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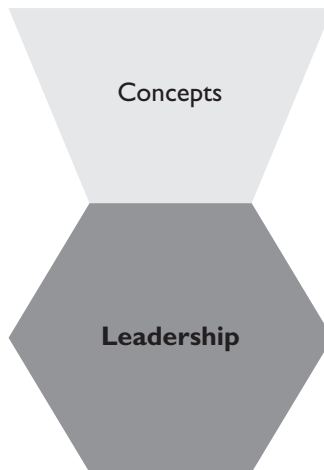
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Leadership concepts

In this chapter:

We note that there are many and varied definitions and ideas about what leadership is and we explore the different interpretations. The chapter examines three main approaches to conceptualising leadership, in terms of a focus on the person, the position or the processes. It is valuable to be aware of these different concepts of leadership in thinking about leadership otherwise talk and action may be at cross-purposes. Each emphasises different facets of leadership and may be incomplete on its own.

Figure 2.1: The concepts of leadership



This chapter examines the first segment of the Warwick Six C Leadership Framework set out in the previous chapter. So, here we examine leadership concepts. Why use the plural (that is, concepts) rather than the singular (that is, concept) when discussing leadership? There are very many definitions of leadership provided by academics and the term is used in myriad ways in everyday speech. Furthermore,

the term has changed in emphasis or approach over time, as overviews of the history of leadership research show (for example, Storey, 2004; Parry and Bryman, 2006).

These different emphases could be the basis for considerable confusion unless we unpack and examine the various ways in which the term leadership is defined and used. Grint (2000) argues that the term is ‘multifaceted’. Many writers avoid the complexity entirely and fail to indicate what they mean by leadership!

What is meant by the term leadership?

An early definition of leadership from the 1950s is still helpful:

Leadership may be considered as the process (act) of influencing the activities of an organized group in its efforts towards goal setting and goal achievement. (Stogdill, 1950, p 3)

This has a number of elements – it views leadership as a social and relational process of influence occurring within a group. So, leadership is seen here not just in terms of individual characteristics but about what happens between leaders and those being influenced. Stogdill’s definition is about an organised group, although there may be arguments that leadership can have wider impacts, for example, outside as well as inside the organisation. The definition also links leadership to purposes – goal setting and/or goal achievement. This suggests that the work that the group aims to do together is central to the definition. This definition is focused not on a person but on a process (influence).

Other definitions emphasise these features, to a greater or lesser degree. For example:

- “leadership over human beings is exercised when persons with certain motives and purposes mobilize, in competition or conflict with others, institutional, political, psychological, and other resources so as to arouse, engage and satisfy the motives of followers” (Burns, 1978, p 18);
- “leadership is realized in the process whereby one or more individuals succeed in attempting to frame and define the reality of others” (Smircich and Morgan, 1982, p 258);
- “the process of inducing others to take action towards a common goal” (Locke, 1991, p 2);
- “mobilising people to tackle tough problems” (Heifetz, 1994, p 15).

These definitions are drawn from a range of fields where leadership has been observed (managerial, organisational, political) and are seen as generically relevant.

In the health field, Goodwin argues for a definition of leadership based on a systems-wide view:

Leadership is a dynamic process of pursuing a vision for change in which the leader is supported by two main groups: followers within the leader's own organization, and influential players and other organizations in the leader's wider, external environment. (Goodwin, 2006, p 22)

These definitions vary substantially – whether the definition focuses on the purposes or goals, or whether it focuses on the social dynamics; whether the focus is the group, the organisation or the social system; whether the intention is to satisfy followers or to engage them in difficult problem-solving (tough problems). They do have in common the idea of influence between human beings, with particular purposes to be achieved.

Perspectives on leadership

In this chapter we use a threefold typology of leadership concepts to reflect the relative emphases placed on:

- the personal qualities of the leader;
- the leadership positions in the organisation;
- the social processes and interactions of leadership.

Hartley and Allison (2000) have conceptualised leadership from the three perspectives of 'person, position and process'. These three approaches are shown in Table 2.1.

Personal qualities of the leader

Research on the personal characteristics of leaders abounds and Yukl (2006) provides a good overview. Early work tried to find the personality types or innate personal characteristics (traits) that were associated with leadership, but this work largely foundered both because the list of possible traits grew and grew and also through lack of evidence on any substantial scale. There is some evidence that intelligence and physical energy are important in leadership and

Table 2.1: Conceptual perspectives on leadership

Conceptual approach	Definitions/models	Features
Personal qualities of the leader	Defined in terms of personality and behaviours of individual leaders	Individual behaviours and attitudes Personality traits Learned skills and capabilities Concerned with standards of personal effectiveness
Organisational positions	Defined in terms of formal organisational leadership roles, position, authority and/or professional status, for example, line management, expertise, reflected in both hierarchical and distributed or dispersed forms of leadership	Status and/or profession Organisational and personal authority Often associated with senior or supervisory roles Linked to organisational effectiveness
Leadership as social process	Defined in terms of social interaction with 'followers' with an emphasis on social influence attempts, communication, empathy for others, empowerment and coaching of others	Relational Influencing/motivational skills Effects on followers

these are influenced by genetics and early childhood experiences. A number of writers emphasise particular qualities such as integrity, self-confidence, self-awareness and resilience (Lord et al, 1986; Locke, 1991; Yukl, 2006), which may be partly innate and partly learned. But most modern leadership research suggests that leaders are not born but are largely made (and developed).

