Leadership and Clinician Managers: Individual or Post-individual?

Professor Liz Fulop
GBS Executive, Griffith Business School
Griffith University
Gold Coast campus
PMB 50 Gold Coast Mail Centre
Gold Coast QLD 9726.

Email: l.fulop@griffith.edu.au
Contact author.

Dr Paul Waight
Department of Management and Marketing
Central Queensland University,
Rockhampton, QLD

Email: p.waight with cqu.edu.au
(Paul Waight helped with the data analysis of Phase One of the study)

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Summary

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[1] A term used by Bolden, Wood and Gosling (2006)

Abstract

The paper reports on the first phase of a three part study of leadership and clinician management in the public hospital system in Australia. While many studies of leadership in health focus on its individual aspects, this paper argues, along with others, that leadership in the clinician management context cannot be understood from such a perspective alone. Clinician managers are described as "hybrid-professional managers" for whom most leadership theories do not easily apply. The paper examines the organizational and institutional contexts in which the clinician manager is instantiated and uses this to identify some problematical aspects of individualizing leadership in this context. It draws on empirical material from an Australian study to interrogate the individualistic approach and concludes by outlining how a post-individualist interpretation of leadership might be advanced in the clinician management domain.

Introduction

The paper reports on *The Leadership Study of Clinician Managers*, which is a three part study focusing on leadership in the middle levels of public hospitals in Australia. The study reported in this paper is of the first phase in which the principal aim was to identify possible case study "candidates" of exemplary leadership for the next two phases of the study. In undertaking the study, we have not pre-supposed that leadership is the domain of one person *per se* (see also Bailey & Burr, 2005: 22-24; Bolden, Wood & Gosling, 2006) or that by focusing on the qualities, attributes and competencies of leaders will help capture the essence of leadership in the clinician management context. Nor are we concerned with evaluating or prescribing what constitutes leadership *per se*, or universalizing it as a construct. Rather, we want to use the first phase of the study to reflect on some of its findings and to consider how a post-individualistic approach to leadership can provide a different way in which to study clinician management in terms of leadership processes. Focusing on a collective approach to leadership, which is in part what a post-individualist account suggests, is actually not new in the health field (see Denis, Langley & Cazael, 1996). A post-individualistic approach in health requires a shift to analysing the process of leadership under situations of persistent high ambiguity and complexity, as is the case in hospitals, where unclear goals, complicated hierarchical relations and difficulties in assessing results are persistent and endemic. These are contexts in which the creation of leadership teams is important but where such teams are under continual challenge and strain and thus, relations are perennially hard to maintain (Denis, Langley & Cazael, 1996; Alvesson & Sveningsson, 2003: 980).

The paper proceeds by considering leadership in the context of public hospitals and the challenges posed by this complex and multi-faceted work place for clinician managers. It examines a number of individualistic approaches to leadership in the health field and reports findings from Phase One of the study, which also used an individualistic approach for exploring identifying leadership cases for the next two phases of the study. It discusses some of the contradictory findings of the first phase of the study and uses these to explore how a post-individualistic approach to leadership might be developed and why it is important to do so when considering the clinician management context and theorizing about leadership.

Leadership and the clinician manager

Clinicians, who hold positions such as directors, managers or heads of clinical units and remain in clinical practice working alongside other clinicians such as doctors, nurses and allied health professionals, are by definition 'clinician managers' in the context of the Australian health care system. If they work in teaching (or tertiary) hospitals they might also be active academics and researchers and these clinician managers represent the most extreme example of the "hybrid professional-manager role" in hospitals (Kitchener, 2000: 137-9; Smith & Eades, 2003: 13-14). Clinician managers do not constitute a homogenous group in Australian public hospitals and the majority of them are staff specialists who are employed by the hospital and not in private practice, though there are some cases of Visiting Medical Officers who are in private practice but head up clinical units.

In terms of clinician managers, it is doctors who are traditionally singled out as being pivotal to health care reforms and to radical change within hospitals yet they are also recognized as the most difficult to integrate into the management systems of hospitals and are thus often targeted as the source of resistance to change (e.g. Carr et al., 2003). It is equally true that systems of administration in healthcare are not always supportive of the clinician manager role, especially doctors (see Scott et al., 2003) because of the myriad of problems these groups pose in terms of embracing management agendas and the predictable struggles that accompany moves to curb the jurisdictional domain of this highly professionalized group (Eastman & Fulop, 1997; Kitchener, 2000: 138-9; Doolin, 2002).

