LEADERSHIP IN HEALTHCARE AS A SOLUTION-ORIENTED PRACTICE

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ABSTRACT

The paper re-theorizes leadership in healthcare as a solution-oriented practice aimed at improving decision making in healthcare contexts. The first part draws on relational leadership theory and in particular, the idea of 'skillful leadership processes' that is theorized as complex political decision-making. Two constructs are identified - intelligent social actions and flexible social order – that are used to link relational leadership theory to the Cynefin framework . The latter approach draws on a multi-ontology sense-making perspective to identify five domains of decision making. The paper discusses the use of this framework in healthcare and its practical relevance to reform and change.

Keywords: healthcare, leadership, decision making, policy and reform

Where do you begin to theorize about leadership when typically the healthcare system in many OECD countries, is portrayed as complex, crisis prone, bureaucratic, and organized around powerful professional silos or fiefdoms, beyond the control of lay managers, under-resourced and funded and in desperate need of leadership to enact change and reform. Healthcare organizations face significant challenges, including the relentless scale and pace of reform and change in healthcare systems throughout the OECD. Cost-cutting and budgetary constraints, doing more with less in the face of rising costs and demand for services, are endemic features of healthcare. Leadership, and clinicians engagement in the management of healthcare services, is one of the 'magic bullets' put forward by policy makers as being critical to healthcare reform; alternatively, their lack of engagement is used to wage the 'blame-game' for failed or stalled reforms (Hewison & Griffith, 2004). In healthcare leadership is mostly framed as an individual skill associated with people who are in positions of management, thus promoting a heroic leadership ethos and one in which the leadership challenge is all about engagement or lack thereof (see Bolden, Wood & Gosling, 2006; Dickinson & Ham, 2008).

This paper seeks to move away from the leadership challenge approach found in many studies in healthcare to a solution-based one that focuses on decision making and dealing with the day-to-day dilemmas and challenges of change and reform (Ham 2003). The paper draws on two different leadership approaches, one that has not been previously applied to healthcare, relational leadership theory (RLT) and the other (the Cynefin framework) that is starting to be adopted in different healthcare contexts. The

paper thus makes an original contribution in developing leadership understanding in healthcare as a solution-oriented practice with a practical intent.

LEADERSHIP AS SOLUTION-ORIENTED PRACTICE

Bate, Mendel and Robert's (2008: 175) book, entitled *Organizing for Quality*, explores seven in-depth case studies from leading hospitals across three counties (UK, US and the Netherlands) that have done exceptionally well (drawing on an evidence-based approach) in their improvement journeys. What they all possessed above all was an ability to identify the challenges they faced and then do something about them. The study focuses on cultural and organizational processes of Quality and Service Improvement (QI) research and set out to look at organizations that were known to be successful early adopters of QI. The study used a qualitative, case study approach (especially narratives) and was able to identify the common challenges that face organizations embarking on such a journey. The researchers never discovered a 'one best way' to improve service quality but found that each organization had its own "template" for change. . The study concluded that an enabling structure and culture were two of the most important things needed to sustain change associated with high performance. They also noted that the mindset needed to sustain a successful journey is one that is flexible and opportunistic because change, was dynamic and often unpredictable, processual and emergent. Importantly, the study takes a different view of leadership than found in most studies of healthcare settings by showing how a variety of leadership forms were found, ranging from macro examples (e.g. collective and distributed, charismatic leadership of a single individuals, knowledge leadership) to micro ones (e.g. leading by example, mentoring and mobilization of leadership, and the division of leadership between technical and political tasks). Bate et al argue that these forms of leadership were provided as *solutions to generic challenges* (structural, political, cultural, educational, emotional, physical and technological) and not as leadership challenges in their own right. The study suggests that in healthcare, a focus on leadership as solutions to generic or common challenges and dilemmas offers a useful way to approach the topic. Ironically, the study did not explore how decision making was enacted in these different contexts, however, reading the text, one finds many examples of decision making processes being discussed (e.g. see pages 62-64 for

example) and it is this aspect of Leadership which needs to be better understood and to which we now turn.

