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Perspectives on healthcare leader and leadership development

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Abstract: Healthcare delivery systems are complex entities that must merge the best of administrative and clinical practices into a new model of leadership. But, despite growing recognition that healthcare organizational leaders must partner with clinical leaders to address patient safety, evidence based practice, financial sustainability, and capacity, tensions between the groups remain. Healthcare is based in large, bureaucratic entities organized in administrative hierarchies with clinical or product line silos that thwart collaboration, limit inter-disciplinary engagement, and foster mistrust. Around the world healthcare accessibility, fragmentation and affordability issues challenge healthcare systems whether they are centralized, socialized systems or free market private and public enterprises. In response to these concerns, healthcare organizations are struggling to address the 'how' of integrating clinician competence in patient management with the financial imperatives of modern day delivery systems. To redesign healthcare services for effectiveness and efficiency and to improve patient safety and outcomes, organizations must redefine leadership using new paradigms that promote the development and diffusion of improvements and innovations. Current research evidence shows that there is a need for not just formal administrative leadership, but also a need to develop integrated leadership processes throughout healthcare delivery systems. Shared leadership concepts framed in the context of complexity leadership theory (CLT) provides a vehicle for rethinking old definitions of leadership and for mobilizing the collective energy of healthcare organizations.

Keywords: complexity leadership theory (CLT), shared leadership, healthcare, leaders, leadership

Healthcare delivery systems are complex entities that must merge the best of administrative and clinical practices into a new model of leadership if improved patient outcomes are to be advanced. Resolving patient care errors that contribute to avoidable deaths has been a goal for over ten years; yet, little has been effective in changing the trends. A 2009 report suggests that around 200,000 Americans still die from preventable medical errors.[1] There is growing recognition and demand that healthcare organizational leaders around the world partner with clinical leaders to address patient safety, evidence based practice, financial sustainability, and capacity; however, tensions between the groups remain. Healthcare is based in large, bureaucratic entities organized in administrative hierarchies with clinical or product line silos that thwart collaboration, limit inter-disciplinary engagement, and foster mistrust. Around the world healthcare accessibility, fragmentation and affordability issues challenge healthcare systems whether they are centralized, socialized systems or free market private and public enterprises. Additionally, documents like *Keeping Patients Safe*

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authored in the United States (US), *In Good Hands* compiled in New Zealand, and *High Quality Care for All* published in the United Kingdom (UK), call for emergent clinical leadership that fosters positive patient outcomes and safety.[2–4] Common recommendations in these reports include placing the patient at the center of care, making quality and safety a central concern for healthcare systems, and mobilizing at the bedside, clinically driven care.

In response to these new demands, healthcare organizations around the world are struggling to address the 'how' of integrating clinician competence in patient management with the financial imperatives of modern day delivery systems. Three common strategies recommended are implementation of shared or clinical governance models, advocacy for frontline clinical empowerment to make changes, and advancement of clinical leadership in organizations.[5–7]

Current strategies used to integrate clinical and administrative leadership

Shared Governance is "an organizational innovation that gives healthcare professionals control over their practice and extends their influence into administrative areas previously controlled only by managers."[8] Governance models take different forms and have varying powers depending on the organizational context in which they are implemented. Typically, these forums oversee practice guidelines, policies and protocols. Most governance entities operate outside the context of line management and serve as recommending bodies rather than having authority to execute change. While shared or clinical governance has been associated with increased nurse empowerment and job satisfaction, very few studies have been conducted to evaluate the impact of this model on patient outcomes or safety.[9–11]