The literature from the mid-20th century focused on the behaviours, skills, mindsets and abilities of leaders, and here there is a large literature, which will be examined more fully in a later chapter (on the capabilities of leadership). For example, considerable research has been undertaken to try to identify the behaviours that distinguish effective from less effective leaders, such as behaviours showing concern for people and concern for the task (see, for example, Ohio State University studies by Fleishman et al, 1955) and getting the appropriate balance between these two dimensions. The work on transformational and transactional leadership falls under the behavioural approach to leadership (Burns, 1978; Bass, 1985), as does work on charismatic leadership (Bryman,

1992) and the more recent interest in mindsets (Ryde, 2007). Bennis and Thomas (2002) suggest that leaders are people with particular qualities or traits who are shaped by the formative experience of leadership. More recently, there has also been work on the dark side of leadership, which focuses on the traits and behaviours that can derail leaders or undermine effectiveness (Burke, 2006b).

Other work has considered the idea that individual leaders may vary their style according to the task and/or the context (for example, Fiedler, 1967; House and Dessler, 1974).

These approaches to leadership have been called leader-centric in that they focus on the characteristics of the leader. The role of individuals with their personal qualities in shaping events and circumstances at certain times is clear. The disadvantage of such approaches is that they can idealise particular individuals and assume that they have pre-eminent capacity and power, which ignores 'followers' and organisational and community constraints. This has been called the romance of leadership (Meindl and Ehrlich, 1987) in that the pre-eminence of the leader may be as much a social construction by 'followers' due to their own feelings and thoughts as due to the actual qualities of the leader.

In fact, Bryman (1992) argues that effective leadership by individuals is an interaction of the individual with their context. Sinclair (2005) argues that the lack of women in senior leadership positions is better explained by how society defines leadership than the qualities of women as leaders. Despite the limitations of taking a solely person-based perspective, however, Alimo-Metcalfe and Lawler (2001) note that a number of organisations are still taking a 'strong leader' approach to their leadership development programmes, with this focus on the individual and his/her personality. The 'strong leader' approach is also found in a number of policy documents in relation to the leadership of public organisations (Hartley and Allison, 2000) and this includes the health sector.

Leadership as position

Leadership can also be conceptualised in terms of organisational position or role. For example, in the NHS, this includes chief executives, medical directors, nurse managers and so on. A chief executive is in a position of authority, which may be a basis for leadership as well as management. Much of the leadership literature has conflated leadership with role, as it has drawn on research with the military or with business managers. Some commentators (for example, Rost, 1998) say that such formal positions give authority, and hence potentially the

legitimacy to lead, but that the exercise of authority is not necessarily leadership. Leadership requires more than simply holding a particular office or role. Heifetz (1994) distinguishes between leadership with authority and leadership without (or beyond) authority, and formal and informal leadership. He argues that each may tackle leadership issues through different processes – for example, informal leaders may work through influence rather than through authority or direct control. Bryman (1992) notes that insufficient research has been directed to understanding informal leadership (for example from peers, or from outside the organisation).

As Hartley and Hinksman (2003) suggest, position within an organisation is one key indicator of leadership. A formal position within an organisation, such as chief executive or team leader or clinical consultant, brings with it the authority and legitimacy to lead others. In terms of social relationships, those in formal positions of authority are most likely to be regarded by staff as being in a leadership role as a result of the power and influence connected to the role they exercise in the working environment.

In healthcare organisations, leadership may be reinforced by the status or prestige of the formal role within the hierarchy. For example, the chief executive, director or chair of the board may be accorded legitimacy and even prestige because of their senior position, and, as a consequence of this position, they have the opportunity to exert greater influence than someone further down the pecking order. This is particularly relevant for complex healthcare systems where there are different types and sizes of organisational structures and cultures, including clinical teams, small clinical practices, multi-agency organisations, independent specialist providers and large hospitals.

However, leadership is clearly not solely about position, because there are many examples of ineffective leadership within particular roles – as well as many examples of leadership taking place outside or beyond the formal role.