LEADERSHIP AS DECISION MAKING

Hosking's work on 'skillful leadership processes' (Hosking 1988; Hosking & Morley 1988) is considered to be ground-breaking in terms of developing the 'process' or 'relational' approach to leadership that is based on a decision-making approach (see Grint 2000; 2005; Bolden, Petrov & Gosling 2008: 360; Uhl-Bien 2006; Fairhurst 2007; Peck & Dickinson 2009: 69-70). Hosking (Hosking & Fineman 1990; Hosking & Bouwen 2000) treats leadership as a special kind of organizing activity which has to be understood as *complex, political decision-making* because it is through particular core processes that social order is either maintained, improved or allowed to decline (see Figure1). Social order is shaped by relational activities which are grouped around cognitive, social/anthropological, political and affective processes (Hosking & Fineman, 1990). Hosking presents the social order as a negotiated order that is inherently political and is collectively shaped through decision making as a 'bottom-up' process. She presents organizing as a co-constructed process in that the '...connectedness, complexity and tacit qualities of organizing arise from interdependent relations between persons and contexts' (Hosking & Fineman 1990: 587). Drawing on a social constructionist approach (Uhl-Bien 2006), she argues that leadership is skillful (effective) to the extent that a 'flexible social order' is achieved and this means leaders (those who are perceived and expected to contribute most to the shaping of social order) being able to produce persuasive scripts and schemas that will engage with and connect to the central values and interests of participants, hence shaping and re-shaping social order and a collective social identity. She also later introduces the idea of 'intelligent social action' to further elaborate on how actors construct social order that help them add value to their lives.

[Insert Figure 1 here]

Originally, Hosking framed her approach emphasizing the cognitive and social processes in which, as Peck and Dickinson (2009: 72) suggest, context is not treated as independent of relational activities – including the sense making – of participants but rather, that values and interests are implicated

in how past, present and futures are constructed, how cause-effect relations are understood, and more generally, the creation of a social order in which participants will 'do business'. As Hosking and Fineman (1990: 588) say,'...actors to some extent choose, and to some extent construct, order in and through their relationships with others. However, actors are not free to make just any social order they like.' especially within healthcare settings.

The concepts of 'projects' and intelligent social action are used to explain why some contexts are made and others are not – basically why a particular social order emerges and not another - because it is through their actions that actors establish relationships with their contexts (1990: 588). 'Projects' are performed in ways that 'add value' to the lives of actors but are 'intelligent' to the extent that they promote the values and interests of actors. She says that '[P]rojects are decision-making tasks 'set', so to speak, both by the person and their context' (1990: 588). The project is characterized as a decision-making task because it involves processes of identification, development, selection and implementation and so action can be meaningfully understood as a set of collective decision-making processes that are neither ordered in any particular way nor determine action in totally predictable ways. Intelligent social action comes into play, for example, when the context is perceived to be such that existing rules and procedures are not working and the 'intelligent social action' is to ignore the existing context and work to create new ones in which value-adding can be considered more likely to occur for actors. This notion of intelligent social action has parallels with Gleeson and Knights (2008: 64) research where they suggest that leadership as a professional process comprise two contradictory aspects. The first involves a high incidence of unintended consequences, ambiguity and wasted effort as well as the ensuing fatigue, low morale and de-professionalization that is common in critiques of the New Public Management (NPM) culture prevalent in the UK. The second entails innovative skills and practices being adopted by professionals in and against the new culture of audits that typically align with core professional values and interests (see also Miller, Dingwall & Murphy 2006: 328). Kelly, White, Martin & Rouncefield, (2006: 192-5) also note that these aspects of leadership (using 'gambits of compliance'), are rarely dealt with in traditional approaches to organizational leadership and decision making in professional contexts.

