Exemplary leadership, the clinician manager and a thing called 'hybridity'

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Published
2010

Conference Title
7th Biennial Conference in Organisational Behaviour in Health Care (OBHC): Mind the Gap: policy and practices in the reform of healthcare

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Exemplary leadership, the clinician manager and a thing called ‘hybridity’

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Word count 300
Abstract

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Background
Critiques of leadership theories, and leadership development programs in health, have pointed to the dominance of individualistic and heroic approaches that focus on developing skills and capabilities of health professionals as epitomized by programs such as the Leadership Quality Framework developed for the National Health Service in the UK. Critics complain that these approaches have led to leadership being selectively blamed for failed health care reforms with clinician managers especially being singled out for negative treatment. To counter these individualistic and heroic discourses, alternative leadership approaches have been proffered including for example, post-heroic (e.g. distributed, shared and followership), post-individual, post-structural and relational leadership theory. Drawing on the work of several of these theorists, the paper explores how hybridity can be used to re-theorize leadership in healthcare as this relates to clinician managers. Empirical material is presented to support the case for looking at hybridized forms of leadership in healthcare. Hybridity is critiqued as it applies to healthcare and a way forward is proposed that might give a better understanding of leadership as exemplary in the realm of the clinician manager.

Aim of study
The study aims to challenge current leadership paradigms and contribute to debates surrounding the role of clinician leadership in health care reform.

Methodology
The study uses qualitative research, i.e. interviews, to present hybridized accounts.

Findings
There is support for hybridized configurations of leadership in interview materials of healthcare employees.

Conclusion and implications
The paper draws on the concept of hybridity to counter the negative image of clinician leadership and in critiquing this approach presents an alternative way to frame leadership in the context of the clinician manager.
Introduction

Healthcare organizations face significant challenges, not the least being the relentless scale and pace of reform and change in healthcare systems throughout the OECD. Cost-cutting and budgetary constraints, and doing more with less in the face of rising costs and demand for services, are endemic features throughout the OECD. The ageing population, increasing chronic life-style related diseases across all age groups (e.g. childhood obesity, teenage substance-abuse), spiraling demand for life-prolonging and end-of-life interventions, and looming skills shortages are but some of the factors contributing to these challenges. Leadership, and the engagement of clinicians 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 used to wage the ‘blame-game’ that usually accompanies failed or stalled reforms (Hewison & Griffith, 2004). However, one group of clinician managers, namely doctors, are more often than not singled out as being the most reluctant to take on leadership roles or if they do, not to perform well in them in terms of either their own or others’ expectations. So while the engagement of this particular group of clinician managers in leadership is a key platform in many healthcare reform strategies, with Australia included, understanding what leadership means in highly complex professional contexts is as contestable as leadership itself (Grint, 2005: 17-18). In healthcare leadership tends to be framed as an individual skill associated with people who are in positions of management and this is reflected in many leadership development programs that promote a heroic leadership ethos (see Bolden, Wood & Gosling, 2006; Dickinson & Ham, 2008; Ford, 2008).

The vast majority of leadership programs run by health departments in places such as Australia can be characterized as leader- development programs (Iles and Preece (2006). As Illes and Preece suggest, this approach seeks to build individual-level intrapersonal competencies and human capital development thus, emphasizing styles, traits and competencies of individual leaders in leadership programs. It is principally an interventionist approach that starts from the premise that the problem of leadership resides with the individuals and that they are the ones in need of fixing, and never mind systems or structures. Thus, leadership interventions fall into a competency and capability approach (Smith & Eades, 2003;, 2006; Bolden. et al., 2006; Fulop & Day, forthcoming) 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. Illes and Preece (2006: 325) offer an alternative perspective that they term “leadership development”, which focuses on collective leadership processes, such as building relationships, networking, trust, commitment as well as appreciating the social and political context and how these give rise to certain preferred leadership styles and practices. This sort of approach sits at the margins of healthcare leadership programs in Australia, despite the term ‘leadership development’ being widely used. It also embraces notions of hybridity.

Engaging clinicians in managerially-based leadership is problematic because a deeply entrenched Discourse of professional leadership already exists in healthcare that is as heroic as it gets. Discourse with a capital “D” describes a general and enduring system in which power and knowledge relations are established in culturally standardized ways that influence social practice as well as shape human subjectivities (Fairhurst, 2007: 7). Thus, there are certain factors more prevalent in sectors such as healthcare that require a re-think about the practice of leadership because account has to be taken of both professional (medical/clinical and academic) and managerial (cum leadership) identities, as well as particular collective forms of negotiation of goals and purpose, and the specific policy contexts (e.g. leadership used as an intervention) that impinge on the situated practice of those doing the leading (Bolden et al., 2009: 373).

Only recently in Australia have we seen attempts being made to question the dominance of heroic approaches to leadership in healthcare and to encourage the adoption of other approaches such as distributed and relational leadership (Fulop & Day, forthcoming). However, focusing on issues of engagement produces a “blind-spot” because lack of engagement, faulty or flawed engagement, especially on the part of doctors, dominates the Discourse of managerial leadership in healthcare. This means that we lose sight of the fact that “successful”, “good” or “exemplary” engagement by clinicians does happen and needs be examined. This “blind-spot” also occurs because the media-hype and rhetoric surrounding healthcare plays to the heroic side of professional practice in reporting of stories of extraordinary medical interventions and the marvels of medicine and medical technologies, or through anti-narratives of tragedy and failure that only serve to make the heroic more compelling! Attention is rarely focused on instances of exemplary managerial leadership or what it means to be accomplishing managerial leadership in exemplary ways in the hospital setting.
The paper makes a contribution to the study of leadership in healthcare, and in the realm of the clinician manager as doctor, by drawing on several leadership theories or approaches that embrace ‘hybridity’ to address the issue of exemplary leadership in a way that has not been previously done. Hybridity is not claimed to be a new form of leadership per se but a way of re-orienting our thinking, especially in looking at the problems that surround theories and practices of heroic and post-heroic leadership (Gronn, 2009; Grint, 2005). It is an interesting way to look at exemplary leadership, but by no means the only way. I am involved in research on clinician managers and leadership, trying to discover how clinician managers, namely doctors who were identified by their peers to be exemplary leaders, interpret their leadership experiences and to what extent their co-workers produce confirming or disconfirming accounts. I am interested in those clinician managers who are at the level of a head of department or equivalent and who, as Bolden, Petrov & Gosling (2008: 363) would say are also situated at the interface of the discipline, the profession, the institution and the academic realms and hence, in ‘the thick’ of leadership contradictions and conflicts. My research has a pragmatic orientation because it seeks to influence how leadership development programs are designed for clinicians who will or are doing the work of leadership.

