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The enactment of dynamic leadership

David Greenfield
Centre for Clinical Governance Research in Health, University of New South Wales, Sydney, Australia

Abstract

Purpose – The purpose of this paper is to empirically examine how clinical team leadership can facilitate a collaborative team and, in doing so, drive change in a health service.

Design/methodology/approach – Ethnographic field work was conducted with a clinical team, comprised of 13 health professionals, in community health, in Sydney Australia. Utilising semi-structured interviews, data were collected and then analysed using Goleman's leadership typology as an analytic lens.

Findings – Leadership can facilitate a team to realise high levels of collaboration, trust and respect. This creates an environment in which collective learning and increased responsibility thrives. Together, these elements enable front-line staff to take ownership of their services, to integrate the organising and delivery of services, and, in doing so, improve health care practice.

Research limitations/implications – The leadership empirically observed here confirms qualities, behaviours and approaches that have been argued as important in the literature.

Practical implications – For health professionals in a clinical team leadership role Goleman's typology can be instructive. Many leaders in complex health care organisations are engaged in, and needing to respond to, unfolding situations to ensure positive improvement. At such times the typology offers a range of leadership styles to draw upon.

Originality/value – The application of the typology to health care clinical team leadership is a new development.

Keywords Leadership, Health services, Team working, Change management, Trust, Australia

Paper type Research paper

Introduction

Enacting effective leadership can drive improvements in team work, quality and safety, and change and innovation in modern complex health care organisations. This can be a challenge for health professionals but one that can reap great benefits. Effective leadership has enabled improvements in health care practice (Rolland, 1998; Manojlovich, 2005), patient care (Marisa and Anthony, 2001), conflict management (Hendel *et al.*, 2005), innovation (Mahoney, 2001) and the instigation of shared governance (Doherty and Hope, 2000; Millward and Bryan, 2005; Scott and Caress, 2005). For many health professionals the challenge of leadership is overcoming the expectations they have historically inherited. Traditionally there has been a separation of the organising of the work from the delivery of the work; the former has been labelled care management work and the latter care production work (Schweikhart and Smith-Daniels, 1996). As such the leadership reproduced is continuation of a hierarchical and authoritative management style (Hackett and Spurgeon, 1998; Mahoney, 2001; Millward and Bryan, 2005; Murphy, 2005). When constrained by history the leadership behaviour mediates against achieving the positive outcomes. To achieve improvements, history must be overcome.

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There is a great deal of writing about leadership. However, much of the writing about leadership is normative, making statements about how leadership should be undertaken (Rolland, 1998; Marisa and Anthony, 2001; Jooste, 2004). Alternatively, the empirical studies focus upon working with individuals (Murphy, 2005) or at a broader organisational level (Doherty and Hope, 2000; Scott and Caress, 2005). In doing so leadership at the clinical team level is overlooked. Understanding how to enact effective leadership at the clinical team level is an important issue, particularly as team work has been shown to be necessary to provide complex health care (Flin *et al.*, 2002; Hall and Weaver, 2001; Harolds, 2005; Hindle *et al.*, 2005). Clinical team leadership is an issue that requires further empirical research (Millward and Bryan, 2005; Viitala, 2004). This paper presents an empirical study that addresses this issue. The study reports how a clinical team was changed by the dynamic leadership enacted by the team's manager. In undertaking this analysis Goleman's (2000) leadership topology is utilised. The application of the typology to health care clinical team leadership is a new development.

The outline of this paper is as follows. First, there is a short discussion about the challenge of clinical team leadership and the leadership typology of Goleman is described. Second, the methodology of the study is noted. The third section, encompassing five acts, details how the team leader enacted leadership that engaged the clinicians to collaboratively negotiate the reorganising of the team. The discussion is the fourth and final section.

The challenge of clinical team leadership

Clinical team leadership is an important role in health care organisations. Fusing managerial and clinical responsibilities, the role exists at critical junctures in an organisation. That is, the role has a dual focus, to both front-line clinical staff and senior managers, including executives, with the responsibility to integrate effective management with high quality care (Firth-Cozens and Mowbray, 2001); more recently the terms "shared governance" (Doherty and Hope, 2000; Scott and Caress, 2005) and "service line management" (Guo and Anderson, 2005) have been used to describe the responsibility. A review of patient safety inquiries records the critical importance of team work, with appropriate leadership, to ensure high quality care (Hindle *et al.*, 2005).

