. They are congruent leaders, but they are not the only congruent leaders.

Many Marys

The many Marys are offered as an example. Between 1854 and 1856, 229 nurses travelled officially to the Crimea and worked to care for wounded and dying soldiers in the military hospitals established near the war zone that were eventually managed by Florence Nightingale. Many other women

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travelled to the Crimea region unofficially. One such was Elizabeth Evans, the wife of Private Evans of the Fourth Regiment of Foot. She journeyed with him to the Crimean peninsula and nursed the wounded men of his regiment. Clearly devoted, her dedication was acknowledged when she was awarded the Crimean Medal following the war.

However, it was Florence Nightingale who emerged from the war with iconic status, a legend even in her own time (Bostridge 2004). Henry Longfellow wrote a poem about her in 1857, 'Santa Filomena', which includes the lines (quoted in Brighton 2004, p. 308):

> A lady with a lamp shall stand
> In the great history of the land,
> A noble type of good,
> Heroic womanhood.

The 'lady with the lamp' has shone glorious and bright (and deservedly so). Her career was the result of her conviction, dedication and commitment to do something with her life, and in many ways Florence Nightingale can be seen as a congruent leader, standing by her values and beliefs and acting from the strength of her convictions, as did Elizabeth Evans.

I wonder, then, if Florence's lamp has blinded us to the many others who can rightly be called clinical heroes and congruent leaders? I believe there are indeed many, so here is some information on a few of the Marys, to remind us that there are many others who made their mark (Stanley 2007).

There were three nuns who travelled to the Crimea for whom Florence Nightingale had great respect. She was not always noted for her acceptance or patience with nurses from religious orders (she described some as being fit more for heaven than hospital; Woodham-Smith 1982). Nevertheless, she wrote generously and in complimentary tones about the care provided by Mary Clare Moore, Mary Stanislaus Jones and Mary Gonzaga Barry. The nuns worked without pay and under strict religious orders and their desire to provide quality care often brought them into conflict with Florence, but their perseverance in the face of the conflict eventually won them her approval and admiration.

The other Mary that Florence was to encounter in the Crimea was Mary Seacole (see Chapter 4), a Jamaican Creole who travelled there unaided to care for the sick and wounded. She built a small hospital near the battlefront and successfully treated men suffering from diarrhoea, cholera, wounds and exhaustion (Brighton 2004). This Mary put herself in harm's way because she believed she could make a difference and contribute to the soldiers' welfare. I believe that she offers another fine example of a congruent leader.

The final Mary is Mary Jones, the superintendent of St John's House nursing sisterhood in London. According to Bostridge (2008, p. 427), Florence 'regularly consulted Mary Jones on all manner of nursing issues' and 'constantly deferred to the older woman's greater practical [clinical] experience'. Bostridge (2008) even suggests that the extent of her contribution to nursing matters (through Florence Nightingale) has meant that Mary Jones may have been overlooked as the real pioneer behind modern nursing. If this is the case, Mary may be an example of a congruent leader, leading from the wings with her values about collaboration and collegial support on show.

These are just a few of the Marys, but the reality is that there are thousands of front-line, clinical and client-focused health professionals in wards, clinics, units, operating theatres, ICUs, A&Es, community centres, rural and remote communities and surgeries, who make a difference to ordinary people by caring more than they think is wise, risking more than they think is safe, knowing more than is reasonably required, dreaming more than others think is practical, and giving more of themselves than might be considered prudent. These are congruent leaders. They do not all carry lamps

(and in reality neither did Florence Nightingale; Stanley & Sherratt 2010), but in my experience a lamp is not a prerequisite for excellent client care or for the recognition of a congruent leader.

Clinical leaders are the genuine stars of the modern healthcare arena. Unfortunately, it is easy to lose sight of their efforts in the glare of government reform, competing political agendas, health service targets, audits, quality standard assessments, hospital and health department financial constraints or managerial burdens. However, the Marys are always there, in the shadows, in the wings, by the bedside, in the clinic, by the cot or on the road, and it is their effort, commitment, courage, team work, collaboration, conviction and dedication that shine brightly as a light for others to follow.