The paper proceeds as follows: the first part takes a necessary excursion into a select body of literature to see how clinician managers or ‘hybrid-professional managers’ are presented in the dominant Discourse of health, which I argue underpins the disconnect many working in clinical units, and especially doctors, might feel about the heroic-individualized discourses of leadership and the problems that arise in the transposition of such discourses for practice (Ziegler & DeGrosky, 2008: 291). The second part develops a framework for considering leadership (and leading) as a ‘hybrid’ phenomena by drawing on two approaches that are popular in Higher and Further Education (HE and FE) research but not in healthcare. Empirical material I used to illustrate instances of hybridity in healthcare. The third part discusses limitation of the hybridity approach and suggests and alternate approach.

The Hybrid-Professional Manager Dilemma
Clinicians are often portrayed as resisting managerial intrusion (Mueller et al. 2004: 78) and as having an aversion to taking up formal leadership positions/roles that are equated with becoming a clinician manager. In terms of clinician managers, it is doctors who are usually singled out in
reports, committees of inquiry and academic publications as the most difficult group to integrate
into the management of hospitals or by extension engage them in leadership roles, however, this
is understood. They are frequently targeted as the most likely group to resist change or
undermine healthcare reforms that threaten their professional allegiances and autonomy (e.g.
Mintzberg, 1997; Carr et al., 2003). By the same token, clinicians, and especially doctors, are
recognized as being central to the successful implementation of reform initiatives, such as
improving quality, safety, cost containment, rationalizations, new forms of accountability and
transparency in public hospitals and thus their leadership is seen as pivotal to healthcare reforms
(as result approach). Though attempts have been made in many OECD countries to reign in
professionals, and especially doctors through new forms of managerialism (Mark & Scott, 1992),
Sheaff et al. (2003; also Ham, 2003) argue that the system still needs clinicians on-side for much
of the time for it to work and hence, the need 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-inspired notion of leadership over their peers and colleagues.

Despite extensive health sector reforms in many countries, including Australia, it is
argued that clinicians have managed to retain significant professional autonomy, and hence
control, over the use, if not the allocation, of resources in hospitals despite the steady stream of
reform measures and changes that have occurred in many OECD countries to counter these very
same things (Kitchener, 2000; Doolin, 2002; Dent, 2003). Clinician managers are not considered
to be the vanguards of change and improvements needed to raise the performance of other
clinicians qua outcomes and targets imposed from ‘above’ (as administrative imperatives). They
are also portrayed as conveniently distancing themselves from these pressures by virtue of the
autonomy and power they garner from their professional roles (Hoque, Davis & Humphreys,
2004) or alternatively, their ability to exit from the management domain when circumstances no
longer suit them and yet not lose legitimacy, status or credibility, with the opposite often being
the case (Mark & Scott, 1992: 217). This certainly adds to often quite popular view that
clinician managers generally lack commitment, lack adequate management skills or knowledge,
and lack leadership capacity to merit giving them the influence and control they desire and that
they still see as integral to their professional autonomy (Hoque, et al. 2004: 367-8). 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, it seems the actions of senior doctors still remain the most crucial factor in achieving management aims (Dent, 2003; also Denis, Langley & Cazale, 1996). Sheaff et al. (2003; also Kitchener, 2000; Ham, 2003) describe how specific strategies adopted in healthcare to remove control of resource decisions from doctors and vest them in management systems (e.g. through evidence based medicine), have come cropper in the face of professional leadership. This leadership has its own form of resilience because many clinicians remain strongly influenced by their professional/colllegial allegiances and obligations.

For Mintzberg (1997: 13), the hybrid-professional manager embodies the worst aspects of the “bundling” together of roles in tertiary hospitals where teaching, research, and clinical service are augmented by an additional management or administrative burden, which he notes is usually forced upon incumbents causing the latter role to become a distracting pre-occupation rather than a serious one. He views the hybrid-role (or professional manager) as contributing significantly to the problems of running hospitals because it creates a flawed model of management and leadership engagement that works on a distraction principle. He concludes that such roles are a waste of talent and ultimately, leads to sub-optimal performance and outcomes across the key areas of teaching, research and clinical practice. Mintzberg reinforces the negative view of the hybrid-professional manager and actually questions their capacity to lead (person problem).