To achieve role integration, the leadership involves engaging and facilitating staff in a self-organising process:

> Clinical (team) leadership will involve facilitating the self-organising process, harnessing structure accordingly to need, rather than depending on or deferring to structure as the primary delivery instrument (Millward and Bryan, 2005, p. xix).

Shifting attention from organisational maintenance to re-creation is a move many with this responsibility struggle to achieve (Drach-Zahavy and Dagan, 2002). To enact leadership as described requires personal and managerial authority being used in an appropriate balance. Achieving the balance in a particular set of circumstances is a learned skill, not one that can be prescribed. Those who have shown this skill have developed their emotional intelligence and have a range of leadership styles to draw upon (Goleman, 2000, 2004).

Goleman's leadership typology

Built upon the characteristics of emotional intelligence, Goleman (2000) has developed a leadership typology from an analysis of the behaviours of over 3800 executives in many diverse fields from across the world. The typology is comprised of six styles – coercive, authoritative, affiliative, democratic, pacesetting and coaching. An effective leader is described one who is able to draw upon the different styles in different situations. The coercive style of leadership is a top-down approach which demands immediate compliance with directives and while not appropriate in many situations, it can be used effectively in a crisis. The authoritative style of leadership mobilises people towards a common vision. While leaving space for flexibility and innovation to achieve the goal, caution is needed to ensure the leader does not become overbearing or aloof in their approach. The affiliative style of leadership focuses upon people, developing strong commitment and open communication amongst a team. A limitation of the style is that constructive feedback and direction can be overlooked. The democratic style of leadership engages people, encouraging participation and teamwork. A potential problem of the style is decision points can be continually put off if the team becomes lost in discussion about options. The pacesetting style of leadership emphasises high standards of performance, directing others to improve. This style can be overwhelming for many colleagues as the leader can impose themselves rather than supporting improvement. The coaching style of leadership focuses on developing the skills and abilities of the team. While generally having a positive impact a trap can be to emphasise development over immediate work tasks.

Methodology

This study was part of a research project examining innovation and change in health services. The focus of the project was the development and institutionalisation of a nursing clinical practice tool in community health of the South Western Sydney Area Health Service (AHS), in Sydney Australia. The research is best described as a "focused ethnography" (Morse, 1991; Boyle, 1994) and the research stance was semi-structured, open and direct (Sarantakos, 1995).

One part of the project involved ethnographic field work with a community health nursing team in one sector, the Liverpool sector, of the AHS. The nursing team, the Child and Family Health Nursing Team (CFHNT), gave informed consent for the presence of the researcher; over 12 months, during 2001-2002, was spent with the team. The CFHNT is comprised of 13 professional nurses, including a nurse unit manager (NUM). The data drawn upon for this study were collected through semi-structured or informal interviews with the CFHNT (Hammersley and Atkinson, 1995; Fontana and Frey, 1994). Following Stewart and O'Donnell's (2007) example, the typology was applied to the data as an "analytical lens". This application enabled understanding of the situation, conduct and changes the team had faced.

The five acts of leadership

This section discusses the leadership enacted by the NUM, with the examination broken down into five acts. Each act presents a change of leadership style enacted by the NUM in response to the changing situation that she was both shaping and simultaneously responding to.

Act one. Authoritative leadership

The current practice, and history, of the nursing team was that it operated on a hierarchical basis. The nursing team was being run as a group with a defined leader (Katzenbach and Smith, 1993), where the word of leader, the NUM, was final. The NUM's vision for the team was that she undertook the care management work and the nurses the care production work (Schweikhart and Smith-Daniels, 1996), that is, there was a clear separation of the organising of the work from the delivery of services. The nurses were told what their work duties were and then expected to carry them out. While they attended team meetings, attendance did not mean participation. The meetings were used to provide information to the nurses, not to involve them in the organising or decision-making process. This style of leadership has been described as "authoritative" leadership (Goleman, 2000) and the autocratic style of the NUM precluded any discussion of change (Pichault, 1995).

At this time there was a change in NUM of the nursing team. The new NUM brought a different approach to the organising and managing of the team. She explained that she had a vision for the team whereby the nurses were involved in the decision making about their work. The new NUM promoted her role as one to facilitate the development of the team rather than direct the team to do specific tasks; this is a strategy that has been shown to promote responsibility (Maudsley and Strivens, 2000). Once again, "authoritative" leadership (Goleman, 2000) was being enacted, as the NUM was mobilising the nurses towards a vision, but this time the collaborative approach being enacted presented the opportunity for change.