The empowerment of frontline staff is another emergent concept that has been given credibility through a number of major initiatives.[12,6] The *Transforming Care at the Bedside* project funded by Robert Wood Johnson has allowed nurses at the bedside to pilot ideas to improve safety and increase patient-centered care delivery.[12] Rapid response teams, reduced hospital acquired infections, and improved outcomes for surgical patients are all innovations prompted through this project.[13] Researchers from a recent study using frontline nurse empowerment note that "this study suggests that frontline nurses and other hospital-based staff, if given the training, resources, and authority, are well positioned to improve patient care and safety processes on hospital patient units."(p. 604)[6] Adding to this finding is a study on the implementation of oncological services in Canada.[14] These researchers found that participant willingness to cooperate was a critical dimension of changing frontline behaviors and that without administrative mandate often results are variable. Central to the effectiveness of frontline teams is having the power to implement a change, without this recommendations must be funnelled through the bureaucracy and await a decision. Additionally, despite education to support nursing's use of evidence based practice at the unit level, "often it is not utilized because of restrictions on the nurse's role in providing patient care … nurses are trained to look at evidence, think critically and intelligently, and make decisions based on their knowledge, but they are not being allowed to do this in their jobs."(p. 256)[15] Furthermore, frontline clinicians often lack the dedicated time and resources to focus on evidence based practice initiatives given the needs of patients and the limitations on staffing.

One of the greatest global efforts to resolve the imbalance between clinical and administrative forces in healthcare decision-making has focused on increasing the number and competence of clinical leaders. This endeavor is aimed at both physician and nurse leadership development. "It is probably reasonable to acknowledge that recent years have perhaps seen an excess of managerialism and centralism that has disillusioned many frontline staff."(p. 11)[16] To counter this reality in the UK, active recruitment of physician leaders has been organized under a project called *Enhancing Engagement in Medical Leadership*.[17] And, in the US multiple programs are being developed to mobilize physician competency in the business side of healthcare.[18] The goal of programs like these is to engage physicians in adopting practices that will not only improve outcomes, but lower costs. By developing physician leaders that can serve as champions of health system intiatives, the aim is for faster and broader support and participation of innovation by peer physicians. Regrettably, these programs are meeting with mixed reviews as physicians, trained primarily in clinical management and accustomed to autonomy in practice, are reticent to take on leadership roles in organizations.[19,17,20]

Parallelling the work focusing on physician leadership education is the development of clinical leader roles and leadership education in nursing. In the US, the American Association of Colleges of Nursing (AACN) has developed a new role in nursing, the Clinical Nurse Leader (CNL).[21] The AACN emphasizes that the CNL role "is not one of administration or management. The CNL functions within a microsystem and assumes accountability for healthcare outcomes for a specific group of clients within a unit or setting

through the assimilation and application of research-based information to design, implement, and evaluate client plans of care."(p. 6)[21] Prepared at the master's level this nurse is equipped to advance front-line decision making, quality care delivery based on evidence, and fiscal stewardship. In the UK and Australia, clinical leadership in nursing is also being promoted as a link to quality improvement.[22,23] These endeavors aim to move nurses into the arenas where decision making about service delivery and patient care are made as well as equip nurse experts to facilitate quality improvement processes at the bedside.[24,21] Despite formalized training and role development, nursing leadership is thwarted by a history of medical subordination, feminized professional roots, and health systems that are not ready to let clinicians lead.[25–29]

While all of these measures add value and possibility, they only address fragmented process changes that are still constrained by disempowering structures and organizational pressures that place healthcare systems financial sustainability in competition with patient-centered care. Adding to the challenge is the autonomy of physicians who see little value in participating in collaborative efforts with other clinicians or advancing organizational priorities.[14] To support the call for clinician driven change, improved patient outcomes, and a safety culture by regulatory authorities, several accrediting organizations have embedded these requirements in their programs.[30,31] More and more the standards developed to reward excellence in the delivery of healthcare require integrative leadership with a strong patient-centered focus. The Magnet Recognition Program is framed by Forces of Magnetism.[30] Combined these forces promote quality patient care, nursing excellence and innovation.[30] The Joint Commission accredits organizations and is a leader in identifying high priority issues and actions needed to promote quality healthcare and resolve safety concerns. Joint Commission promotes viewing the healthcare organization "as a conglomerate of units, think of it as a 'system' – a combination of processes, people, and other resources that, working together, achieve an end."(p. 7)[31] And that end is the provision of high-quality, safe care to patients. Healthcare organizations that have received the Balridge National Quality Award must evidence a focus on mission and values, a culture of teamwork, transparent communication, rewards and recognitions, and leadership development.[32] These organizations and the Institute for Healthcare Improvement (IHI) are all working to make apparent a need for new synergies within healthcare systems and transformative changes in leadership.