Healthcare is problematic because leadership is generally conflated with management and in order to address the problem of clinician engagement and this is reflected in the wide-spread use of the term ‘leadership’ rather than ‘management development’. The hybrid-professional manager in healthcare is largely presented as a deficit model when it comes to leadership, but one that could be fixed or righted in some people’s opinion, if doctors play their part and become engaged in leadership (and by extension, let management take care of itself or leave it to others). This fixing of the meaning of leadership and management in a hierarchical and bifurcated way creates its own problems, and plays to heroic notions that are already a significant part of the professional ethos in healthcare. Leadership in the realm of the clinician manager is fundamentally premised on a professional and not managerial understanding of leadership and this is glossed over in many leadership development programs and interventions in the hope that it will be dealt with somehow by someone at some point in time. In healthcare, and amongst clinician managers (and especially doctors), the professional identity is usually the dominant as
well as default identity in relation to management practices, creating for many a ready-made heroic Discourse that entails charisma and command. The managerial leadership discourse is just another competing discourse amongst many that, as Hall (2008, cited in Fairhurst, 2009: 1620) says, places leadership actors into sensemaking environments in which they have to manage a number of quite complex and un-unresolved tensions and where in the case of clinicians (and especially doctors) the heroic is compelling because they are positioned at the intersection of the professional and collegial domain from whence they garner their power and influence, status and identities. Alvesson and Sveningsson (2003a: 983) suggest that in knowledge-intensive contexts where there are high levels of professional expertise, the leadership discourse is often interpreted in terms of esteem-enhancing identity work and with celebrating the idea (often a myth) of professional discretion and the concomitant denial of bureaucracy and control or management.

Gleeson and Knights (2008) argue that the framing of leadership in such contexts must take into account the tensions and conflicts that shape notions of leadership as part of a professional process (Gleeson & Knights, 2008: 53) that means acknowledging that professionally-based leadership often comprises a cadre of highly qualified reluctant leaders who do not necessarily see management as a career goal and who work in systems that they generally see as failing to engage them in ways that “…enrol their commitment and goodwill, and mobilize their willing expertise” (2008:65). Gleesons and Knights found that in their study of reluctant leaders in the Higher Education sector in the UK there was significant danger of over-subscribing to the heroic discourse of leadership and adopting a ‘tough stuff” attitude to work intensification common in the UK under the New Public Management (NPM). This manifests in managers cum leaders trying to prove that they can thrive on pressure and have strong individual resilience and hence, can demonstrate a requisite toughness. In healthcare this is the normative model of professional leadership that comes with medical training of clinicians. The dilemma of the purported multiple forms of leadership pose significant challenges in theorizing leadership in this domain (Degeling, et al., 2003; Degeling & Carr, 2004) and it is to this issue we now turn.

This Thing called ‘Hybridity’
For Grint (also Bolden, et al., 2006; Ford, 2008) heroic, individualized accounts of leadership are problematic and pose significant dilemmas for organizations, groups or individuals who adopt
them as a universalizing, “one-size fits all” approach. He illustrates this by creating four frameworks that he says pretty much covers how managerial leadership is talked about in either heroic or post-heroic terms. He treats his four categorizations as an ideal-type, and hence a heuristic device, and include the following: leadership as Person (the **WHO**), as Results (the **WHAT**), as Process (the **HOW**) and as Position (the **WHERE**). Grint explains that most accounts of leadership typically draw on a combination of these, so when we talk about leadership, it usually involves multiple meanings, contested concepts and significant identity issues for those who are doing leadership work. In the end, he says the first definitional step is the critical one because it affects how we recognize, train, teach, exert and limit leadership (Grint, 2005: 32).

**TABLE 1 HERE**

Using his four frameworks, Grint is able to shows how particular interpretations of leadership open or forecloses certain options affecting how things get organized and get done. **Table 1** provides a brief summary of his heroic and post-heroic assumptions. Grint considers hybridity as one of several ways in which leadership can be thought of as a collective phenomenon. He does not suggest that individual leadership is unimportant or is automatically replaced by collective forms, but that each has to be understood in relation to the other. In one sense, Grint’s notion of hybridity informs recent developments in leadership theory but in another, it remains locked into a leader and follower binary that is precisely what critiques of post-heroic leadership are railing against.

‘Hybridity’ is emerging as a “‘blanket term’ used to describe leadership approaches that either have in the past been, but are no longer, wedded to heroic - post-heroic approaches to leadership, or never saw it this way in first place. Gronn (2009: 383, 389) suggests that the over-reaction to heroic leadership led to distributed, shared or collective forms of leadership being seen as the alternative to heroic and individual forms. In the case of distributed leadership, this has manifested in one of two ways: either it was seen as leadership by large numbers of people or an aggregated sharing of influence in which the distributed came to mean leadership ‘stretched across the organization’. This either/or dichotomy denied the agency of individual leaders and left distributed leadership discourses with nowhere to go when individual leadership appeared.
Gronn says he could conceive of leadership in organizations comprising teams, networks or individuals who are deemed as charismatic and even as mini-Obamas. These he says are not examples of distributed forms of leadership but a hybrid or mix that more accurately describes the situated practice of leadership. He says a hybrid (or hybridity) can accommodate individual and holistic leadership in which the idea of a ‘leadership configuration’ replaces other pre-determined collective forms (e.g. distributed or shared) thus, encompassing a mixture of tendencies and not one specific form, and where both the focused and distributed can co-exist. This means entertaining elements of top-down, bottom-up, ‘horizontal’ (informal or cross-institutional) forms of influence, authority and power (Bolden et al. 2008: 304). As stated above, there is no hybrid leadership theory per se, so it can be left to others to fill in the framework and hang examples of it. Gronn says what hybridity no longer allows though, is for the reinstatement of collective and individual and leader(ship) and follower(ship) binaries because these do not capture a hybrid or leadership configuration as the co-existence of different forms.

**Blended leadership**

Collinson and Collinson (2006; 2009) provide one of the best examples of an empirically-grounded interpretation of hybridity, which is based on their research on ‘blended leadership’ in a number of Further Education (FE) institutions in the UK. In fact Bolden et al. (2008: 364) use the term ‘blended’ and ‘hybrid’ interchangeably. Collinson and Collinson developed their approach through trying to discover how leadership was enacted, distributed and experienced at various hierarchical levels within FE institutions. They did not start off with heroic assumptions and so did not treat leadership as “…the mysterious, individual characteristics of charismatic individual heroes” (2009: 369). The study was undertaken in seven FE institutions and lasted 2.5 years and set out to explore the dynamic and asymmetrical nature of leadership relations. One part of the project explored effective leader-led relations and sought individual respondents’ own definitions of effectiveness and attributions of the cause. They also conducted interviews with employees on their preferred practices of leadership which covered all hierarchical levels. They discovered all seven college interviewees were remarkably consistent in terms of seeing leadership as a vital ingredient, and significantly so, in terms of governance issues. Their main finding was that employees expressed a desire for both heroic and post-heroic
forms of leadership as complementary and mutually desirable even though these views were incompatible with the literature (Collinson & Collinson, 2009: 370).