Hosking says that intelligent social action requires two types of expertise: the first is of a general kind that enables actors to recognize the kind of problem or issue they are dealing with and is often associated with expertise. This form of knowledge is transferrable and knowable to the extent that even if the content of the issue changes, if the 'type' is understood, then intelligent social action is possible. Hosking says, '...actors act intelligently when they show an understanding of the relationship between *their values and interests* and their context' (Hosking & Fineman 1990: 590 their emphasis). The other form of knowledge that she says accompanies intelligent social action refers to 'issue specific knowledge' that is related to things that are familiar and have been experienced in the past and thus, serve as guides to how best to handle a situation. Creating or making a particular context (over others) often hinges on actors trying to mobilize issue-specific knowledge (Hosking & Fineman 1990: 591).

There are three ways in which intelligent social action is portrayed: (i) as actions to 'correct' perceived problems in a context; (ii) a form of problem identification and as, (iii) experience of 'been there done that' (also Kelly et al 2006:197), and each has the potential to shape the context in different ways, including interfering with how others would prefer things to be and thus, not allowing them to add value to their lives. It is for this reason that Hosking asserts that leadership is first and foremost a political process of decision making. Hosking's approach has been evolving and relational leadership theory (RLT) has gone in many new directions (see Uhl-Bien, 2006). In particular, sensemaking approaches have become more popular in RLT (e.g. Pye 2005), especially around the consensual framing of problems and hence, decision making (Grint 2008). Most of these studies are critiqued because they '... do not tell us much about the *practical ways* in which leaders may shape the sensemaking of others nor shed much light on the *nature of the* contexts within which such sensemaking take place' (Peck & Dickinson 2009: 81, our emphasis). While most approaches to sensemaking draw on Weick's work (e.g. 1995, 2001), the Cynefin framework (pronounced 'kun-ev'in') uses sense-making to develop an approach to decision making that draws mainly from the work of Dervin (1998, cited in Snowden, 2005; 122-3). Dervin was not concerned with sensemaking in an organizational context, as was Weick, but rather on how people make sense of the world and how actors make and unmake sense as they move through time

and space and respond and adapt to different modes of communication (Peck & Dickinson 2009: 76). Snowden's approach is therefore, focused on '...how individuals choose between multiple possible explanations of sensory and other input as they seek to conform the phenomenological with the real in order to act in such as way as to determine and respond to the world around them' (Snowden 2005: 123). Others have indeed pointed out how there are significant similarities between Weick and Snowden's approach (Browning & Boudès 2005) and both are relevant to understanding leadership in healthcare.

THE CYNEFIN FRAMEWORK

Cynefin, which is a Welsh word and has no equivalent translation in English, means 'habitat' when used as a noun but as an adjective, acquainted or familiar. It describes the relationship to your place of birth and your upbringing, and the environment in which you live and are naturally acclimatized; it also conveys the sense that we all have multiple pasts of which we can only be partly aware: cultural, religious, geographic, tribal etc. Snowden uses it to create the platform for advancing individual/collective knowledge that links a community into a shared history that allows it to adapt to profound uncertainty (Snowden 2005; Mark & Snowden 2006). 'Cynefin' describes a way of understanding the relationships between how things are and how they are perceived in terms of how systems operate. As a sense-making framework, it is an approach that seeks to foster a learning culture of understanding and action. Sense-making (with a hyphen) has emerged from a practice-oriented approach (as distinct from Weick's research on power plants, aircraft carriers and fire fighters with disaster and crises being the focus, as well as on jazz bands where creative response to uncertainty is the essence of improvisation), and Snowden uses processes and techniques that are co-developed through workshops with practitioners and clients (as a form of action research), and is thus always emerging and changing depending on the context or contextualizing experiences involved (Browning & Boudès 2001: 34). The framework has emerged from projects originally in the field of knowledge management, cultural change and community dynamics and other diverse areas, (Kurtz & Snowden 2003). Snowden also differs from Weick in that his approach to sense-making is concerned with what he terms 'multi-ontology sense making' to achieve a requisite level of diversity as well as having a sufficient level of divergence with

systems to enable the sensing of weak signals (e.g. a terrorist threat) or avoiding the common pattern entrainment of past success. As he says, above all it is about ensuring cognitive effectiveness in information processing (2005: 123).