It is also widely recognized that clinicians and especially doctors, are pivotal to cost containment and rationalization of services in hospitals and that their leadership is posited as essential to reforms that have proliferated health systems in OECD countries. Yet despite extensive health sector reforms in many countries, including Australia, clinicians have managed to retain significant professional autonomy, and hence control, over the use, if not allocation, of resources in hospitals (Kitchener, 2000; Doolin, 2002; Dent, 2003). Clinician managers are often caught in the "cross-fire" between calls to increase their role in relation to improving performance *qua* outcomes and targets across a range of areas while at the same time, still drawing significant autonomy from their professional roles (Hoque, Davis & Humphreys, 2004).

The institutional context of the clinician manager is fraught with tensions and contradictions as well as time honoured power struggles. As Eastman (2001) has noted in the Australian context, finding a leadership role for many clinicians is difficult when rather than seeing many professional groups, such as clinicians as partners, some hospital administrators fear and resent these groups treating them as "amateur administrators." By the same token, he observed that many health professionals blame professional, non-clinically trained administrators for all their problems and see them as the main obstacles to overcome in order to improve the management of hospitals and clinical practice. He goes on to say that the complex hierarchies that health professionals work in, the intensely politicized nature of hospitals, the often poor alignment of responsibility, accountability and authority to perform one's job as a clinician manager, and the deeply embedded collegial system

of professional health workers (leading to tribalism and calls for autonomy and independence), pose unique challenges for leadership in health care at all levels of management (see also ; Kitchener, 2000; McDermott, Callanan, & Buttimer, 2002; Hoque, Davis & Humphreys, 2004).

The unique bureaucratic nature of hospitals, and the dilemma of the purported multiple forms of leadership existing in them, pose significant challenges for all concerned (Dopson & Mark, 2003). Sheaff et al. (2003; also Kitchener, 2000), for example, describe how the professionalized network of clinicians (i.e. doctors) is under threat in the UK due to a number of specific strategies being adopted in healthcare to remove control of resource decisions from doctors and vest them in management systems (e.g. evidence based medicine). They go on to describe how professional leadership has its own form of resilience with many clinicians remaining more strongly influenced by their professional allegiances and obligations, including deeply entrenched collegial/peer affiliations. They argue that professional leadership is *de facto* informal in many hospitals and that by creating clinician manager positions, hospital administrators have sought to actively integrate clinicians into systems of management and governance. Sheaff et al. also argue that hospitals are an example of what is termed a "soft bureaucracy" because of their strong professional-medical forms of legitimation and control. Typically, they say hospitals have a hard and rigid exterior of managerially-based practices that symbolize what the public and external stakeholders expect of such institutions in terms of accountability, transparency and responsibility but on a day to day basis, their inner workings are characterized by loosely coupled practices and control systems that legitimate the authority of clinicians (see also Clegg, Courpasson & Phillips, 2006; 397). So despite the fact that there have been widespread changes in the health sector and the emergence of a new paradigm of professional-managerial relations based on the so-called "responsibilization" of medical autonomy, which is accompanied by the integration of medicine and management around new structures and management interventions, the actions of senior doctors still remain the most crucial factor in achieving management aims (Ackroyd, 1996: 613, quoted in Dent, 2003; also Denis, Langley & Cazale, 1996).

By the same token, even though attempts are made to apply various forms of managerial tools to reign in professionals, especially doctors, Sheaff et al. point out that the system needs clinicians on-side for much of the time for it to work and hence, the pressures to co-opt the best professionals, and often the informal leaders, into the ranks of clinician managers, in the hope of exerting a more managerially defined notion of leadership over their peers and colleagues. This co-opting or enrolment serves to institutionalize "hard" governance with a "soft" form of regulated professional autonomy. In such contexts, clinician managers, who are mainly in the middle ranks of management, have to legitimate their leadership somehow, and most often they do this by what Alvesson and Svenginsson (2003) describe as contradictory logics and responses that lead to serious identity issues and confusion over what is good or bad leadership and often based on popular imagery and language. In taking on such identities, Alvesson and Svenginsson (2003: 984) also suggest that there will be considerable identity struggles at the individual level as the leadership talk, usually in the form of various popular competency-based studies, are promulgated at the corporate level to exert some control over professional identities.