The key area in which the blended form emerged was in relation to the matter of ‘delegation and direction’, where employees expressed strong preferences for consultation but also decisive decision making and direction. ‘Distributed’ in these contexts meant a ‘top down’ delegation that was considered to enhance team working and employee commitment but where employees also wanted direction, vision and clear expectations from their leaders. Clearly defined jobs, reporting-structures and decision making were also perceived to enhance effectiveness (Collinson & Collinson, 2009: 370). Collinson and Collinson noted that there were inconsistencies in their finding with research undertaken on the UK Higher Education (HE) sector (i.e. universities) where Bolden et al. (2008, 2009) had found a preference for ‘bottom up’ distributed practices also co-existing with preferences for strong and inspired leadership at the top (i.e. charismatic), in relation to managing change. Collinson and Collinson discovered other paradoxical relations that they though added to the blended nature of leadership. The first of these related to issues of distance and proximity, i.e. leaders being seen to be visible, close to operational matters, ‘getting their hands dirty’ and ‘leading by example’ (2009: 372), which they say reflected a strong informal culture in these institutions. Similar paradoxical issues were noted in relation to internal and external engagement, especially with leaders having to deal with audit regimes and pressures for high levels of accountability and compliance, yet employees also wanting them to stay in touch with internal matters in order to be effective. They concluded that the discovery of the blended or hybrid form indicates that leadership practice can longer be seen in as an ‘either/or’ dichotomy but as a ‘both/and’ option (2009: 377).

Collinson and Collinson do not suggest that blended leadership is going to be evident in all contexts but that their research indicates a need to develop versatile practices in order to be seen to be effective in leadership roles, which they interpreted in terms of a position, such as a principal. They acknowledge that hybridity is not a “one best way” to lead but that it will “…take different forms and shift according to different interpretations and circumstances” (376). Thus, the challenge is to interpret the hybrid nature of leadership across different contexts and know how to frame appropriate responses. It is the ability to be flexible that is important for effectiveness or for any possible claims to be exemplary. The extent to which Collinson and
Collinson’s finding are mirrored in healthcare remains speculative as the blended approach has not been applied to this sector that the author is aware.

However, aspects of hybridity have been identified in interview materials collected for the third phase of a study of clinician managers and exemplary leadership being conducted by the author. The study has been undertaken in four phases, the first used a mail out questionnaire (open-ended) to identify clinicians who other clinicians believe are exemplary leaders (Fulop & Waight 2007); the second involved interviewing eight of these clinician managers (Cs), who had to de-identified for the study, and used face-to-face, semi-structured interviews based on open-ended questions to elicit descriptive and reflexive accounts (Klenke, 2008: 126-133); the third used phone interviews (a requirement of ethics approval) to interview 24 co-workers (CWs) of the eight clinicians about a range of issues and included some of the questions that had been put to clinician managers; and a final phase involved re-interview the clinician managers focusing on specific leadership issues. This exploratory study is part of a larger project that will develop an in-depth, longitudinal study of a select number of clinical units, several of which are in the current study, and where there is evidence of high performance (see Bate, Mendel & Robert, 2008). The phone interviews with co-workers involved using short structured questions suitable for interviewees who were deemed “off limits” because it was felt that to keep these respondents anonymous, given they were providing views on a colleague and possible head, no physical contact should be allowed (see Klenke, 2008: 134). Interviews were recorded and transcribed. The respondents were of a mixed gender and a number were also clinician managers. They came from allied health, nursing and medicine as well as administration and all worked in teaching or tertiary hospitals. They were chosen from lists given to the researcher (some by the clinicians involved and others by co-workers) from which names were selected. Clinician manager had no knowledge of who was to be interviewed. Selection was based on gender representation and nothing else. The respondents came from areas such as pediatrics, neonatal, anaesthesia, surgery, rehabilitation (children), internal medicine and general medicine. Their units range in size from 50 to approximately 1000 staff and a budgetary range of $1 million to $140 million or to no knowledge of the budget.

Exhibit 1 contains extracts from interview material that reflect hybridity as expressed in responses to a very general question about the nature of leadership in the clinical unit but not on exemplary leadership per se. This was done deliberately to elicit as wide a range of responses as
possible and not privilege a leader-focus, which questions of effectiveness might. I have chosen several responses that reflect Collinson and Collinson’s findings in relation to delegation and direction because these were most often commented upon by co-workers. Delegation and direction also showed marked differences in findings between FE and HE as reported by Collinson and Collinson, as well as the unexpected finding of charismatic leadership.

EXHIBIT 1 HERE

The responses are necessarily selective but representative of the strong emphasis placed on collaboration in relation to decision making and consultation that align with findings in the HE study and the ‘bottom up’ pressures in such environments. There were no hints of charisma in the responses and possibly reflects that leadership at the clinical level (middle levels) is not necessarily seen in strategic terms (see Gleeson & Knights, 2008), but rather, as an aspect of individual leadership along the lines of the position, as mentioned by Grint (see above). The concerns with decision making are consistent with studies that confirm this to be a significant challenge for leadership practice in healthcare. The responses of co-workers also aligned with answers given by clinician managers to a similar question in respect of mentioning collaboration and consultation in decision-making.