Congruent Leaders beyond the Ward

These examples are offered to clarify congruent leadership from a health professional perspective and to support the theoretical foundation for why clinical leaders should be seen as effective leaders. Yet there are many others who can be identified as employing congruent leadership. I could have discussed the life and work of Mahatma (meaning 'great soul') Gandhi, Harriet Beecher Stowe, Nelson Mandela, Joan of Arc, Galileo Galilei, Edith Cavell, Mary Wollstonecraft, George Washington, Susan B. Anthony, Emmeline Pankhurst, Emily Murphy, Helen Keller, Odette Sansom, Oskar Schindler, Franklin D. Roosevelt, Dian Fossey, Mairead Corrigan Maguire and Betty Williams, or many others.

I could also have discussed the actions of Rosa Parks, who refused to give up her seat to a white man on a bus in Montgomery, Alabama in 1955. A black woman, she was arrested under racially motivated laws and later, when asked to explain why she did not give up her seat, said simply, 'Our mistreatment was just not right, and I was tired of it.' Here was a congruent leader who stood (sat) for her values and beliefs, and by simply acting on those values and beliefs became a figurehead for the American civil rights movement.

Clinical leaders do no less when they refuse to continue with outdated practices when aware of evidence of better, more effective interventions, even if it means challenging traditional approaches to care or treatment. Clinical leaders do no less when they stand by a patient who voices a wish to be 'not for resuscitation' (NFR) in the face of physician or family opposition and reluctance. Clinical leaders do no less when they stand up for a student who feels bullied and ridiculed by a clinical teacher who has misunderstood, judged too early or not waited for all the relevant information when failing a student in practice. Clinical leaders do no less a hundred times a shift when they act out their values and beliefs about care and health practices as they fulfil their role in whatever clinical field or environment they are in.

Things often change when clinical leaders make a stand but, like Rosa Parks, it is not always their intention to lead change as much as simply making a stand. Rosa said that she was not angry, she just felt determined to take the opportunity to let it be known that she did not want to be treated this way any more, and she had no idea how people would react to her arrest. What she did not know was that she was a leader and that she had followers. Clinical leaders often do not know this either. In the initial research study that supported the development of the theory of congruent leadership, half the clinical leaders who were identified did not recognise themselves as leaders. I suspect that the people who arrested Rosa Parks did not know they were dealing with a leader either. In the same way, I wonder if some managers, educators, organisations or departments of health recognise the leaders at work in the trenches, at the coalface or by the bedside.

However, I feel that it is vital that managers, educators, organisations, departments of health and other health practitioners do recognise the virtual army of clinical leaders who are there to drive, develop and support innovation and change, and bring about a quality health service. Organisational

goals and patient-focused innovation can best be led by clinicians who are recognised and valued for the contribution they can bring to the organisation at every level, not just as facilitators of care or deliverers of treatments.

The First Step: Finding Your True Voice

Kouzes and Posner (2010) suggest that the first step on any leadership journey is to find your own true voice. What they are saying is that you have to choose your own values. The second step is to listen, observe and understand other people's values.

Personal values drive commitment. You can only commit to organisations, political action, personal ambition, professional progression or indeed anything else if there is a fit between what you are doing and what you value and believe. To lead effectively means being aware of what you believe, what your values are and where you stand. Clearly, belief alone is not enough. There must also be evidence, grown from research into clinical practice and experience. There must also be a commitment to breach the nexus of research, clinical practice and education, and a desire to be open and honest. Clinical leaders also need to act with dignity, respect and professionalism in communicating or proposing a change or innovation. They have to be resilient, courageous, calm and passionate, and have a robust sense of humour. Finally, a clinical leader should also be clinically competent, knowledgeable and visible, and act as a positive role model for the change or innovations being suggested or discussed. Once these features are established or clear, and progress is made towards their further development, it is possible to change a clinical practice standard, an in-service teaching module, a communication process, a clinical guideline, a ward routine, a departmental policy, an organisational strategy … the world.