Current leadership challenges in healthcare systems

While mandates for outcome improvements have arisen from government, regulatory and accrediting bodies, no comprehensive restructure of leadership systems and processes within healthcare have been developed. Much like industry, leadership is still seen as a role rather than a process that can be facilitated and extended beyond the administrative hierarchy. Demanding leadership from clinicians without considering the context in which that leadership must occur is an inadequate approach to making the changes needed in healthcare.[33] While leadership is an essential area for development, "if not of greater importance, is the need to create the conditions, which support and enhance new models of leadership."(p. 471)[33] Another dimension for consideration in the implementation of clinical governance and leadership is the disempowerment of the nursing profession.[34] Unless nursing as a discipline gains the respect of other professionals and organizational cultures are transformed where nurses work, the appointing of the title clinical leader will do nothing to change care delivery outcomes.[34] A survey of professionals related to their attitudes towards healthcare system reforms found variations explained by professional background.[35] This research determined that general managers, nurse managers, and nurse clinicians supported standardizing clinical systems and working in teams to address safety and outcome issues, the medical constituents rejected systemization of clinical initiatives and were skeptical about the value of team work.[35] At National Health Service (NHS) where physician leaders have been working with managers to improve outcomes, a recent study found that over the past five years of working together there were increased conflicts over goals, team work, and how decisions should be made rather than improved relationships.[36] Physician autonomy complicates safety and quality improvement initiatives and unless clinical leadership is fortified by administrative leadership, change will not easily occur.[14]

Despite growing demand for patient safety and improved healthcare outcomes, a 2009 survey of 1,275 hospital Chief Executive Officers (CEOs) in the US found that financial challenges were the number one concern in this group of leaders. This is the fifth year that this has been ranked as the most critical concern. While 76% of CEOs reported a concern for finances, only 32% reported patient safety and quality as primary issues and patient safety did not even make it into the top three areas of focus.[37] In the *Seven Leadership Leverage Points for Organizational-Level Improvement in Health Care*, IHI concludes that what is the "top of the mind" for executives

is what is being managed and that in healthcare organizations that are making demonstrative changes in quality and safety, CEOs monitor quality and safety performance measures as frequently as they monitor financial ones.[38] This report also recommends that the Chief Financial Officer (CFO) be a member of the quality team, focusing on core processes that address wasted time and effort rather than staff and supplies as areas for reducing costs.

While the need for service improvement, innovation and integration in healthcare is clear and reiterative around the globe, proposed solutions for addressing the issues lack empirical evidence of success and merely attempt to reformat roles and decision-making strategies without addressing the underlying authoritative structure and processes that restrict transformation. The essential question remains, how do we transition from a system that operates using top down leadership accentuating formal, non-clinical executive roles and business values to one that respects clinical value systems in light of financial complexity and explores leadership as a process shared among both clinical and business disciplines? Fundamentally, until clinicians, finance officers, patients, boards, and senior administrators collaborate to address system issues, effective change will not occur. Current clinical leadership and governance recommendations propose structural changes without addressing the larger issues of adopting a new leadership paradigm that promotes processes that bring together the divergent groups of stakeholders in healthcare.