The framework is relational (Bradbury & Bergmann Lichtenstein 2000: 552-4) because '[It] is particularly useful in collective sense-making in that it is designed to allow shared understandings to emerge through the multiple discourses of the decision-making group' and guide actions (Kurtz & Snowden 2003: 468). Its most powerful potential is in providing a discourse about the appropriateness of different paradigms. In developing the framework, five key principles have been used: humans make decisions based on patterns (first fit pattern matching with past experience); humans maintain multiple identities and these include contextual identities that are not easily transferred to other settings; humans ascribe intentionality and cause when none necessarily exists; humans have learnt how to structure their social interactions to create order; contextual complexity means that humans have the ability to operate under conditions of order, un-order as well as disorder or any combination (Snowden 2005).

Figure 2 describes the Cynefin which is especially important in health where a paradigm hierarchy exists based on a positivist rationality found within the knowable or complicated space, Cynefin offers a way removing this privileging of perspectives by showing that validity must rest on the problem and its context (Mark.A & Snowden, 2006).

[Insert Figure 2 here]

The domains

In the **Simple Domain** or space (*known* and *ordered*) cause and effect relationships are generally linear, empirical in nature and not open to dispute. Repeatability allows for predictive models to be created and the objectivity is such that any reasonable person would accept the constraints of best practice that can be found here. This is the domain of such interventions as process re-engineering, Six-Sigma, and other practices that focus on efficiency. The decision model here is to recognize the type of problem as belonging to this domain, sense incoming data, categorize the data and respond in accordance with predetermined practice. Structured techniques are desirable and mandatory and quantitative techniques

such as randomized control trials and statistical models (Snowden 2005; Kurtz & Snowden 2003; Mark 2006; Mark & Snowden 2006). However, the application of Six Sigma in healthcare as vehicles for hospital-wide change management runs the risk of sub-optimal results when applied to areas with higher levels of ambiguity than the ordered (for an example, see Weiner's (2000) work on re-engineering of hospitals in US, cited in Miller et al 2006: 328). The rigid application of evidence-based medicine and clinical guidelines are also a case in point where given the diverse behavioural contexts involved, minimum standard specifications work better than rigid, highly specified procedures and manuals (Minos 2005: 37). Similarly, the movement from the simple to chaotic domain (known as *asymmetric collapse*) occurs when decision makers don't see things coming because of entrained patterns of thinking (Kurtz & Snowden 2003: 475). Table 1 shows the dangers signals and responses across all the domains.

[Insert Table 1 here]

In the **Complicated Domain** (*knowable* and *ordered*) stable cause and effect relationship exist but they may not be fully known, or may be known only by a limited group. Everything in this domain is capable of movement to the simple domain but resources and time don't allow this and expert opinions have to be relied on and trusted. This is the domain of system thinking and learning organization strategies where experiments, expert opinion, fact-finding and scenario planning are appropriate. The decision model here is to sense incoming data then respond in accordance with expert advice (panels) or interpretation of analysis. The doctor-patient relationship is such an example, where decisions depend on the level of confidence in the expert opinion of doctors and decision makers (e.g. policy makers), and hence a key dependency relationship exists. Structured techniques are desirable but assumptions must be open to challenge. This is the domain in which entrained patterns are most dangerous because a simple error in assumptions can lead to false conclusions that are difficult to isolate and may not be seen at all (Snowden 2005; Kurtz & Snowden 2003; Mark 2006). In health care such errors are usually accumulated on a large scale such as took place in the UK in Bristol, where high volume of inappropriate childhood deaths occurred before questions were asked of experts involved (Mark 2006; Mark & Snowden 2006; and were also shown in Bosk's earlier (1979) work on how surgeons sanction medical errors, cited in

Miller et al 2006: 332); Van Der Weyden (2005) chronicles similar events in Australian health jurisdictions as those that occurred in Bristol.