The high ambiguity of hospitals , especially given their crisis driven nature and the uniqueness of clinical decision making, have also been proffered as major factors militating against the universal application of many management and leadership theories and practices in the hospital context (Smith, 2002; Smith & Eades, 2003: 14). Unlike "high efficiency" organizations (Weick & Roberts, 1993), where errors and mistakes and even crises are understood in terms of standard "bottom line" measures and indicators, such as the market, hospitals lack a similar arsenal of measures and indicators and are characterized as "high reliability" organizations because their performance is most often associated with averting accidents, disasters, deaths and the like. Smith (2002: 1) likens acute hospitals to non-linear systems where there are few simple cause and effect relationships to use for assessing outcomes or performance across the board. In the latter case, it is usually adverse events, medical errors, especially patient fatalities, patient safety and breaches of ethical standards, that often signal a lack of reliability in the system and even these are subject to politicization by a range of stakeholders. Moreover, given the lack of predictability in diagnosis and treatment, which involves decision making that is ill-defined and complex (Smith & Eades, 2003: 16), and the technical and complex nature of many interventions, including routine procedures, crises and adverse events are a major threat in many areas of clinical practice.

According to Smith and Eades (2003: 16-17) as well as having medical knowledge and skills, the clinician manager also has to have knowledge of management theory and practice but also the skills to create team-based work environments and processes of learning that can deal with non-routine problem solving and decision making. While Smith and Eades are interested in rethinking management competencies, their work also suggests that leadership is likely to be far more than the sum of one person's heroic qualities or style in the clinical management context (e.g. Hamlin, 2002; Bailey & Burr, 2005; Alimo-Metcalfe & Alban-Metcalfe, 2005). Indeed, the high performing clinical unit is most likely to be a combination of different people who perform a variety of leadership roles across different contexts and times. Smith and Eades (2003) also say that the nature of communication processes between patients and medical staff and the problems of managing the uncertainty that typifies the non-routine problem solving and decision-making that surrounds prognosis and treatment, provides important insights into theorizing about competence and leadership. They suggest that effective dissemination of knowledge and "divergent expert opinions" are affected by institutional boundaries and these influence how people learn from their experiences and those of others and are able to share knowledge, particularly in the context of interdisciplinary teams that are the dominant contexts in which most clinicians work. To individualize leadership at this level is to reinforce the core problem of much of the medical profession's history of dealing with medical errors and adverse events, which has been to create cultures of individual blame that instils fear and secrecy and inertia in reporting such events and thus preventing learning from mistakes and correcting them (Frith-Cozens, 2004; Leape, 2007).

What constitutes leadership in the context of clinician management has become a political and ideological battleground in which the focus on individual leadership predominates. Yet the above discussion suggests that there are other ways in which leadership in this context needs to be theorized and researched.

Research on health leadership

While there have been many studies examining health leadership, the focus on clinician management and leadership is still an under-researched area, especially where doctors head up clinical units. Moreover, much of the recent research on health leadership in the UK falls into what has been termed a competency and capability approach (Smith & Eades, 2003; Bolden, Wood & Gosling, 2006) in which the principal aim is to catalogue key leadership qualities, attributes and capacities of individual leaders in order to provide better training and selection of health leaders to enhance performance related outcomes. While much of this research is instrumental in its orientations and prescriptive in its purpose, the extent to which these works can be universalized from one context and country to another remains contested (see Hamlin, 2002: 247; Smith & Eades, 2003). Nonetheless, there is a strong normative flavour in much of this research and while qualitative research is often used, it is used to create a categorisation, labelling and sorting approach to leadership studies. These approaches represent a dominant paradigm in the field and for this reason they merit attention. They form the core of the individualistic approach and this approach is also attracting attention in health departments throughout Australia.

Studies conducted by Alimo-Metcalfe and Alban-Metcalfe (2001, 2005) have dominated leadership studies in health in the UK. The latter research has focused on transformational leadership studies in public sector organizations with staff being the main informants, thus focusing on "nearby leadership" (Powell, 2004). The researchers take the view that transactional and transformation leadership are both needed to be effective leaders but that transformational in the UK context is about enabling others and doing transactional tasks in a transformational way. These studies are also significant in that they identify gender differences and are inclusive in their approach and analysis, questioning gendered constructs such as empowerment and theorizing gender implications of the categorisations of leadership dimensions. One study involving Alimo-Metcalfe (McAreavey, Alimo-Metcalfe & Connelly, 2001) specifically asked health leaders about excellent leadership but the study itself did not focus on clinician managers or necessarily health leaders. It did include gender dimensions though these seem to differ from later studies work with Alban-Metcalfe.