Not convinced? Do some research of your own and read about Mahatma Gandhi, Harriet Beecher Stowe, Nelson Mandela, Joan of Arc, Galileo Galilei, Edith Cavell, Mary Wollstonecraft, George Washington, Susan B. Anthony, Emmeline Pankhurst, Emily Murphy, Helen Keller, Odette Sansom, Oskar Schindler, Franklin D. Roosevelt, Dian Fossey, Mairead Corrigan Maguire, Betty Williams, Rosa Parks, Rosie Batty, Chai Jing, Alicia Garza, Patrisse Cullors and Opal Tometi or the many others, congruent leaders all. Or read on to consider the links between congruent leadership, innovation, change and quality.

Innovation, Change and Quality

Recognising the significance of values and beliefs and their impact on actions is vital, but in terms of influencing innovation, change and quality, it is also essential that clinical leaders understand the tools that can be used to facilitate change. Nurses and other health professionals in countries all over the world can be heard sitting in tearooms or at the lunch table discussing what is wrong with the health service, or how 'the recent changes in care delivery will have this or that impact' and 'if only they could do this or the other' or 'if only someone would listen to my view'. They complain, suggest, theorise and propose, but these ideas and opinions often go no further than that tearoom or lunch table. Sadly, what is left is a residue of disappointment, hopelessness, oppression or disenchantment with the clinical area, managers, colleagues, organisation, health service or government policy.

It could be that whingeing is the natural state of the hard-pressed health professional, but I do not believe that. Sometimes change or innovation is slow or resisted because health professionals have not learnt to listen to their 'true' or inner voice (Buresh & Gordon 2013) or simply have not learnt the skills associated with effectively managing or driving change and innovation, how to drive quality or

the liberation of empowerment. It may also be that they are not clear about what leadership means, who can be leaders or who are recognised as leaders in clinical practice. So often, as I talk to clinically focused health professionals about leadership, the response I have had is, 'What me… a leader, no… don't you want to talk to my manager?'

While managers might have the authority to support change, they might not have the practical or clinical insights to see what change is needed in practice or how quality can be improved. Thus, it is clinical leaders who are in an ideal position to see the change that is needed, and the value and impact that change and innovation can have for patient or client care. They may feel nevertheless that they lack the authority to take their ideas and suggestions further. Part of the proposition of this book is to point out that there are tools that clinical leaders can use to facilitate change, improve quality and develop innovation without recourse to authority and power.

- The first lesson for clinical leaders is to know and understand the significance of their own values and beliefs.
- The second lesson is to recognise that they have followers, because followers recognise a match between the clinical leader's values and beliefs and their actions. People look to clinical leaders for clinical leadership even if the clinical leader is not aware of it.
- The third point is that change can occur and quality can be affected even without managerial power or formal authority, if clinical leaders can learn to use reflection and change management techniques, employ creativity, benefit from evidence-based approaches, network, delegate effectively, motivate others and minimise conflict. Then they can exercise considerable influence over clinical change and support substantial innovation and quality improvement.

Leadership in clinical practice need not be about vision, powerful authoritarian positions or budgetary control. Clinical leaders are the front-line, coalface, bedside doers (Stanley 2006a, b, c, 2008, 2009, 2010, 2011, 2012, 2014; Stanton, Lemer & Mountford 2010; Swanwick & McKimm 2011; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015; Scully 2015) and when they employ (or can learn to employ) collaborative strategies to limit conflict, approaches to motivating and influencing others and other change management and quality improvement techniques, they can be the force that will help deliver high-quality, more effective care and shape a better tomorrow for the health service.

Two Final Examples: Actions from Values for the Poorest of the Poor

Mother Teresa

While she was not a health professional (initially), an outline of the life of Mother Teresa is offered here as another example of a congruent leader who was innovative and who changed the health and life outcomes for many people because she applied her values and beliefs to her actions.

When Agnes Gonxha Bojaxhiu (later known as Mother Teresa) set off for Darjeeling in 1929 to join the Sisters of Loreto, she was originally assigned the role of teacher at St Mary's High School, where she taught for 15 years. However, in 1946 she received what she described as 'a call from God' to give up her teaching role and 'follow Christ into the slums to serve him among the poorest of the poor'. She undertook some medical training and after many obstacles were overcome, she set up the Missionaries of Charity order, who took a fourth vow to give free help to the poorest people (the original three are poverty, chastity and obedience).