In the **Complex Domain** (*patterns and interactions* and *un-ordered*) the patterns that prevail are not controlled by a directing-intelligence, they are self-organizing systems because cause and effect relationships between agents, both in the number of agents and the number of relationships, defy categorization or analytic technique. There are, however, patterns emerging through the interaction of many agents that can be perceived but not predicted. This is called 'retrospective coherence' and aligns with the notion of 'post hoc rationality' used by Weick (1995). However, in this space structured methods that seize upon retrospectively coherent patterns and attempt to codify them into predictable and repeatable procedures will only confront new patterns for which they are ill-prepared; consequently relying on expert opinions based on historically stable patterns will leaves leadership unprepared for unexpected patterns that emerge. The decision making approach needed is to create probes to make patterns or potential patterns more visible before taking action, then stabilizing patterns that are most desirable, i.e., find where the attractors in the system are in order to change behaviour (Snowden 2005; Kurtz & Snowden 2003; Mark 2006; also Minos 2005). Understanding this space requires the following: multiple perspectives; unstructured and novel experiments; increased levels and variety of communication and interaction across stakeholders; use of open discussion to stimulate attractors; encouragement of dissent and diversity; and the management of the starting conditions for change. Narrative techniques, learning network strategies and sense-making software (Kurtz & Snowden 2003; Kurtz & Snowden 2007) are also appropriate. The development of cancer patient stories and patient journey improvement narratives as demonstrated in *healthtalkonline.org* belong in this domain. Martin and Armstrong (2005) apply the approach to understanding primary healthcare reform in Australia in relation to general practice (GP), distinguishing between the different decision-making modes of generalists (complex) v's specialists (simple, complicated) and the evolution of self-organizing networks amongst GPs.

In the **Chaos Domain** (*patterns and interactions* and *un-ordered*) there are no specific perceived cause and effect relationships. The system is turbulent and the time needed to investigate is not available.

The decision model in this domain is therefore, to act quickly and decisively to reduce turbulence, and then to sense immediately the reaction recognizing that the trajectory of any future intervention varies according to the nature of the space. An authoritarian intervention might be used to make the space knowable or known and this is acceptable where the threat is symmetric and where parameters of behaviour are known and intentions can be determined, such as when a hospital closure occurs. When there is an asymmetric threat for example as an infection outbreak, the dimensions of the threat are unknown or dispersed, and not necessarily perceptually linked then the heuristics of relevant professional groups come into play rather than organizational ones; doctors responding in an accident and emergency department provide another example of this context.

DISCUSSION

Kurtz and Snowden note that it is easier to move across domains in the un-ordered (chaos to complexity and vice-a-versa) and ordered (simple to complicated and vice-a-versa) than the other ways(Kurtz & Snowden 2003: 475). As they say, '[T]he known and knowable domains (more recently called simple and complicated) are not based on individuals as one does not move between domains on learning something new but rather it means something known to society or the organization...and this collectivity of itself maintains the power and credibility of shared practices (Kurtz & Snowden 2003: 469). It is not only the way in which people think about the domains that they find themselves in but the movement across boundaries that demand different leadership practices as expressed in the decision-making of a group. In terms of healthcare, the central domain of **Disorder** (uncertainty about uncertainty) is where much of the disagreement and conflict exists because of the failure by entrenched professional groups to engage with the other domains in their decision making (see for example, Mintzberg 1997; Smith & Eades 2003). As Mark (2006) notes, those most comfortable with stable order (simple domain) will seek to create and enforce rules through control, in healthcare this mostly means managers and/or politicians. From the complicated and knowable domain, experts will seek to conduct research to find the 'right' evidence-based answer, especially clinical professionals and managers. In the complex domain politicians and policy makers are more likely to develop and seed experiments to probe and find answers

or groups such as those involved in areas such as community-based healthcare for example. In the chaotic domain non-consultative leadership, sometimes dictatorial in nature, will decide that chaos has arisen and this will be seen as an opportunity to gain absolute control of a situation, such as when budgets blow-out and the media gets wind of it.