The Transformational Leadership Questionnaire (TLQ) was developed by Alimo-Metcalfe and Alban-Metcalfe (2001, 2005) for use in 360º feedback and is one of the most well-known leadership tools in the UK. It incorporates 14 themes or characteristics organized into three overarching themes; Leading and developing others; Personal qualities; and Leading the organization. These are compared to performance related outcomes as well. The questionnaire was devised from constructs developed from data elicited from roughly equal numbers of male (44) and female (48) managers from local government and the NHS. The managers in their interview survey ranged from Chief Executives through to middle managers. From their first phase material, 48 groups of constructs or leadership dimensions were developed. Once the constructs were identified, two pilot questionnaires were designed, one for local government and one for the NHS (Alimo-Metcalfe & Alban-Metcalfe, 2001). The NHS version of the TLQ omitted the *Political sensitivity and skills* dimension as the authors considered that the latter was unique to local government in terms of influencing politicians. The pilot study for the NHS version

of the TLQ was conducted across a range of NHS Trusts, with 1098 responses being received. Of these responses, 467 were male and 672 female. The respondents ranged from Board/Chief Executive to Middle/Section-Unit Head, and comprised of both managers and doctors. Our own research found some similarities with the TQL and especially gender, but it is referred to as UK-based model with limited claims for universalization.

Hamlin (2002) also used a combination of qualitative and quantitative research methods to develop a Generic Model of Managerial and Leadership Effectiveness. His work was specifically set in a NHS Trust hospital and only focused on middle managers. It did not seek to replicate the TQL but rather used qualitative methods, including critical incidents, to identify effective and ineffective leadership. He triangulated his findings with the TQL and other studies in order to test for the generalization of the model, though the single sample hospital was acknowledged as a limitation. The positive indicators of good leadership were grouped into six dimensions; effective organisation and planning/proactive management; Participative and supportive leadership/proactive team leadership; Empowerment and delegation; Genuine concern for people/looks after the interests and development needs of staff; Open and personal management approach/inclusive decision making; and Communicates and consults widely/keeps people informed.

Hamlin's negative indicators paint a picture of dysfunctional leadership and are comprised of five dimensions and these are: Shows lack of consideration or concern for staff/ineffective autocratic or dictatorial style of management; Uncaring, self-serving management/undermining, depriving, and intimidating behaviour; Tolerance of poor performance and low standards/ignoring and avoidance; Abdicating roles and responsibilities; and Resistant to new ideas and change/negative approach. As our material was expressly collected to identify characteristics of 'Exemplary Leaders, we would not expect to find support for these dimensions in our schema. We did, however, find positive mirror images for each of Hamlin's negative aspects.

Lastly, the NHS Leadership Qualities Framework (LQF) was developed by the Modernisation Agency Leadership Centre which is part of the NHS. The framework was initially developed as a competency model for Chief Executives and Directors within the NHS, but has since been extended to apply to all leadership levels in the service. The final framework was developed in consultation with all levels of leadership in the service using techniques such as focus groups and interviews.

The LQF comprises three clusters of leadership qualities considered to be important in the delivery of effective health care and the first comprises: Personal Qualities: self-belief, self-awareness, self-management, drive for improvement and personal integrity. The second cluster of qualities is more strategic in nature and is entitled: Setting Direction. Leadership qualities relating to direction-setting are: seizing the future, intellectual flexibility, broad scanning, political astuteness and drive for results. The third is called Delivering the Service, and comprises of: leading change through people, holding to account, empowering others, effective and strategic influencing and collaborative working. As with the TQL and Hamlin's leadership dimensions or characteristics, several of the LQF leadership qualities also parallel those found in Phase One of the current study.

Phase One of the Australian study

We never set out to test, replicate or adopt any of the above studies of leadership. Nor did we commit to a rigorous methodology but rather, our aim was a much modest one. In order to satisfy ethics approval, we needed a transparent, "arms length" method of selecting case study candidates for the next phase of our study,. Our project is funded through an area health service and they were concerned with bias in sample selection, having applied scientific criteria to our proposal. Phase One did provide us with an opportunity to engage with the approaches described above and to reflect on how to refine and proceed with the next two phases of the study.

In undertaking Phase One, we used a mail out survey, which was sent to past members of the Management for Clinicians Program (MFCP), and used an open-ended question to elicit our main empirical material. Approximately 400 clinician managers, which included doctors, nurses and allied health professionals, had participated in the program from 1990-2001 (see Eastman & Fulop, 1996). At the time of the survey in mid-2006, the majority of respondent were still clinician managers. Access to old mailing lists was difficult and those provided were incomplete and thus we did not survey all participants who had participated in the Program. A total of 162 questionnaires were sent out in the first round in which the respondents were asked to nominate a doctor with whom they had worked over the last five years, who is still a clinician manager and who, in their opinion, is an exemplary leader and then, in no more than 50 words, give reasons for nominating this person. Ethics approval required we reveal the purpose of the study and thus, we had little scope to avoid asking a direct leadership question (see Alvesson & Deetz, 2000: 50-60). The survey was anonymous, though colour coded for gender identification. A further survey, with a mail out of 58 questionnaires, was sent to clinical heads in Queensland's tertiary hospitals. Except for one doctor who attended the first MFCP, no others from this State participated in the MFCP with Queensland preferring to run its own. From the two samples, 33 useable responses were received from the MFCP sample, and 9 from the Queensland group. In both groups, the majority of responses came from males with only one third coming from females, and this reflects the gender composition in the medical field.