Leadership for improvement, integration and innovation

Most healthcare systems continue to use leadership paradigms from the Industrial Age where the focus is on administrative roles, rather than framing leadership as a process that fosters collaboration needed for the Knowledge Age. Post-industrial leadership models are relational, value-based, and affirm a need to tap into the collective wisdom of members of the organization.[39] These theoretical transitions require moving from considering only the characteristics of the leader to also recognizing the role followers and context play in leadership.[39–41] Leadership theory is evolving from a focus on an individual to one that defines leadership as a process.[40,41] In this new context, leadership development is an "integration strategy" that promotes collaboration, communication, and achievement of common goals.[41]

Current theories of leadership also address system complexity and interactions that mobilize change and innovation.[42] Promoting and implementing quality innovations in an organization is a multifaceted process influenced by many individuals and factors.[43] In an extensive research review, the perspectives of clinical networks, degree of decentralized decision-making, adequacy of communication, and attitudes of opinion leaders were found to impact adoption of innovation. Additionally, top and middle leadership support and engagement influence change implementation.[43] Therefore, synergizing the will, ideas, and execution of all participants is critical for changing processes and improving outcomes.[38] In a recent study when changes in patient satisfaction were correlated with individual scores of effectiveness from three levels of leaders, the impact was not statistically significant; however, when leader's scores from all of these levels were aggregated, the relationship to patient satisfaction was positive and significant.[44] This supports the theoretical perspective that alignment of both formal and informal leaders within an organization impacts the incorporation of change and innovation in an organization. These findings echo a comprehensive review of the research on linkages between leadership and improvement.[45] Outcomes of this review affirm that actions by boards, CEOs, senior and middle leaders/managers, and physician and nurse formal and informal clinical leaders all influence, not necessarily in a linear fashion, the development and acceptance of innovation and improvement endeavors in organizations.[45]

To redesign healthcare services for effectiveness and efficiency and to improve patient safety and outcomes, organizations must redefine leadership practices in a way that promotes the development and diffusion of improvements and innovations. Current research evidence suggests that there is a requirement not just for formal administrative leadership, but also a need to develop integrated leadership processes throughout healthcare delivery systems. Healthcare organizations and policy advisors are comfortable with the current distribution of power and leadership; hence, the attempts to improve patient safety and outcomes using existing structure and bureaucratic processes. The failure of these recommendations to effectively resolve these concerns indicates a need for redirection. While administrative leaders are needed, so are informal and formal leaders at every level and department. Without embracing leadership as a collective action and the redistribution of authority throughout the organization, healthcare delivery will remain burdened by adverse events and randomized care. To address the growing public demand for accountability and improvement, healthcare delivery systems must be founded on complexity science and the principles of shared leadership.

Leadership framework for healthcare system transformation

"If the nation's healthcare problem requires significant shifts in thinking, new partnerships, reframing of old paradigms, disruptive innovation, and breakthrough transformational change, the understanding of leadership and leadership process and how leadership is enacted must change too."(p. 22)[46] Healthcare organizations must move from staid entities built around principles of stability to risk taking systems that are flexible and built to change. "Built-to-change organizations need to practice shared leadership … to get everyone moving in a new direction, leaders need to be dispersed across the countryside."(p. 22)[47] Three advantages to shared leadership have been noted: a) it spreads information and power throughout an organization, b) it promotes strong leadership succession capacity, and c) leaders that are closer to the service delivery and the customer see things that need to be addressed more readily than senior executives.[48,49] Leadership in the 21st century requires a move from a central command center that is all-knowing, to a dispersed cadre of leaders who are able to access knowledge from both autonomous participants and integrated teams.[48] Shared leadership does not preclude senior administrative direction; rather it engages formal and informal leaders in ways that allow for mutual influence and empowered change.[48] Shared leadership can be defined as a process that "often involves peer or, lateral influence and at other times involves upward or downward hierarchical influence."(p. 1)[49] The Center for Creative Leadership team defines leadership as "the process by which groups, communities, and organizations accomplish three tasks: setting direction, creating alignment, and gaining commitment."(p. 22)[46] While some might argue that the move to promote clinical leaders and governance is a method of shared leadership, the inability to engage physicians, the mistrust among administrators and clinicians, the limits placed on team authority, and the lack of empowerment in the nursing profession continue to negate these intiatives and demand a new perspective on how to mobilize leadership throughout an organization. Shared leadership requires trust, potency, and commitment (see referenced article for more specifics).[50] Shared leadership requires "knowledgeable and empowered individuals who are in possession of the necessary resources and authority."(p. 626)[51]