Leadership work

Bate, Mendel and Robert (2008: 175) offer a different take on hybridity based on their study of Quality Improvement (QI) in nine leading hospitals across four counties. They list quite a number of different kinds of leadership ranging from what they term a macro to micro examples (e.g. collective and distributed, charismatic leadership of a single individuals, knowledge leadership (macro), leading by example, mentoring and mobilization of leadership, and the division of leadership between technical and political tasks (micro-level). They 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 as is the case with the blended leadership approach. The aforementioned are examples of different types of leadership across and not within a setting, which together create hybridity. Bate et al.’s study suggests that in healthcare, hybridity might be more usefully thought of as leadership solutions to challenges and dilemmas, generic or otherwise, as distinct
from the usual way leadership is framed. This also provides another avenue from which to consider exemplary leadership.

Bate et al.’s approach shares similarities with Kelly et al.’s (2006) research on ‘patterns of leadership’, which did not start from a theory of leadership but with the pragmatic concern of designing leadership programs that managers in the public sector can relate to and that recognizes the role of researcher and others as implicated in such a design project. They actually claim that most leadership theories are unable to explain the phenomenon they purport to and mostly create confusion (2006: 184). They do however lean towards a critical approach and hence, emphasize the power dimensions of leadership and thus, its politicized nature, which reflects their research on FE institutions in the UK. They treat leadership as a form of work that requires certain skills that can only be understood if studied in situ and that these entail social, political and technological dimensions. More importantly, they claim that in the public sector ‘leadership’, ‘performance’ and ‘effectiveness’ have to be understood as organizing devices or ‘policy technologies’ through which political agendas are played out. Their aim is to understand the work that leadership does in such contexts, especially under the NPM in the UK. They set out to discover how this work is accomplished so that the reoccurrence of familiar situations can be used as the patterns upon which to build “teachable (and shareable) moments” (2006: 185).

Kelly et al. (2006: 186) suggest that leadership work is a situated accomplishment and what we need to do is develop sensitizing cases and examples that will resonate with the experiences of managers who occupy similar positions (in their case senior managers). However, they say this will require presenting leadership work as “the extraordinarization of the mundane” (citing Alvesson & Sveningsson, 2003b: 377) rather than the heroics of crisis management and organizational transformations that dominate leadership studies, and probably more so in healthcare then elsewhere.

They conducted ethnographic research and started from the premise that design has to do with a sense of quality and creating something that is “good”, that really works, and fits with the social circumstances of its use. They say questions such as: ‘what is good leadership’ or ‘what makes a good leader’ have to broken down to manageable parts which the concept of ‘leadership work’ allows because it translates into questions such as, what makes “…a good meeting; a good public presentation, a good staff briefing, a good presentation of [financial] accounts , and so forth…” from which patterns (repeated, grossly observable phenomena) can be discerned that
will help us to learn about leadership work (Kelly et al. 2006: 186-7). While they admit that the idea of patterns is not new, Kelly et al. say that what is new for them is that they are able to look for patterns in the setting itself – in the mundane, recognizable, nitty-gritty experiences of leadership work. From the ethnographic research they discovered three discernable experiences of leadership: *pattern 1- the public face of leadership; pattern 2- the stuff of meetings; and pattern 3- playing the figures*. These align with the blended leadership approach but in different ways.

The first pattern refers to the need to manage the public face of the institution that involves both ‘front stage’ and ‘back stage’ performances in which core values around empowerment, democracy, commitment and professional identity are forged by multiple actors, and especially figures such as the principal in his public addresses. It is through the telling of stories (e.g. sagas of change, etc.) about the institution that figures such as the principal can come to be doing leadership that can involve charismatic themes (2008: 188; see also Grint, above). Kelly et al. explore how the repeated telling of stories and sagas rely on the use of modern technology and when used creatively and innovatively, also become critical to adopting and spreading the language and presentational practices of business, which drives the NPM. As Grint (2005: 23) reminds us, it not the consciousness of leaders that make them effective but their hybridity and how they are linked.

The second dealt with the patterns of work through which meetings were accomplished. It was not about an accomplishment such as getting new building up, for example, that is often construed as the work of leadership, which often underpins heroic-individualistic assumptions, but rather, the ordinary ways in which things were done, such as writing submissions, reports, preparing applications and so on. These involve individual and collective work in which meetings provide the structured environment to tackle issues, which were often treated as an organizational game. What Kelly et al. found was that leadership in such contexts was about principals having ‘organizational acumen’, which entail quite mundane skills that give people the ability and entitlement to interpret rules in particular ways. This type of acumen is used at all levels of organizations to make credible presentations and ensure a convincing story is told to relevant stakeholders. (2006: 192).

The third pattern focused on accountability (in auditing and financial reporting terms) and how this gets done, but also how it is managed so that is seen to be done for the sake of others.
They framed this finding around the inspection regime of FEs that create enormous demands for accountability (same as Collininson & Collinson, 2006; 2009), in which doing leadership is much more than visions and strategies. It is more ordinary and involves skilful management of accounts that are produced collectively and ensure the performance of ‘leadership’ for others (who are in the accounting regime) through things being seen to be done. They observed that managers and their co-managers do leadership work through such things as the preparation and rehearsal of performances of effectiveness (such as holding meetings and pre-meetings to prepare submissions), through the work they do producing figures and facts, and how they work continuously and often in ingenious with technology and data to produce convincing and “authentic” performances of that work so others can see it as done. Doing well at these performances depends on being accomplished and having mastery over “the gambit of compliance”, which comprises leadership work:

The ‘gambit of compliance’ (Bittner, 1965) …requires that considerable experience and skill be used to legitimately accomplish this kind of work. Knowing which story to tell, which figures to use and which stakeholders to communicate to is an activity built up over time, through many repetitions (including success and failures) through which leadership work is refined and crafted into a stock of what Bittner has also termed ‘organizational acumen.’ (Kelly et al., 2006: 195).