Two sets of analyses were initially undertaken, the first by Investigator 1 who has a PhD and is experienced in qualitative analysis but is more comfortable with a positivist ontology and methodology. He was not given any detailed information about the study and asked to go away and independently analyse the material. The second analysis was undertaken by Investigator 2, who is the main author, is a female and is more comfortable with qualitative methodologies.

Investigator 1 undertook two separate analyses using cut out answers to ensure all elements in the responses were included and then put into computer graphics. On completing the first theme analysis, he realised that some themes were not homogenous, and may have been made up of groups of text that were somewhat disparate. The two analyses are compared, along with a breakdown of the responses by gender. It can be seen that females nominated vision and motivation to a greater extent than males. On the other hand, males proffered most of the other dimensions, which of course is also indicative of the over-representation of males in the sample.

Table 1. Emerging themes and gender analysis of Investigator 1

Original Theme Analysis	Second Theme Analysis	N	Female	%	Male	%
Vision	Vision/strategic	11	7	64%	4	36%
Leadership	Leadership skills	7	2	29%	5	71%
Teams and shared decision-making	Builds teams/inclusive	13	2	15%	11	85%
	Problem solver/decision maker	9	3	33%	6	67%
Communication skills	Active listener/communicator	9	2	22%	7	78%
Research, education and training	Motivator/encourager	5	5	100%	0	0%
Quality of patient outcomes	Staff development, teaching and research	12	2	17%	10	83%
Change agent	Change agent	12	6	50%	6	50%
Clinical skills	Respected clinician	12	4	33%	8	67%
	Respected professional	8	2	25%	6	75%
Managerial skills	Managerial ability	16	2	13%	14	88%
Influence in the wider context	Organisational skills and influence	7	2	29%	5	71%
	Leads a respected unit	11	3	27%	8	73%
	Advocate	4	1	25%	3	75%
	Helping/caring	2	1	50%	1	50%
Personal qualities	Personal qualities including dedicated, pragmatic, articulate, good humoured	17	6	35%	11	65%

Over-representation of female responses

Over-representation of male responses

Investigator 2's method of analysis was less technical and used a large spread sheet to manually record each piece of text in a grid, adding cells for each new theme that arose. Investigator 2 also made notes about interesting overall impressions formed by certain responses and kept these for later reference and discussion with Investigator 1. Thirteen themes were put forward but with reservations expressed regarding the ambiguity of some terms and potential aggregations that might be made at a later stage. The results were put into a spreadsheet for comparison with Investigator 1's themes. A gender comparison was also conducted on the themes put forward and the results are detailed in Table 2. The overall response pattern also appears to be different between the two sets of empirical material with very different labelling. Moreover, in Investigator 2's analysis, females were over-represented in the areas of vision, encourages change and skilled at hospital bureaucracy. Males, on the other hand, were over-represented in the categories of communication, clinical skills, created a centre of excellence, fair and balanced, advocate, people skills and inclusive/empowers. Similarities between the gender distribution in responses in the two analyses were found in vision for females, and inclusiveness, advocate, communication and centre of excellence for males.

Table 2. Investigator 2 theme analysis

Theme Analysis	N	Female	%	Male	%
Communication	9	4	44%	5	56%
Clinical skills	9	3	33%	6	67%
Visionary	8	5	63%	3	38%
Centre of excellence	4	0	0%	4	100%
Fair/balanced, democratic	7	3	43%	4	57%
Advocate	5	1	20%	4	80%
People skills	5	2	40%	3	60%
Inclusive/empowers	5	1	20%	4	80%

Team player	2	1	50%	1	50%
Encourages change	5	3	60%	2	40%
Encourages innovation	2	1	50%	1	50%
Skilled at hospital bureaucracy	3	2	67%	1	33%
Good humour	4	2	50%	2	50%