Complexity leadership theory (CLT) can be used to explain and ground shared leadership as a process. CLT describes leadership of complex adaptive systems (CAS) and bureaucratic healthcare systems clearly meet the definition of "neural-like networks of interacting, interdependent agents who are bonded in a cooperative dynamic by common goal, outlook, need, etc. They are changeable structures with multiple, overlapping hierarchies, and like the individuals that comprise them, CAS are linked with one another in a dynamic, interactive network."(p. 299)[39] CLT requires consideration of context, the patterns and persona of an organization, differentiaties between leaders and leadership, and can be used to distinguish management from leadership.[39]

Critical leadership theory promotes understanding of bureaucracies where formal chains of command (administrative leadership) must engage with informal leaders and processes that occur when individuals and teams work to develop and implement changes needed in the organization (adaptive leadership).[52] Adaptive leadership creates new ideas, innovation, and improvements that will foster success for the organization. This form of leadership may occur at any level within the organization and may be organized by individuals and teams at the frontline or in the boardroom. The third form of leadership describe in CLT is enabling leadership. Enabling leadership works like a liaison between administrative leadership and adaptive leadership to facilitate the adoption of new knowledge and work processes. Enabling leadership in healthcare systems balances the regulatory, rule-driven environment that drives administrative anxiety with the energy of new ideas and practices that need to be authenticated and approved through administrative leadership. CLT acknowledges the dissonance between administrative leadership and adaptive processes and calls this entanglement. In healthcare where there is strong administrative leadership, it is important to marshal and empower adaptive processes that will allow clinicians, engineers, information technology staff, and other support personnel to innovate and practice frontline leadership. It is also relevant that healthcare systems move from viewing entanglements as problems needing quick solutions to seeing them as opportunities for synergy, dialogue, and improvement. CLT helps view conflict and perspective differences as creative, untapped energy and languages the experiences reflected in current research on innovation and improvement in healthcare. CLT also offers a vocabulary that moves analysis of leadership from hierarchical, linear views to more dynamic, non-linear understandings of how people and events disrupt planned change.

Leaders (individuals throughout the system) in bureaucratic organizational forms need to understand the entangled nature of adaptive and administrative processes and manage this entanglement. Administrative leaders need to design systems and structures that allow the adaptive function

(adaptive leadership and complexity mechanisms) to operate effectively. Enabling leaders can help generate the adaptive function by operating in the interface between administrative and adaptive, fostering enabling conditions to promote adaptive dynamics and helping incorporate adaptive outcomes back into the formal administrative systems. Adapative leaders can influence adaptive dynamics by being adept at 'reading' effective emergent outcomes. All leaders need to understand that leadership is contextual and learn to interact effectively with the dynamic and complex contexts in which they operate. (p. 647)[52]

Conclusions and recommendations

In 2006 four pillars critical for creating an organization that wanted to be a collaborative system and one that could continually learn, grow, and improve were proposed.[53] The first pillar, that an organization must be committed to something beyond size and profitability and the last, that organizations must lead using a sense of shared values rather than authority and power, work synergistically.[52] Bringing disparate parts of an organization together involves finding a shared need.[52] This perspective contrasts sharply with a leadership philosophy that says organizations must be united around a shared goal. This is an unrealistic expectation in a system where clinicians value patients, chief executives focus on profitability, and boards desire sustainability. What can unite these team members is the shared need to provide high quality, safe patient care. "Patient centered leadership is about ensuring a focus on patients, their well-being and experience is the center of everything we do and when there are obstacles using various leadership qualities to overcome them."(p. 904)[5] "People can lead for personal or institutional reasons, or for the benefit of patients. We need the latter."[54] Focusing on this need through the often juxtaposed perspectives of senior business and finance leaders, nurses, and physicians will ultimately assure profitability; if all voices are considered equally and all members make decisions from the perspective of this shared need. Another pillar essential for innovation and collaboration is the creation of a partnership between administration and clinical staff.[53] Partnership by definition requires affiliation and relationship but does not necessitate similarity in role or function. Partnerships are founded on democratic ideals, equality, mutual respect, and empathy.[55] Partnerships recognize a need for each other in order to succeed. Finally, systems must be organized in a way that promotes, even requires, collaboration.[53] Health systems that want to make this happen must create space, time and resources where the partnering agents can meet, exchange information, and build trust. "Collaboration is defined as a dynamic transforming process of creating a power sharing partnership for pervasive application in healthcare practice, education, research, and organizational setting for the purposeful attention to needs and problems in order to achieve likely successful outcomes."(p. 6)[56] Together these four foundational tenets, or pillars, can redirect organizational efforts aimed at innovation, improvement, and integration. These propositions are supported by critical leadership theory and serve to help leaders visualize the essential changes in power and culture that are needed to address patient safety and outcomes. Power and authority must be spread throughout the organization, not just retained at the senior executive level. Recognizing a need for administrative leaders, adaptive leaders, and enabling leaders is a critical step towards improvement and innovation.