Act two. Democratic leadership

The new NUM endeavoured to engage the nurses in the organising and delivery of the nursing services. Enacting a "democratic" leadership style (Goleman, 2000), the NUM strove to do this through opening for negotiation the purpose, direction and activities of the work, rather than directing or ordering what should, or should not be, the work of the team. The nursing team was encouraged to examine the current arrangements for the provision of services. A guiding focus became the question – how could they learn from and support each other more effectively as a team, rather than continue to operate as a collection of individuals under the one administrative unit? Collectively the nursing team began to discuss and reflect upon their situation and how it could be different. The support and encouragement of the NUM was critical in beginning to shift the nurses from being a collection of individuals to a collaborative team (Sheard and Kakabadse, 2000). This democratic approach enabled the establishment and enactment of trust within the nursing team (Gilson, 2003); alternatively described as "mutual dependency based on reciprocity" (Zuboff, 1988). Hence the new NUM was a "change agent" (King and Anderson, 1995; McPhail, 1997; Boonstra and Gravenhorst, 1998), or "change leader" (Diamond, 1998), necessary to initiate and drive forward a change process (Porter-O'Grady and Wilson, 1995).

Act three. Coercive leadership

At this time, as the nurses engaged in a discussion about how their service was organised, a practice crisis occurred. The manager of a local family support service reported to the NUM that two babies seen in early childhood clinics, by two different nurses, had presented as seriously underweight. Both babies were referred for

immediate medical assessment. The clinical service provided by the nurses had left the babies at serious risk. In response the NUM issued a local directive regarding early childhood nursing practice, to which she demanded compliance. The directive required that all babies whose birth-weight is not regained within 14 days after birth must be referred to a medical practitioner on the same day. This directive aimed to provide a last resort or safety net for practice. In this instance the NUM is exercising a "coercive" leadership (Goleman, 2000), directing the actions of staff to ensure compliance, a form of leadership appropriate in a crisis. While this directive could be taken as extreme, in fact the directive was a strategy by which the NUM provided initial guidance prior to handing over responsibility to the nurses for their work.

Act four. Pacesetting and coaching leadership

As well as the directive to manage the immediate crisis the NUM took another action, this one aimed to resolve the underlying practice problem. Initial enquires by the NUM revealed that many of the community health nurses were unequipped, theoretically and practically, for the early childhood work. To address this practice problem the NUM provided an intensive in-service seminar and encouraged a collaborative culture for the nursing team – to ensure they had the knowledge, skills and support to provide the service. The seminar covered both the theoretical and practical knowledge and skills required for the early childhood work, demonstrating and discussing the nursing tasks and common problems encountered. In addition a collaborative culture was promoted to break down the isolation of practice and normalise the need to seek advice and support. In doing so the NUM provided "pacesetting" and "coaching" leadership (Goleman, 2000) simultaneously, emphasising high standards of care whilst providing mentoring and guidance to achieve such standards.

Taking the lead of the NUM, the nurses increasingly began to seek advice and assistance from one another, particularly over the telephone when they were conducting clinics or home visits on their own. Collaboration via the telephone is an example of the nurses enacting a coaching form of leadership with one another, where together they are being a resource and support for one another, engaging in collective learning (Benner *et al.*, 1999). This collaborative conduct, also labelled "mentoring", has been shown to transfer knowledge (Singh *et al.*, 2002) and is the basis for a "community of practice" (Lave and Wenger, 1991; Wenger, 1998).

Act five. Affilitative and democratic leadership

Having effectively managed the practice crisis, the NUM's attention returned to the organisation and ongoing operation of the team. Team meetings became a venue to examine this issue. Facilitating the team meetings, the NUM engaged the nurses to define the goals and targets of the service and in doing so to take responsibility for the organising of their work. The NUM encouraged a context of questioning, involvement in decision making and risk taking (Clarke and Wilcockson, 2002). Outside of the formal meetings the NUM continued to enact collaborative relationships with the team, moving the emphasis away from the traditional hierarchal structure (Dobuzinskis, 1997).

Together the NUM and the nursing team examined the organising of the work, with the view of the NUM only one amongst many; the inclusion of all the nurses contributed to the building of trusting relationships (Davenport and Prusak, 1997; Hall,

2001; Gilson, 2003). The nurses reported that the breadth of their work in community health was too much to keep their practice knowledge and skills up to date. On any given day the work ranged across palliative care, wound management to early childhood nursing. In the morning a nurse could be providing palliative care to several elderly people and then in the afternoon seeing two-week old babies in an early childhood clinic. The consensus of the team was that maintaining practice standards across such breadth of clinical areas was reportedly too stressful.