Over-representation of female responses

Over-representation of male responses

Reflecting on the exercise

Before proceeding further, the two Investigators undertook a form of "Rich Points" (Agar. 1996) analysis to reflect on how the themes had been interpreted. Rich points – a term coined by Agar (1999) - can be found by looking at empirical material to identify those aspects that are incomprehensible, present contradictory findings or departures from expectations, involve a repetition of terms or ideas (themes), reveal a packaging of old ideas as new ones or arouse anxiety, anger or some other emotion on the part of the researcher. Agar likens this to a form of noticing rather than theory building and while it is not our intention to follow his approach to the letter, he states that rich points are a way of translating qualitative material that focuses on the researcher's reflective activity as distinct from respondents or 'targets', as he refers to them. Given that we had no direct contact with our respondents and we were really second-guessing much of what we were interpreting in our themes, Agar's reflective approach helps counter-balance pre-suppositions and the tendency to look for what one wants to find. It prevents unconsciously bracketing ideas that can readily occur because of the gross compression and distortion of empirical material that categorisation entails (Bolden, Wood & Gosling, 2006). However, this form of reflection is focused on a specific method or level of interpretation and is not reflexive in terms of employing an array of interpretations of the material (Alvesson & Sköldberg, 2000: 248).

In terms of departure from expectations, the mention of humour was an interesting inclusion. Humour has been explored in the context of leadership studies (e.g. Avolio, Howell & Sosik, 1999; Priest & Swain, 2002) though its meaning in the area of clinician management is likely to be different. A study by Dent (2003) gives some clues to the type of humour that might be alluded to in these responses. In the hospital context that he studied, irony as an expression of humour, was employed to manage tensions and conflicts between medical staff and management under a period of significant threat and uncertainty – terms such as "Prayer Meetings" were used to describe strategy meetings and other colourful expressions and language were deployed to disrupt and challenge common sense understandings in order to persuade and allay fears and build new coalitions of support or actor networks. The point that Dent makes though is that irony and rhetoric are important as means of persuasion and identification with particular audiences to influence others and are also a part of a cultural system that has its own rules of manipulation and action (Dent, 2003: 111). It is likely that humour is particularly important in heterogeneous cultural contexts, such as hospitals, with divergent professional groups who are constantly being enrolled into projects of managerialism. However, grim humour, which is not a part of irony, can also be a common in hospitals for dealing with grave and unpleasant events, particularly around death and illness.

Investigator 1, who had not previously worked with clinician managers, was surprised to find the themes of professional standing, being expressed in terms of a skilled clinician and the standing of the clinical unit, figuring so prominently in the responses. For Investigator 2, this confirmed a belief that leadership in the clinician management context does not sit well with heroic and universalistic prescriptions found in the general leadership literature, and with studies of leadership in health that focus on individual aspects (see also Smith & Eades, 2003). It also reinforces the claim made by Alvesson and Svenginsson (2003: 983) that leadership discourses in knowledge intensive contexts are often also interpreted in terms of esteem-enhancing identity work and with celebrating the idea (myth) of professional discretion and the denial of bureaucracy and control.

The gender differences noted were interesting inasmuch as they confirmed previous studies on gender and leadership, both in terms of self-reporting on leadership qualities and perceptions of leadership by men and women, especially the visionary aspect for women (see Rosener, 1990; Wilson, 1995; Powell; 2004; Alimo-Metcalfe & Alban-Metcalfe, 2005).

The theme analysis yielded repetition of terms that represented common themes found in the leadership literature, especially the popular discourse of leadership. Alvesson and Svenginsson (2003: 984) suggest that highly professional groups are likely to be well versed in the popular leadership discourse and appropriate the language of leadership found in the management training and the business press as a part of being progressive and informed professionals. However, the majority of respondents had participated in the Management for Clinicians Program so their ability to draw on well known leadership discourse also provides evidence of repackaging ideas, which was to be expected, but themes also contained unexpected answers.

We noted that some respondents nominated clinician managers who did not display the majority of the common attributes or categories that dominated the themes, but had a combination of others that made them appear “outside the square” of conventional notions of leadership, and these were usually women (e.g. ‘good work-life balance’ was mentioned). Nonetheless, following the logic of theme analysis and aggregation, which in fact by this stage was starting to frustrate us, items that had three or less “scores” were rejected so, “quality and best practice: and “forming multidisciplinary teams”, for example, were excluded.

From discussion of the similarities and differences between the two analyses, the number of themes was reduced to 23, but there was no special reason for choosing this number. These themes were graphically represented so that overlaps could be considered. As several of the smaller theme groups appeared to have many similar characteristics, and seemed to be addressing a central theme of motivation, empowerment, interpersonal skills and caring, it was decided to group these together into a theme titled “Motivates, empowers, cares for people”. The concentration of Supports and guides staff, Motivator/encourager, Empowers staff, Fair, democratic/balanced, Compassionate/caring, Leads by example, and People skills resulted in a schema of 17 themes ranging from Professional standing and Managerial efficacy through to high-level and generic leadership attributes such as

Vision/strategy, Motivates, empowers, cares for people, and Organizational skills/influence/political/bureaucracy. The themes are shown in Table 3.