The domain of disorder represents a dimension that is not usually included in similar approaches, with Kurtz and Snowden noting this as a distinguishing feature of their approach as a process of complex political decision making (2003), which they say otherwise parallels many others in the field of complexity and chaos theory. It is our contention that many areas of healthcare leadership is de-facto associated with dealing with intelligent social action as a problem response as well as entrained patterns of responding that come with expertise and experience. It is also about creating a flexible social order that mirrors professional values and interests (see Figure 1).

Thus, there are three key ways in which the framework can have significant leadership potential in healthcare as a solutions-based practice. First, the domain of disorder allows us to broaden our understanding about the political and emotional dimensions of decision making so the we can better appreciate the resistance to ideas such as the Cynefin framework in environments that are dominated by single ontology sense-making and paradigms (epistemology) such as is prevalent in healthcare. Second, those who have engaged with the contextualized framework through the various exercises that accompany the approach have generally been able to identify entrained patterns of thinking about problems and this helps to reveal intelligent social actions as well as *unintelligent ones*. Lastly, it is a powerful way of developing a new shared language for members of decision making groups to confront their own preferences for action and hence biases and to use it as an artifact for negotiating and creating common meanings that are key to creating a flexible social order in healthcare.

CONCLUSION

While the development of understanding around complexity in healthcare (Plsek & Wilson, 2001) and leadership is ongoing, the problems of defensive response to it (Peterson JB, 2002) have highlighted the need for intelligent understanding of different perspectives. Where these new perspectives are seen as

contentious their acceptance may be modified, but the power of the Cynefin Framework, that has already influenced leadership training in a number of settings worldwide, is that it provides an explanatory framework with which to understand and respond to complex and turbulent environments. Snowden's work originally focused on identifying patterns within whole communities rather than just organizations but understanding decision making within the context of chaos will be of increasing importance as those affected by the global downturn seeing healthcare budgets reduced often in arbitrary ways. The notion of skilfull leadership, in such circumstances, will require special attention to how disorder works in respect of stakeholders working and using the health system but also the community at large. What they will expect and look for is an intelligent response to what may be a chaotic intervention by politicians. Those who see the world through this multi-ontology sense-making will be more likely to devise strategies to cope successfully, but further work is needed to understand the heuristics of practice that are required.

IMPLICATIONS FOR HEALTHCARE MANAGERS

As a tool for healthcare leaders the new ideas presented in this paper notably the Cynefin framework provides a way to interpret and negotiate understanding of what is happening and how to address the decisions that arise from this, for example when negotiating budget cuts or an emerging crisis. It is solutions focused allowing, for example, those experts from the complicated domain to identify a way forward based on familiar linear approach, but also for this to be contested by those who, while unable to contest their expertise may be aware of the limits to time and perceptions in relation to the problems. Instead an approach based on the complex domain through a probe sense respond mode allows for action to be taken more quickly, as it is not dependent on research and data collection in the same way. The immediacy this offers to leaders faced with time limited decisions is both important to their role and purpose ; yet does not negate the stabilizing effect of expert knowledge creation of outcomes, reinforcing team understanding and joint decision making.