Kelly et al. argue that both these accomplishments comprise the often taken-for-granted patterns of interactions and activities as well as skills that comprise everyday leadership work when it is no longer presented in an extraordinary way, though it does not exclude ‘extraordinization” through stories that frame leadership as charismatic. They also say that the patterns identified entail the sort of experiences that are typical of “…been there done that” (2006: 197) accounts that can be used to build a stock of knowledge to share and educate other managers in leadership work. This work largely amounts to producing and mobilizing convincing accounts of what is being done (e.g., achievements, financial status, performance etc.) and this involves effort and collaboration as well as the manipulation of figures, stories, systems and technologies to get
work done. This leads Kelly et al. to describe leadership as a pattern of activity that is summed up as “leadership through the management of accounts” that must be seen to be done adequately by others (Kelly, et al., 2006: 192-3).

These findings have parallels with Gleeson and Knights (2008: 64) who also found that leadership as a professional process comprise two contradictory things. 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 NPM culture. The second entails innovative skills and practices being adopted by professionals in and against the new culture of audits. To quote:

Such practices, involving brokerage and mediation skills, often require professionals mediating contradictory policy-practice agendas at the interface of their everyday practice. These processes (sic) have been variously described in recent research as ‘underground working’, ‘hidden-trade’, ‘restorying identity’. ‘tacit knowledge’, ‘principled infidelity’, ‘conscientious objection’ and ‘added value’ as ways in which professionals both seek to sustain a sense of meaning, identity and autonomy [in] their lives as well as getting the job done. (Gleeson & Knights, 2008: 64).

Such knowledge is mostly invisible and Gleeson and Knights suggest that when it is recognized by politicians, policy makers, and the media, it is usually in the context of being ‘part of the problem’ of leadership in the public sector. Kelly et al. (2006: 192) also note that these aspects of leadership are rarely dealt with in traditional approaches to organizational leadership and decision making and so do not get included in leadership development programs.

In the second phase of my research, I found evidence of instances of organizational acumen and gambits of compliance being used in the responses clinician managers gave to questions which had nothing to do with leadership per se (see Exhibit 2). Three of the five clinician managers in the study are reluctant leaders by the definitions used by Gleeson and Knights. In Australia when someone talks about a ‘clinician manager’ they are usually referring to clinicians who hold positions such as CEOs, directors, managers or heads of clinical units but
who also engage in clinical practice in their hospitals. It includes doctors, nursing and allied health professionals as distinct to lay professional managers who in healthcare can also be either ex-clinicians or lay persons. As in the HE sector, there is a recognized valuing of expertise, clinical reputation and credibility in leadership roles (Fulop & Waight, 2007; Bolden et al. 2008). Again as in HE, the roles of clinician managers are changing to the extent that they are not necessarily hospital-based but belong to networks and other configurations that add more complexity to their already hybridized roles (Whitchurch, 2008).

EXHIBIT 2 HERE

When co-workers were asked to give an example of something that illustrates exceptional leadership in the context of their clinical unit, a number referred to things that would require organizational acumen (e.g. a space acquired against all odds where the focus was on how this was achieved by the clinician manager and his team and not the space itself) and gambits of compliance (e.g. waiting lists, new systems and even the acquisition of a new coffee maker).

A question was also asked of the clinicians about the performance of their unit and several options were given as to why a certain level of performance might have been achieved and one of these was leadership (see Bailey & Burr, 2005). Only one respondent gave leadership as a main reason. Lastly, when clinicians were asked to comment on what they thought should be the role of a clinician manager, none of the responses mentioned the word “leadership”, “leading” or being a “leader”. All bar two thought the role of the clinician manager was appreciated in their hospitals, the others repeating the negativity associated with the role of the hybrid-professional manager. Shock, surprise, embarrassment and dismay would describe their reactions to being nominated as an ‘exemplary leader’ in their clinician manager role.

**Discussion and Conclusion**

Hybridity, as presented in this paper, has provided two complementary ways of looking at leadership in healthcare, and in particular within the realm of the hybrid-professional manager. Each affords new possibilities for developing more relevant leadership approaches and programs in healthcare settings. Kelly et al.’s work in particular moves us beyond the leadership challenge conundrum that seems doomed to endless failure in the healthcare context, to one that presents
leadership as a solution oriented practice through which leadership work is scaled down to manageable components (see also Ham, 2003) but also realistic in terms of how things get done on a day to day basis in the name of management and leadership. For those who wish to see leadership as still only concerned with strategy and change, or things that are novel and yet to be discovered and not as déjà vu experiences (e.g. Grint, 2005: 15), Kelly et al.’s approach will prove disappointing because leadership work is an unremarkable affair, especially in the context of the demands of NPM that pervade many public sector organizations such as healthcare and have changed the nature of the work that has to be done. Both blended leadership and leadership work encompass the talk of leadership that is contained in Table 1, with results coming to the fore because of the prevalence of the NPM culture. However, these are not the only approaches to hybridity that we should entertain when the issue is leadership in the professional contexts of healthcare where ‘skillful’, ‘effective’, ‘good’ and ‘exemplary’ will mean different things. What I have tried to show with my research is the relevance of this line of theorizing for exploring the nature of leadership in healthcare with a view to finding what counts as exemplary through exploring hybridity.

