IJHPM
International Journal of Health Policy and Management

Commentary

Responsibilising managers and clinicians, neglecting system health? What kind of healthcare leadership development do we want?

Comment on "Leadership and leadership development in healthcare settings - a simplistic solution to complex problems?"

Graham P. Martin*

Abstract
Responding to Ruth McDonald's editorial on the rise of leadership and leadership development programmes in healthcare, this paper offers three arguments. Firstly, care is needed in evaluating impact of leadership development, since achievement of organisational goals is not necessarily an appropriate measure of good leadership. Secondly, the proliferation of styles of leadership might be understood in part as a means of retaining control over public services while distributing responsibility for their success and failure. Thirdly, it makes a plea for the continued utility of good administrative skills for clinicians and managers, which are likely to become all-the-more important given recent developments in healthcare policy and governance.
Keywords: Leadership, Healthcare, Evaluation, Training, Quality, Patient Safety
Copyright: © 2015 by Kerman University of Medical Sciences
Citation: Martin GP. Responsibilising managers and clinicians, neglecting system health? What kind of healthcare leadership development do we want? Comment on "Leadership and leadership development in healthcare settings - a simplistic solution to complex problems?" *Int J Health Policy Manag* 2015; 4: 43–44. doi: 10.15171/ijhpm.2015.02

*Correspondence to:
Graham P. Martin
Email: graham.martin@leicester.ac.uk

Ruth McDonald offers a sceptical but reasoned viewpoint on the increasing onus placed on leadership and leadership development in the NHS and elsewhere, as a means of responding to the multiplicity of challenges that face today's public services (1). She highlights the weak evidence base for the association between leadership behaviours and organisational outcomes (often neglected by the more fervent advocates of leadership development programmes), and lauds a recent call from the UK's National Institute for Health Research for more robust research on leadership development. Such calls are indeed to be welcomed, even if they do represent another example of evidence following, rather than preceding, investment. Exactly how such programmes should be judged, however, and according to whose criteria of success, is a critical question.

As McDonald notes, discourses of leadership have moved away from a sole focus on those at the apex of organisations, towards various forms of distributed leadership. Such shifts might be seen as reflecting the more complex reality of healthcare networks and markets, where the authority of a small group of leaders at the top of a hierarchy is no longer sufficient on its own to determine organisational direction (2,3). With this shift towards distribution of leadership has come a proliferation of forms of leadership behaviour, with concepts such as 'quiet' and 'servant' leadership joining more traditional understandings of transformational and heroic leadership (4). This poses challenges for evaluation: if leadership is a multifaceted entity, with different forms of leadership for different purposes, then how should its impact be assessed?

One common answer is that leadership should be contingent: the good leader is a chameleon who can adjust her leadership style according to the challenge in hand. Accordingly, the impact of leadership can be judged (subject to methodological limitations) both in terms of individual tasks or processes, or in terms of its aggregate effect on organisational outcomes as a whole. In this understanding, different leadership behaviours are to be deployed judiciously, but in pursuit of a singular aim: their effectiveness is to be judged according to their "fit with … organisational goals" (1). Yet sometimes, of course, seeing good leadership in these terms is problematic. In the same way that, as McDonald points out, senior leadership positions can bring with them myopia and hypocrisy (1), adherence to organisational objectives in lower-level distributed leadership roles can also cause problems. The scandal at Mid Staffordshire, and other organisational calamities in healthcare and elsewhere, were not just a matter of poor care by some clinicians and maladministration by some managers, but also a failure on the part of leaders of all kinds to identify, anticipate and act (5). Despite warning signs and a host of attempts to speak out at Mid Staffordshire (6), many managers and clinicians found it difficult to defy the overarching organisational

Department of Health Sciences, University of Leicester, Leicester, UK

narrative that things were more-or-less OK (5). The short-term interests of the organisation are thus not always aligned with the long-term interests of patients, the public or the wider system. Good leadership is sometimes about rejecting organisational goals in favour of ethical priorities. Evaluating leadership development in these terms is difficult, and enacting such leadership behaviours in practice is hugely challenging—arguably even more so in increasingly marketised healthcare systems where competition between organisations is purported to be the lifeblood of system healthiness, and so individuals' pursuit of organisational interests is valued and rewarded (7).

