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Clinical Leadership Explored

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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

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, Lemer & 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, Lemer & 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, Lemer & 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 |
|--|
| <p>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?</p> |

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 <i>controlling</i> 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 <i>visionary</i> 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% | 51% | 20% | 40.9% | 34.2% |
| | Ranking 27th out of 42 | Ranking 37th out of 54 | Ranking 33rd out of 54 | Ranking 38th out of 54 | 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 <i>creative/innovative</i> as an attribute likely to be linked to clinical leadership | Nurses 76.5% Ranking 25th out of 42 | Paramedics 51% Ranking 32nd out of 54 | Residential care staff 60% Ranking 27th out of 54 | Volunteer ambulance officers 59.0% Ranking 27th out of 54 | Allied health professionals 56% Ranking 22nd out of 54 |
| Percentage of respondents who identified <i>artistic</i> 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.

| Attributes | Study 1 | Study 2 | Study 3 | Study 4 | Study 5 |
|------------------------------------|------------------------------|------------|------------------------|------------------------------|-----------------------------|
| | 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 health-care 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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