In this context, adminstrative leadership retains the responsibility for setting broad strategic direction, assuring sustainability, and managing oversight of compliance and regulatory adherance. Adaptive leaders are those on the frontline where innovation and collaboration is essential for designing more effective and efficient systems of care, promoting patient safety, and researching best practices. Adaptive leaders, most often physicians and nurses who are not in administrative leader roles, must team with other healthcare providers and patients to address the complex care needs of chronically ill and aging patient populations. It is these clinician, at the frontline of care adaptive leaders, that must be empowered and mobilized to implement change, pilot innovation, and recommend intervention and structure strategies. Clinicians want to improve care and are motivated to improve care, but unless they are held accountable, given authority, and rewarded for this kind of adaptive leadership in an organization, innovation will take too long and result in frustration by staff. Clinicians must also be trained to use leadership processes such as communication, collaboration, and consensus building, that promote effective teamwork. Administrative and enabling leadership processes that will accomplish these goals must ask the clinicians, "What is getting in the way of your being able to impact changes at the bedside?" And, when the clinicians answer, they must remove those barriers.

This will take trust building so that administrative leaders can relinquish some control and allow innovation in a highly regulated and risk adverse environment. Enabling leaders, those leaders that dance between the team giving care at the bedside and the executives assuring results, are key to building this kind of trust. These leaders must be trained

in administrative and clinical skills and must be able to teach and use leadership processes. They must understand the big picture strategic vision of the organization but also be articulate in reminding administrative leaders that the strategic need for accomplishing that larger vision, is patient safety and quality outcomes. The enabling leaders translate the innovations proposed through adaptive leadership processes into a language that allows administrative leaders to feel confident that these changes will support both financial and patient health.

IHI notes that the leaders in healthcare systems want to make healthcare better and safer, but they struggle with the "how" of undertaking this enormous task.[38] CLT provides a framework for rethinking old definitions of leadership and for mobilizing the collective energy of an organization. By making patient outcomes and safety the number one strategic goal of the healthcare system, all participants are united around a shared need. By defining leadership as a process and not just a role, organizations can develop leadership capacity throughout healthcare organizations, equipping participants with the ability to communicate, collaborate, and collectively address barriers to safe and effective patient care. By building integrated teams of patients, nurses, finance officers, physicians, and managers that participate equally in finding solutions and designing strategies, the multi-faceted expertise that can transform structures and processes will be liberated. By moving the authority and accountability for patient care, safety and outcomes throughout the organization, nurses, physicians, and allied health workers are mobilized and motivated to innovate and improve patient care.

Only the daring will take on the challenge of operating healthcare delivery systems with these priniciples. By retaining the best practices that the industrial age evidenced for administrative leadership and by taking the risk of opening up to the innovative practices of shared leadership and complexity science, new knowledge that promotes health and healing will be generated. Those organizations that accept this challenge will define leadership in healthcare for the 21st century and beyond.

Disclosure

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