The current arrangement, whereby all nurses undertook all aspects of nursing practice in community health, was clearly one that placed both the clients and nursing staff at risk. As a result of this discussion the nursing team made the decision to separate the work into early childhood nursing and community health nursing. The nurses would work in one area only but they would have a choice in which area they wanted to work, with further training and development to be provided. In this ongoing conversation the NUM is exercising a blend of "affilitative" and "democratic" forms of leadership (Goleman, 2000). By developing open communication and commitment amongst the nursing team the NUM was able to direct and lead a conversation of change.

Simultaneously encouraging collaboration the NUM mobilised energy for change by involving the participation of all the nurses (West and Wallace, 1991; Clarke and Meldrum, 1999). As a result of the collaborative discussion the nursing team separated into two teams. One became the early childhood team and the other the community health nursing team, with the clinical areas as the names suggest.

Discussion

The leadership empirically observed here confirms qualities, behaviours and approaches that have been argued as important in the literature (Guo and Anderson, 2005; Jooste, 2004; Mahoney, 2001; Millward and Bryan, 2005; Storr, 2004). Consequently, for those in a clinical team leadership role Goleman's typology can be instructive. For leaders in complex health care organisations engaged in, and needing to respond to, an unfolding situation to ensure positive improvement, the typology offers a range of leadership styles draw upon. The capacity to alter leadership style during a change period is recognised as an important skill (King and Anderson, 1995). In particular, the open democratic approach was shown to be effective in empowering front-line staff to take collective ownership of their work. Negotiating all aspects of work by front-line staff requires a collaborative effort where participation can be encouraged, supported and indeed necessitated (Hay and Hodgkinson, 2006; West, 1990). Involvement of the team in this way has been described as a change from superior-subordinate relationship to collaboration with authority (Diamond, 1998). The outcome being that a collaborative team has been shown to encourage people to take risks and learn (Hoskins *et al.*, 1998), whereby individually and collectively they are rewarded through their interactions and they develop their common knowledge (Smith *et al.*, 1995).

The leadership styles of Goleman's typology have weakness that can be overcome through their combination. For example, through combining pacesetting and coaching styles leaders can promote high standards and goals while simultaneously supporting and assisting front-line staff to achieve them. In doing so, staff are not set expectations that they do not know how to fulfil nor is the task of delivering services lost in a period

of skill development. At such times the leadership is about negotiation, about working with people in a collaborative way to see what can be achieved (Heiftez and Laurie, 2001; James *et al.*, 2007). Taking this approach the leadership tasks focus upon valuing, supporting and encouraging; not inspiring the follower (Alimo-Metcalfe and Alban-Metcalfe, 2001). These actions create trust, exposes and deals with conflict, gets people to assume responsibility, and instils confidence in, and gives voice to, front-line staff (Heifetz and Laurie, 1997). The outcome is the enactment of responsibility and team work (Ashkenas *et al.*, 1995; Connelly *et al.*, 1999; Guo and Anderson, 2005; Sheard and Kakabadse, 2000). Alternatively, this outcome has been called shared governance and is one which engages front-line staff to have an active role in their workplace, to be responsible for their own choices (Doherty and Hope, 2000; Scott and Caress, 2005), and to develop their capacities and identity (Gilson, 2003; Lave and Wenger, 1991).

Collaboration does not imply harmony. Teams need to discuss, debate, agree and disagree about options for the organising of their work. What is important is that different views are encouraged, voiced and considered openly in the team forum or "community of practice" (Lave and Wenger, 1991; Wenger, 1998). The construction of reciprocal relationships, open communication and positively motivating a team has been shown as critical to re-organising processes (West, 1990; Mintzberg *et al.*, 1996; Hoskins *et al.*, 1998). Such an approach is appropriate as the implementation of health care programs cannot be successfully achieved through using a top-down model (Hanks and Smith, 1999); a top-down model constructs distrust and commonly ends in failure (Diamond, 1998; Rainey, 1999). Rather, there has to be room for local discretion when meeting organisational requirements (Plsek and Wilson, 2001), with the benefit being increased professional responsibility (Hanks and Smith, 1999). When this is achieved, the leadership displayed in these circumstances can be understood as "knowledge leadership" (Viitala, 2004). Such leadership can facilitate a team to realise high levels of collaboration, trust and respect. This creates an environment in which collective learning and increased responsibility thrives. Together, these elements enable front-line staff to take ownership of their services, to integrate the organising and delivery of services and, in doing so, improve health care practice.

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Corresponding author

David Greenfield can be contacted at: d.greenfield@unsw.edu.au

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