There is much to be learnt from research that adopts either the blended or leadership work approach as each draws insights based on in depth, longitudinal research that includes ethnographic work, which is hard to do in many healthcare settings. However, there are other approaches that need to be considered that can build on the ones we have already looked at. While both the blended and leadership work approaches allude to, and in fact point to, the need to frame leadership as a relational phenomenon, this aspect is not well developed. Nor do they sufficiently theorize context or account for how context which is more complex an idea than situated practice. These omissions would need to be addressed by an leadership approach in healthcare. For example, the stuff of meetings in healthcare is contextualized around professional regimes that have to be theorized and accounted for in any hope of affecting practice. This is illustrated by Mintzberg who says that the big problem in hospitals might well be the style of problem solving itself because “…systemic problems have to be solved systemically, and ideally preemptively” (1997: 17, emphasis included). However, he says hospitals are organized through the committee system and these systems divide into different worlds and meetings become reflections of these divided worlds. Mintzberg says that added to this, you have take into account how decision making occurs in many areas of medicine –
quick, decisive, individual, often of dramatic in nature, treating parts of the patient, and only intermittently interventionist (a cure or a cut) – and the problem gets even bigger. The uniqueness of clinical decision making, has been proffered as major factors militating against the universal application of management and leadership theories in the hospital context (Smith, 2002; Smith & Eades, 2003: 14). The lack of predictability in diagnosis and treatment, which involves decision making that is ill-defined and complex, and the technical and complex nature of many interventions, has led Smith and Eades (2003: 16-17) to suggest that 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 that typify their work context. But even this does not get to the core of the problem, which Ham (2003: 1978) summarizes well when he says (…that hospitals and other health-care organisations have an inverted power structure, in which the people at the bottom generally greater influence over decision-making on a day-to-day basis”.

Hybridity became an important ‘corrective’ against relational approaches to leadership, notably distributed leadership, that were imbued with pluralist assumptions of power that drove the push for democratizing the workplace through a representational approach to leadership (hence, the number and stretch across the organization) that had in turn taken an aim at individual and unitary views of power (see Hosking 1988; 2000). Hosking’s work on ‘skillful leadership processes’ (Hosking, 1988; Hosking & Morley, 1988) is considered to be ground-breaking in terms of developing what is now termed the ‘process’ or ‘relational’ approach to leadership (see Grint, 2000; 2005; Bolden et al. 2008: 360; Uhl-Bien, 2006; Fairhurst, 2008). Her work, and those of her colleagues (e.g. Hosking & Fineman, 1990; Hosking & Bouwen, 2000), has been widely cited for this reason, but her approach is not fully elaborated in any study that I am aware yet might have particular relevance to healthcare settings. She actually treats leadership as a special kind of organizing activity which she says is complex, social, political decision-making through which social order is maintained, improved or made to decline. The social order is shaped by power relations and values (Hosking & Morley, 1988: 91; also Hosking, 1988) and is a negotiated order (collectively shaped as a ‘bottom-up’ process, hence the distributive bias). She argues that leadership is skillful (effective) to the extent that a ‘flexible social order’ is achieved and this means leaders 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 social identity. She also later introduced the idea of ‘intelligent social actions’ to further elaborate on how actors construct social orders (as contexts that are relational and co-created through social interactions) that help them add value to their lives. She illustrates this by saying that a context in which agreed rules and procedures do not work, and hence are not adding value, will mean that intelligent social action can lead into ignoring the rules and in their place inventing new ones. This gets close to the idea of ‘gambits of compliance’ but in a way that takes into account the role of values and identities (Hosking and Fineman, 2000: 590). Hosking’s work offers promise for healthcare leadership research because also takes account of cognitive, social, political, and emotional aspects of leadership that are important to any understanding of leadership in professional contexts. It also offers an approach that can build on leadership through a solution-based approach that possibly holds to key to finding out what is exemplary leadership in healthcare and for whom.

References


**TABLE 1: Four Ways of Talking about Leadership: Adapted from Grint (2005)**

**Person (WHO ‘leaders’ are )**

*Individual – heroic assumptions*: It is who you are that determines if you are a leader or not- your traits – your personality – are important – your characteristics or competencies are the essence of leadership.

**Result (WHAT ‘leaders’ achieve)**

*Individual-heroic assumptions*: attributes things produced or other outcomes to an individual – makes it explicit that an individual can be responsible for results. Results are treated as if they “speak for themselves”. Role of leader is not to make things happen but act as a hero when they do and accept being a scapegoat when they do not. Encourages authoritarian/ command leadership and plays down contributions of others who are not designated a formal leader.

**Process – (the HOW ‘leaders’ get things done)**

*Individual – heroic assumptions*: leaders act differently to non-leaders; leaders embody exemplary performance; leadership processes can be copied, are neutral to context and followers are passive recipients of acts of the leader.

**Position – (the WHERE ‘leaders’ operate)**

*Individual - heroic assumptions*: in a hierarchy, positions and individuals are very important’ so promotes the idea of Leadership-in-Charge; or Leadership-in-Front; power and authority is positional attribute, promotes bureaucracy and stagnation

**Person (the WHO)**

*Post-heroic – collective assumptions*: focus on role of informal leaders, or even leaderless groups (e.g. hunter gatherer societies); instances where no-one leader can claim credit for a something only a collectivity (e.g. running an operating theatre); where leadership is not a person but a collective act of defiance (the “Mexican Wave” syndrome); a symbol (e.g. Swastika); a story (tales of heroism), and technology. The *hybridity* of the world means that leadership is a mix of relations and is something that occurs creatively in collaborative *hybrids*. Leadership is about being linked and networked. It is about putting the “ship” back into leader-ship. Leader-ship cannot be rolled out in scripted ways.

**Result (the WHAT)**

*Post-heroic – collective assumptions*: impossible to establish causal links between leaders and results; even if followers make such attributions; results of leadership incredibly difficult to quantify in terms of aims achieved or longer term impacts.

**Process – (the HOW)**

*Post-heroic – collective assumptions*: leadership is a relational concept. Possessing certain skills and resources is not enough. Leadership is only meaningful if followers are engaged in leadership. Leadership means making followers face up to their responsibilities and leaders learning from their followers. Leadership seen as *process of dynamic collaboration* that allows people to experiment with new emotional and intellectual meanings.