Table 3. Seventeen leadership themes

New Dimensions (categories)	Count				
	Total	Male		Female	
Motivates, empowers, cares for people	16	12	75%	4	25%
Managerial efficacy	15	12	80%	3	20%
Good communicator	14	8	57%	6	43%
Skilled clinician	13	7	54%	6	46%
Encourages change/innovation	13	6	46%	7	54%
Inclusive decision making	13	9	69%	4	31%
Created/leads respected unit	11	8	73%	3	27%
Team player/builder	11	7	64%	4	36%
Vision/strategy	10	4	40%	6	60%
Organisational skills/influence/political/ bureaucracy	9	6	67%	3	33%
Respected professional	9	7	78%	2	22%
Staff development/education and training	8	6	75%	2	25%
Professional standing	7	6	86%	1	14%
Problem Solver	7	5	71%	2	29%
Advocate	6	3	50%	3	50%
Good humour	5	3	60%	2	40%
Balanced approach	4	3	75%	1	25%
Totals	**171**	**112**	**65%**	**59**	**35%**

These themes were also analysed in regard to the gender of the nominator with some differences becoming apparent. Male respondents appear to be over-represented (75% or more) in the areas of Motivates, empowers and cares; Managerial efficacy; Creates/leads respected unit; Respected professional; Staff development; Professional standing; and Balanced approach. On the other hand, female respondents appear to be over-represented (54% or more) in the area of Encourages change and Vision/strategy.

Comparing the themes across other categories

The decision to compare our findings with other category-based studies was done out of curiosity and to demonstrate that we had not made an arbitrary selection of our cases. Although our analysis of the material in Phase One has produced differently labelled dimensions, the three fundamental themes of the TLQ are evident in both the data and our analysis. Table 4 illustrates the relationships between leadership characteristics identified in our study with those of the TQL, Hamlin, and the LQF. It can be seen that empowering others, leading change through people, working collaboratively, focusing on the future, team building and being politically and strategically effective are qualities that appear to be common across many of the typologies of interest, though not necessarily all of them.

Table 4. Comparison of leadership characteristics

Phase One	Hamlin	TLQ	LQF
Motivates, empowers, cares for people	Genuine concern for people/looks after the interests and development needs of staff Empowerment and delegation	Showing genuine concern Enabling Acting with integrity being honest and open	Empowering others
Managerial efficacy	Effective organisation and planning/proactive management		
Good communicator	Communicates and consults widely/keeps people informed	Inspiring others	
Skilled clinician			
Encourages change/innovation		Encouraging change	Leading change through people
Inclusive decision making	Open and personal management approach/inclusive decision making		Collaborative working
Created/leads respected unit			
Team player/builder	Participative and supportive leadership/proactive team leadership	Focusing team effort	
Vision/strategy		Building shared vision	Seizing the future
Organisational skills/influence/political/bureaucracy		Networking and achieving	Political astuteness, Effective and strategic influencing
Respected professional			
Staff development/education and training	Genuine concern for people/looks after the interests and development needs of staff	Supporting a development culture	
Professional standing			
Problem Solver		Resolving complex problems	
Advocate			
Good humour			
Balanced approach		Being honest and consistent	

The characteristics that do not appear to be shared are of significant interest. The LQF does not make mention of managerial efficacy, communication skills, staff development, professional standing, problem solving, humour or a balanced approach. The lack of inclusion of basic management skills may be due to the fact that many approaches to leadership tend to separate characteristics, skills and abilities into two categories; management and leadership. This approach may well be flawed, as it is hard to conceive of a good leader who does not have the complementary management

skills. Alvesson and Svenginsson (2003: 985) document in detail the confusion and contradictory claims that people in knowledge intensive firms make in relation to leadership and micro-management, and the significant challenge that most middle managers would have in sustaining the grandiose notions of leadership that many academics and leadership studies promulgate. In a similar vein, Hamlin (2002) notes the preponderance to separate management and leadership theoretically thereby distorting for many middle managers critically important elements of their roles, instead favouring a heroic leadership model (also Alimo-Metcalfe & Alban-Metcalfe, 2005). Despite this, Hamlin's own categorisation fails to mention the skilled clinician, respected professional and unit aspects of leaderships, which lends support to Smith and Eades' (2003) arguments about the problems of theorizing leadership in the clinical context without reference to the medical-technical complexities of the situation. These unique characteristics might also appear because we limited our survey to clinician managers only. Thus, it can be seen that the LQF, for example, fails to address the more mundane, but important characteristics that clinician managers find important in other clinician managers. In the current study respondents appear to believe that a clinician manager requires more than just typical leadership qualities (see Smith, 2002) and lends support to the claim that following a leadership qualities approach ignores the largely uncertain, fragmented and incoherent nature of leadership (Alvesson & Svenginsson, 2003: 985).