Her mission, in her words, was to 'care for the hungry, the naked, the homeless, the crippled, the blind, the lepers, all those who feel unwanted, unloved, uncared for throughout society, people that

have become a burden to society and are shunned by everyone'. The first of the order's centres opened in Calcutta and from there others gradually spread across India. Mother Teresa was to be honoured with some of the world's greatest awards, but it remained her beliefs and values that centred her life. 'Love', she said, 'begins at home and it is not how much we do, but how much love we put in the action(s) that we do'. She is now acknowledged by the Catholic Church as a saint and I feel she is an example of a congruent leader. It could be argued that Mother Teresa is the very definition of a congruent leader, because her life was lived as a very testament to her values and beliefs.

Although I am not suggesting that congruent leadership is the same as religious devotion, I do believe that it is this type of leadership that clinically focused health professionals employ as they face the challenges of working in the ever-changing, increasingly difficult, financially constrained health service. Congruent leadership may not define a clinically focused leader's life, but the principles of congruent leadership do offer an explanation for how and why some health professionals do what they do and are followed in the way that they are.

Tank man

My second example is not from a health professional perspective, but it demonstrates that congruent leadership theory can be applied across a range of areas.

On 5 June 1989, a single man dressed in a white shirt and black trousers stood defiantly before a long line of Red Army tanks as they attempted to leave Tiananmen Square in Beijing. When the tanks turned to avoid him, he stepped into their path. They turned back, again to avoid him, but again he stepped into their path. He stood his ground, until eventually the tanks' engines were turned off. The man then climbed up on the first tank and spoke to the commander. Although no one knows exactly what he said, it is reported that he chastised the tank commander for taking part in the brutal suppression (slaughter) of the protesters in Tiananmen Square.

His name is not known, nor is his fate, because at the end of the standoff he was grabbed by two men and he disappeared into the crowd that had gathered to watch. We will never know if these men were friends taking him to safety or goons taking him to a prison, or worse.

What is remarkable about this event is that although the student uprising that was a catalyst for his protest failed, the image of 'tank man' (captured on film and broadcast around the world), standing courageously before a line of lethal armaments, symbolises the raw heroism of an ordinary person and offers another example of congruent leadership.

Here was a man – not a great politician, not a military leader and not a person with assigned or titled leadership responsibility – literally standing for what he believed. He did not look on or shout his disapproval from the wings. He stood up, walked out and held his ground. He was not seeking to voice a vision or to take control and we do not even know his name. Yet *Time* magazine named him one of the 100 most influential people of the 20th century. His influence, his leadership, came from the expression of his beliefs and values in action. He sought to defy the tanks and make a point about their inhumanity, but he did not seek to express a vision. Yet the image of him standing resolutely before the tanks in Tiananmen Square has been burnt into the global consciousness and influenced China's domestic and international policy in subtle yet significant ways. 'Tank man' is another example of a congruent leader.

Conclusion

Clinical leadership is evident in any clinical environment. It is practised by a clinical leader who is directly involved in providing nursing or other health professional care. Leaders who 'control' and manage from within offices or who fail to display values and beliefs that are in congruence with their actions

are rarely seen as clinical leaders. Instead, clinical leaders are visible to their colleagues and considered to be clinically knowledgeable, skilled and competent clinicians (although not necessarily experts) who motivate and inspire others because their values, beliefs and guiding principles are on show and are recognised as such. These principles and values motivate and guide the clinical leader to act in ways that support patient/client rights and address issues of confidentiality, dignity, privacy and advocacy. When they address critical problems, face challenges and direct or provide care, it is the clinical leader's application of congruent leadership theory, based on values, beliefs and principles, that is evident.

Summary

- Clinical leaders are found in great numbers and across the spectrum of the health service.
- Clinical leaders display congruent leadership, matching their values and beliefs with their actions.
- Practitioners can be and often are congruent leaders who have gone to the edge and flown, stepped boldly in the direction of their values and beliefs or confidently stood by them.
- Congruent leaders can have a dramatic impact on the quality and initiatives that help make the health service better.
- Congruent leaders are not selling a vision or communicating a path for others to follow. They are living their vision and walking their path with conviction, commitment and determination and, whether they are aware of it or not, others see them as leaders and follow.

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