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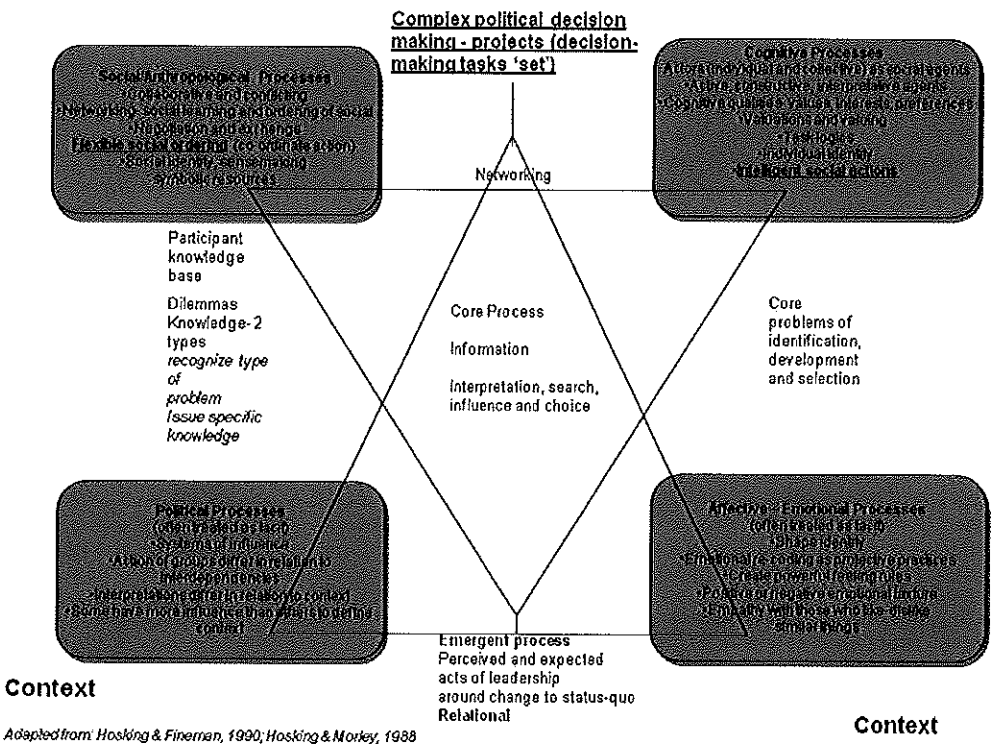
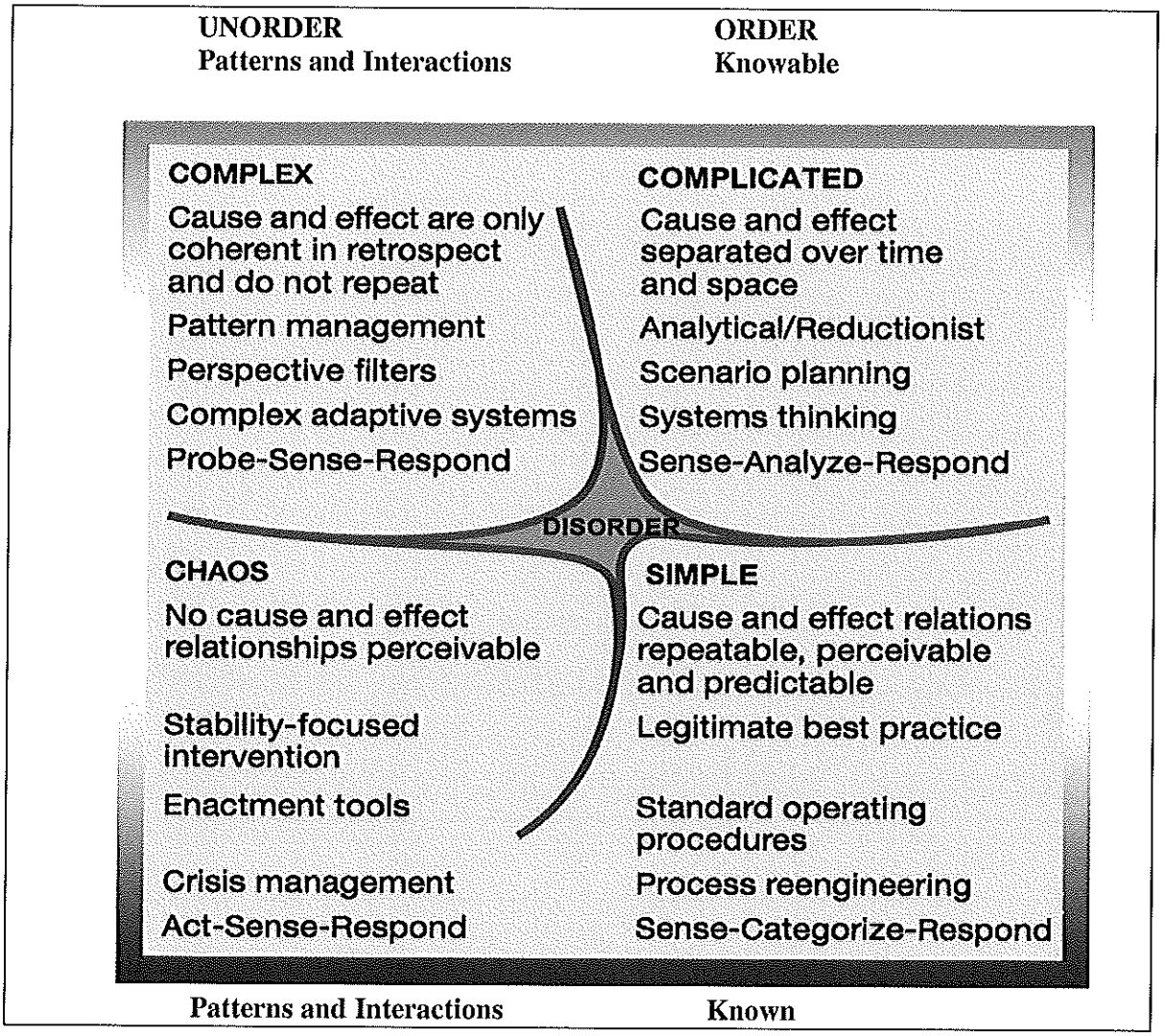
Figure 1 - Leadership as Skillful Leadership Process