Furthermore, leadership is not only found at the top of the organisation or in senior roles in teams. Writers have noted and commented on distributed or dispersed leadership in a variety of organisations including in health and in schools (Denis et al, 2001; Gronn, 2002; Spillane, 2005), for example, a team leader may operate with influence from a range of people in the team. Indeed discussion and debate about the efficacy of leadership in healthcare organisations is often concerned with questions about leadership across professional and managerial boundaries, both formal and informal, within single organisations and across organisational boundaries. We will explore this

further in the Chapter 3 – here we note particularly the idea (concept) of leadership being based in organisational position, role or power.

The extent to which, for example, NHS chief executives are authoritative as leaders is complicated by their relationships with both politicians who set the policy context and clinicians on whose professional expertise healthcare delivery relies. The capacity for both these groups within and outside the organisation to affect the leadership of senior managers is significant. The expectations on chief executives to achieve organisational change, improvement and innovation are high, but charismatic ‘celebrity’ bosses who do achieve transformation by virtue of their position have been described as ‘dangerous leaders’ who may achieve much in the short term but leave their organisations destabilised (Buchanan, 2003).

Leadership as a social process

Leadership research in general has emphasised the importance of not just formal authority but also influence (it occurred in many of the definitions earlier). This involves thinking about leadership as a relationship and set of processes occurring between those trying to influence and those being influenced. Influence may occur at the team or group level, at the organisational level or at the societal level.

Influence may involve authority and/or formal power or it may involve mobilising and engaging others, for example through vision, passion or the clear articulation of goals. As this view of leadership is about processes, there is a need to also consider the relationships between ‘leaders’ and ‘followers’ – and also processes of mutual influence, because ‘followers’ may shape the kinds of approaches that leaders use (Collinson, 2006; Shamir et al, 2007).

Much of the work on leadership in healthcare has focused on leadership as a social process with the accent on how people in leadership positions transform organisations through influencing other people.

Acknowledging leadership as a social process suggests that effective leaders need to engage the hearts and minds of colleagues, staff and stakeholders to achieve leadership goals. This means taking care of relationships both internally and externally. Ferlie and Pettigrew (1996) have underlined the importance of external as well as internal relationships in a network-based approach to leadership that is increasingly important in healthcare. For example, Goodwin (1998) summarises the network of external relationships for a trust chief executive, showing the need to establish relationships including with

NHS providers, GPs, the private sector, local government, voluntary organisations, consumer groups, community groups, trade unions, local MPs and the media.

The social interaction aspects of leadership are also at the heart of another influential conceptual approach: adaptive leadership (Heifetz, 1994), which will be explored further in Chapter 5 on the challenges of leadership.

Studies of clinical leadership now recognise the importance of relationship management (for example, Millward and Bryan, 2005) and the need for emotional intelligence and coaching skills to achieve this (Henchowicz and Hetherington, 2006). Paying attention to the interrelational aspects of leadership is also reflected in the notion of ‘communicative’, ‘democratic’ or ‘shared’ leadership, which highlights the importance of discussion and deliberation as a means of organisational development to empower staff (Jackson, 2000; Eriksen, 2001). In their case study of nurse leaders in New Zealand for example, Kan and Parry (2004) acknowledge leadership as a social process, arguing that it contributes to a better understanding of the group dynamics between nurse leaders, nurses and other professional groups, and highlighting the importance of networking, coalition building and persuasion. Similarly McDonagh (2006) points to the importance of the governing board as a site for deliberative processes that provide organisational leadership.

As we have indicated earlier, leadership is multifaceted and can be conceptualised in a number of ways. Here, we have concentrated on three major strands or perspectives, about the person, the position and the process. Each has something to contribute to our understanding of leadership but each is deficient if applied in isolation on its own. Different writers emphasise these perspectives to different degrees and so it can be helpful to be aware of this in discussing and analysing leadership in healthcare.

Leadership or management?

It is not so long since everyone was arguing that ‘management’ was the answer to improving organisations, so why is there now a focus on leadership?

There are varied views about whether ‘management’ and ‘leadership’ are different or basically the same, as activities (not roles) within organisations. For example, Kotter (1990) argues that organisations need both leadership and management but that they are different: leadership is concerned with setting a direction for change, developing a vision

for the future, while management consists of implementing those goals through planning, budgeting, staffing and so on. Others concur with this view (for example, Zaleznik, 1977; Bennis and Nanus, 1985). Kotter (1990) comments that most organisations are over-managed and under-led. Table 2.2 gives some commonly understood (though perhaps slightly caricatured) views of leadership activities compared with management activities, which some writers consider to be valid.