Discussion and conclusion

Researching leadership presents a number of challenges no matter in which context it is undertaken (see Alvesson & Deetz, 2000: 50-60; Bolden, Wood & Gosling, 2006). Under the heading: "The sorry state of the art of leadership research", Alvesson and Deetz catalogue the most common problems facing leadership research and they argue that normative based research only finds what it sets out to and fails to appreciate the nuances and subtle ways in which leadership is practised in different settings. Bolden, Wood and Gosling (2006) go further in criticising much of the NHS leadership research in the UK because of its preponderance to produce categorisations of 'good' and 'effective' leadership that are translated into leadership competencies and capabilities that tell us nothing about the experienced and lived nature of leadership. Despite the plethora of studies that now use qualitative and mixed methods (including grounded theory, focus groups, in depth interviews, observations, critical incident research and the like), the dominant paradigm of research in health leadership, especially in the UK, is still within an individualistic, competency and capability approach that is epitomised by the evidence-based management movement. Bolden, Wood and Gosling see this manifesting in leadership studies that crudely "tearing apart" what are really leadership relationships into discrete areas such as leader and followers, for example.

Instead Bolden, Wood and Gosling suggest adopting an approach to leadership that is focused on meanings and understandings and treating leadership as one form of social influence that is embedded in institutional contexts in which relations, connections, dependencies and reciprocities are important parts of giving shape and substance to leadership as an emergent and socially constructed phenomenon. They term this a "process studies perspective" in which the focus is no longer on an individual leader but on processes of social influence in situated contexts, that are studied using an ethnographic methodology (also see. Denis, Langley & Cazale, 1996;

Dent, 2003). This echoes Alvesson and Deetz (2000) who also suggest that what we need is qualitative research that is sensitive to local practices and institutional contexts and avoids researchers one-sidedly deciding on what does and does not count as leadership (also see, Jackson & Parry, 2003: 3; Grint 2000, 2-4 for similar arguments). Bolden, Wood and Gosling propose some interesting ways of studying leadership in the quest to arrive at a post-individualistic approach, in which we are able to move beyond the individual while at the same time not destroying his/her significance and integral role in leadership processes. At the very least, they say we should do three things: (i) study "…a representative range of stakeholders and approaches to leadership"; (ii) identify if leadership is considered as individual qualities as distinct from collective ones; and (iii) explore other competing accounts and interpretations of leadership.

Denis, Langley and Cazale (1996) offer a more concrete manner in which to consider a post-individualistic approach to leadership based on their research of strategic change in a hospital setting, in which they specifically focus on how collective leadership emerged and the tactics used by those in the leadership team and the impact these had on the change process and the leadership roles of the team. While their case study is not meant to be generalized their processual approach and the five propositions they suggest to explain the dynamic and fragile nature of leadership teams in highly ambiguous contexts., provides a concrete example of a post-individualistic account of leadership. Their work also accounts for potential leadership failures and setbacks and to the importance of context and symbolic management of meanings. The approach is not dissimilar to the work of Dent (2003) on actor network theory and the role of top management teams. Both these approaches also lend support to Grint's (2000) notion of acts of leadership that we suggest need not be individualized.

In developing our case studies, we are unable to use an ethnographic approach but rather we rely on interviews with a range of stakeholders who are associated with the clinical leaders nominated for study. Our interviews will be conversational (Grbich, 1999; also Scott et al., 2003) and involve repeat interviews with clinician managers in Phase Two and with co-workers in Phase Three. We will use different forms of questioning that deliberately avoid asking about leadership per se until the end of the study. In the second round of interviews with clinician managers we will draw on critical incidents relating to crisis in the unit, "landmark" events for the unit, major strategic changes, and any other significant occurrences that are proffered in talk about the unit. We will rely on narratives accounts, stories, metaphors, the use of irony and rhetoric to further explore how leadership figures in the accounts of clinician managers and their co-workers and what kinds of discourse of leadership emerge. We have chosen to use topics of discussion around the areas that we think can reveal something about post-individualistic leadership. At the conclusion of the study we will ask clinician managers and their co-workers to discuss what they believe leadership means to them. While this is a work-in-progress, Phase One of the study has already led us to look beyond an individualistic account of leadership.

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