**Position – (the WHERE)**

*Post-heroic – collective assumptions* - focus on social processes of organizing to achieve leader-ship. In a *heterarchy*, developing *concertive action* (collaboration) is linked to decentralization, social responsibility and collective learning through flexible roles and relationships. Concertive action is where a number of individuals agree to share/divide leadership and ensure that the relevant accountabilities and responsibilities are also divided so that taking collective responsibility for leadership action and activity occurs when and if needed. Distributed leaders relinquish their roles and responsibilities when they are no longer needed. When there is concertive action (not delegated) then an organization can be described as *leaderful*, i.e., not driven by heroic leadership and the cult of the individual.
**Exhibit 1**

**CW18 - Heroic and Post-Heroic**
Well in terms of the leadership that I receive from C5, I find that supportive…and I find it helpful because it allows me to talk out the things that are most difficult, and I find it supportive ‘cause sometimes it even involves taking some issues out of my hands where they’re really tricky. And dealing with them at a higher level …So C5 is really good at having that wisdom to know when that is required, and he’s also supportive of where I’ve had sort of major registrar issues. So he’s there as a really good back-up …but he’s happy to let you get on with stuff where things are being managed well and you could equate it with good parenting, without being sort of patronising of myself …Good parenting lets kids go and have that bit of extra freedom and, make some decisions for themselves where it’s appropriate, but you know, he provides is a sort of supervisory role where it’s needed but he leaves us …on a long leash.

**CW 20 – Post-heroic**
We work in a collaborative relationship between myself and with C6 and X6 to make things come to fruition, if possible I guess. Not everything is possible. It’s being proactive…and really leading by example.

**CW4 - Post-heroic**
It's very much a team leadership around particular issues. The team that's involved would make decisions and so within Dept 2, there's clinical streams, with XY being one of them, and we have a head of XY (Dept) who's another doctor and, so a lot of decisions would be made between C2, and Dr 2 and myself and members of the team in relation to the you know, direction of the X2 service. So it's really very collaborative.

**CW5 - Post-heroic and heroic**
I think it's collaborative. We have an Executive which has all the Heads of Services, and Lead Clinicians that helps in the process of making decisions. C2 does not make decisions without consulting. At times he has to, and then he wears it and he says, I'm sorry I had to make a decision and sorry if you don't like it, but I had to, but, it does happen. But usually things are decided very collaboratively. If he does make a decision and there's a bit of an outcry about it, it's done in a structured way and feedback …probably not the best decision and we need to look at that again, and that's done in the Executive meeting that we have once a month. The Executive meeting is an excellent forum for making sure that you know, he has a feel for things.

**CW7 – Heroic**
I want to say loose, like he lets them do their own thing. He's not dictatorial, at all, at times it's good and times it's not so good. Everybody should be allowed to do their own thing but occasionally I think he needs to be a bit more involved, or a bit more, have a stronger opinion about things, if something’s going wrong.

**CW 20 - Heroic**
….I believe a clinical manager is important because the leadership of being a role model to their own peers and to their own, like so with the consultants you know, being a role model to the junior staff, so they are basically guiding. There’s that leadership.

**CW23- Post-heroic**
Well we could have an authoritative leadership where the director actually tells you what you're doing; it's in reverse. Director C7 starts off by saying this is our problem; how do we go about solving it and lets the department come up with a solution. To a large extent C7 had a reasonable solution himself. It’s far easier for the department to realise where it needs to be cooperative rather than the other way around.

**CW24 – Heroic and Post -heroic**
I suppose the leadership would be C7, but then he has all these assistant directors, and they’re enthusiastic. So I suppose we feel that they all very enthusiastic, but that they have our interest at heart, but also, you know, wanting to take the unit forward.
Exhibit 2

- Clinician Manager (A): gambit of compliance and manipulating figures and calculations that will be credibly received by stakeholders and presenting a convincing story about finances

An answer given in response to a question on budgetary responsibilities –

My key budgetary responsibility is to make sure that whatever we spend has been spent effectively….As I say, we’ve changed every single roster, all the rest of it, all these changes have been made out of commonsense. Not because of finance. But the result of it has been financially better management. So by being more consistent, by having better rostering practices, by reducing overtime, not because we tried to reduce overtime but because we tried to give people decent rosters. We’re just been involved in a massive change to how we run our department starting next year to give better cover. And so we said, what’s the cost? Who cares! It’s not the cost. Why not? Because it’s actually not relevant….If you come from a profession, we have to improve what we’re doing and how we’re doing it. So let’s work that out, let’s do it that way, and we’ll end up spending money wisely… Have I stuck to budgets? No, definitely not. Do I really know what my budget is? No.....

- Clinician Manager (B): gambit of compliance through manipulating technology

A comment made in regard to performance targets (and changing the practice of using their own information system to record appointments that was initially designed to help families)

We’ve got about a thousand appointments a year that we can use in one particular clinic and we didn’t really want to muck around too much with missing appointments and that sort of thing in terms of trying to make the most of the time, because we couldn’t back it up with anything other than just our own information, it was our, our, key performance indicator there, if you like, was, in our own mind as far as the administrators were concerned. It just sort of made us grow up a bit so we put all of our appointments on to the hospital system. The waiting list has ballooned ah, and um, hopefully, um, if, you know, we go down this line we get a bit more support and I suppose it's, you know, playing the political game.

- Clinician Manager (C): gambit of compliance to challenging the ritualistic nature of compliance

Describing what he thinks makes an outstanding clinical unit

Flexibility.

…..I think that any kind of rigidity of the process in any organization or system, ultimately makes you stale and encourages errors. You have to be able to look beyond the square. If you, for example, us clinical practice guidelines as an example, if you were to use them exactly as they are written and never look at any other solutions, you would never provide high quality care and nothing every covers every situation.

And that has been demonstrated in many different settings and people have done research in airline pilots and what makes good captains and it is people who can think laterally and not the ones that are locked into the one system.