Table 2.2: Managers versus leaders

Managers	Leaders
Are transactional	Are transformative
Seek to operate and maintain current systems	Seek to challenge and change systems
Accept given objectives and meanings	Create new visions and meanings
Control and monitor	Empower
Trade on exchange relationships	Seek to inspire and transcend
Have a short-term focus	Have a long-term focus
Focus on detail and procedure	Focus on the strategic big picture

Source: Storey (2004)

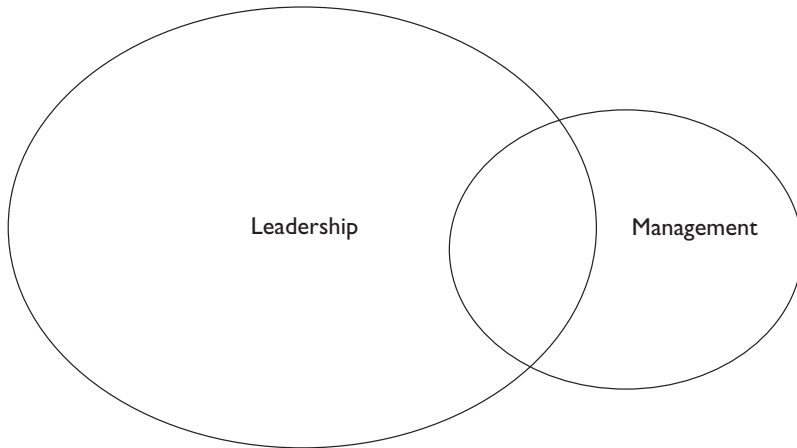
However, there is an alternative view that is also strongly held. Yukl (2006) argues that defining leadership and management as distinct roles, processes or relationships may obscure more than it reveals: “Most scholars seem to agree that success as a manager or an administrator in modern organizations necessarily involves leading” (pp 6–7). Many studies of leadership have been based on managers in any case, so clearly some managers can be assumed also to be leaders (although being a manager does not per se make one a leader). Mintzberg (1973) described leadership as a key managerial role.

So managers are potentially leaders but they are not the only ones. Leadership is broader than management because it involves influence processes with a wide range of people, not just those who are in a relationship based on authority. It involves change but also can involve the routine; the transactional as well as the transformative.

The overlap, for many writers, between leadership and management is illustrated in Figure 2.2 on the next page

The debate about the relationship between management and leadership may in part be driven by the disciplinary interest of management theory, and the dominance of business schools in research and writing about leadership. Leadership analyses from different perspectives would pay as much attention to a variety of types of

Figure 2.2: The relationship between the activities of leadership and management



leadership in and around organisations. It is notable that the literature from healthcare specifically pays attention to medical leadership, clinical leadership and nurse leadership as well as to managerial leadership (for example, Berwick, 1994; Hackett and Spurgeon, 1998; Ham, 2003; Øvretveit, 2005a; Dickinson and Ham, 2008).

Anyone who influences others can be seen as a leader and therefore the leadership is not just the top managers or consultants in a hospital or surgery or Primary Care Trust. Nurses, occupational therapists, ward sisters and many others may at particular times and in particular contexts work in ways that exercise leadership. Clinical leadership and professional leadership are as important as managerial leadership in healthcare settings.

Leadership is multifaceted. Understanding leadership requires an understanding of the relationship between the behaviours of individuals in leadership positions and those they seek to influence.

Policy and practice implications:

- Too many studies fail to define what they mean by leadership. Creating an evidence base about leadership will be helped by clarity about how the term is used.
- How leadership is understood will have an impact on how and where we recognise (and accept) leadership. If leadership is seen as primarily about particular individuals with special accomplishments (heroic individuals), then there may be under-recognition of the contributions that others in the team or unit can make.
- If leadership is understood as primarily about position in the organisation then the focus on leadership will be primarily on the upper echelons of the organisation and the opportunity to cultivate and practise distributed leadership may be impaired.
- If the concept of leadership is pictured primarily in terms of social processes of influence and mobilisation, then attention will need to be paid to how the leader understands, interacts with and engages with the group. Leadership through influence requires the cultivation of interpersonal skills and emotional intelligence, among other things.
- 'Followers' have a responsibility to think about how they can influence and support, if appropriate, the formal leader in the group's tasks.
- In practice, leadership may have elements of all three of the concepts of person, position and process in various combinations.
- The concept of leadership also shapes how leadership development is viewed. A focus on the individual will mean particular emphasis on selecting and developing individuals. A focus on organisational position may mean that only particular positions in the organisation are given certain types of training and development in leadership skills. A focus on social processes will mean some development emphasis on working in groups and teams.
- 'Talent spotting' for people with leadership potential, for example, fast-track trainees, clinical staff shifting into managerial roles and so on, will be affected by the leadership concept used.
- Confusion about leadership can sometimes be avoided by paying attention to how people understand and use the term leadership.