Adapted from Hosking & Fineman, 1990; Hosking & Morley, 1988

Figure 2 – the Cynefin framework



Adapted from: Kurtz, CF and Snowden, DJ (2003) The new dynamics of strategy: Sense-making in a complex and complicated world, *IBM Systems Journal*, 42(3): 468

Table 1 Decisions in multiple contexts: a leader's guide

	Simple	Complicated	Complex	Chaos
Danger Signal	*Complacency *Make complex problem simple *Entrained thinking *No challenge to current wisdom *Overreliance on best practice	*Experts overconfident in their own solutions or in the efficacy of past solutions * Analysis paralysis *Expert Panels *Viewpoints of non-experts excluded	*Temptation to fall back into habitual, command-and-control mode *Temptation to look for facts rather than allowing patterns to emerge *Desire for accelerated resolution of problems or exploitation of opportunities	*Applying command-and-control approach longer than needed *"Cult of the leader" *Missed opportunity for innovation *Chaos unabated
Response to Signal	*Create communication channels, to challenge orthodoxy *Stay connected without micro-managing *Don't assume things are simple *Recognize both the limit and value of best practice	*Encourage external and internal stakeholders to challenge expert opinions to combat entrained thinking *Use experiments and games to force people to think outside the familiar	*Be patient and allow for reflection *Use approaches that encourage interaction so patterns can emerge	*Set up mechanisms (such as parallel teams) to take advantage of opportunities afforded by a chaotic environment *Encourage advisers to challenge your point of view once the crisis has abated *Work to shift the context to complex

Source: Snowden, DJ and Boone, M (2007) *A* leader's framework for decision making, *Harvard Business Review*, 85 (11): 73.