More broadly, the multiplicity of forms of leadership, each with its own application, purpose and benefits, ironically reflects, I suggest, a crisis of leadership on the part of those in senior positions. The spread of leadership discourse, it has been argued, seeks to enlist an increasing number of individuals into governmental objectives (8), acting as a 'remote control' (1) on a wide range of individual subjectivities. Those identified as leaders extend beyond senior managers, now including junior and senior clinicians, assistants, administrators, technicians, and even patients and the public (8). Those at the top can no longer dictate, so they must enrol. In the same way, the proliferation of leadership programmes, and their associated propagation of different leadership styles, might be understood as an imperfect attempt at resolving the tension in a desire to retain control while distributing responsibility. Leadership offers the answer, but it is the responsibility of the leader herself to enact that leadership, in all its polymorphous forms, appropriately and effectively. The UK's recently removed Secretary of State for Education, Michael Gove, purportedly once said that *"If anyone asked me what my ideal education policy would be, it would be to clone Rachel [de Souza, the headteacher of a highly performing school] 23,000 times"* (9). This statement perhaps exemplifies the faith put in the panacea of leadership: it is the answer, regardless of the specifics of the challenges faced by 23,000 schools (or 160 hospital trusts or 211 clinical commissioning groups) in divergent local circumstances. It is a universal solution with an underlying instrumentalist logic, to be enacted (or 'implemented') by diffuse individual leaders. If leadership does not achieve what is vaunted, that is the individual leader's fault, and she can be replaced by a better leader whose application of leadership accomplishes what policy intends.

Finally, amidst all the enthusiasm for leadership, we should surely be careful not to neglect one less fashionable aspect of the job of the effective clinician or manager: good administration. While networks and markets undoubtedly bring new challenges that require creative responses, including adaptive leadership, healthcare organisations are still bureaucracies, and will still to a large extent thrive or flounder on the organisational and administrative skills of their managers in particular (10). Contractual relationships between independent organisations in marketised systems require, if anything, more intensive and skilled administrative capacity, as well as specific legal and accountancy skills, as the greater bureaucratic costs associated with more market-based systems suggest (11). In the rush for leadership, let's not forget the importance of competent administration.

Ethical issues
Not applicable.

Competing interests
Author declares that he has no competing interests.

Author's contribution
GPM is the single author of the manuscript.

References

1. McDonald R. Leadership and leadership development in healthcare settings – a simplistic solution to complex problems? *Int J Health Policy Manag* 2014; 3: 227-9. doi: 10.15171/ijhpm.2014.101
2. Martin GP, Currie G, Finn R. Leadership, service reform, and public-service networks: the case of cancer-genetics pilots in the English NHS. *J Public Adm Res Theory* 2009; 19: 769-94. doi: 10.1093/jopart/mun016
3. Hartley J, Martin J, Benington J. *Leadership in healthcare*. Coventry: Institute of Governance and Public Management; 2008.
4. Trastek VF, Hamilton NW, Niles EE. Leadership models in health care—a case for servant leadership. *Mayo Clin Proc* 2014; 89: 374-81. doi: 10.1016/j.mayocp.2013.10.012
5. Macrae C. Early warnings, weak signals and learning from healthcare disasters. *BMJ Qual Saf* 2014; 23: 440-5. doi: 10.1136/bmjqs-2013-002685
6. Jones A, Kelly D. Deafening silence? Time to reconsider whether organizations are silent or deaf when things go wrong. *BMJ Qual Saf* 2014; 23: 709-13. doi: 10.1136/bmjqs-2013-002718
7. Evetts J. New professionalism and new public management: changes, continuities and consequences. *Comp Sociol* 2009; 8: 247-66. doi: 10.1163/156913309x421655
8. Martin GP, Learmonth M. A critical account of the rise and spread of "leadership": the case of UK healthcare. *Soc Sci Med* 2012; 74: 281-8. doi: 10.1016/j.socscimed.2010.12.002
9. Williams Z. The entire schools inspection culture is the problem. The Guardian [Internet]. [cited 2014 Oct 19]; Available from: http://www.theguardian.com/commentisfree/2014/oct/19/schools-inspection-ofsted-rachel-de-souza
10. Boyne GA, Meier KJ. Burdened by bureaucracy? Determinants of administrative intensity in public organisations. *Int Public Manag J* 2013; 16: 307-27. doi: 10.1080/10967494.2013.817261
11. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med* 2003; 349: 768-75. doi: 10.1056/nejmsa022033