4. Health Management and Organisation

Interactive session

Leadership in Victorian Clinical Directorates: An insider's perspective

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Abstract

The paper presents the insider perspectives of leadership within the clinical directorate (CD) structure of Australian tertiary hospitals. The clinical governance structures of Australian public sector hospitals have undergone significant change in the past three decades. Though the structure has been modified to suit individual hospital requirements, there is little evidence that the issue of relationships, particularly communication relationships, between staff has received such attention. This has a profound influence on the types of leadership in healthcare when the implementation of some of the most innovative leadership styles favored by management theorists is foiled through relationship disparities. Adapting innovative leadership styles and interdisciplinary communication to the current hospital structures is problematic. A research study is proposed to explore and cast light on the issues raised.

Key words: Health Leadership, Healthcare Professions, Health Workforce Issues, Healthcare Management, Hospital Management, Practice, Climate, Culture, Environment, Professional Identities

Modern hospital hierarchies present a problem in discerning which type of leadership is in place. The hospitals of today are complex in structure and employ a vast number of highly educated professionals who are task driven and socially embedded. While management scholarship has highlighted many of the issues which have become apparent over the preceding three decades since the introduction of the CD governance structure; communication between the various professional bodies remains one area of inquiry where consensus is equivocal, and where there is little consistency. This is apparent also in the discussion on leadership styles which leave their mark on all facets of hospital administration from succession planning and leadership development to driving productivity within and between local units of hospitals. It is important to understand the communication processes and the types of leadership that takes place in healthcare not only for consistency within each organisation (West, Armit, Loewenthal, Eckert, West & Lee, 2015), but also to align practices and policies to mobilise large numbers of staff towards good fiscal management and excellent patient care. The purpose of this paper is to introduce a

new project designed to review the current communication practices and leadership styles of executive staff in a major metropolitan hospital in Victoria, Australia. We also review the leadership scholarship for current leadership concepts found within healthcare. And further, we seek to compare what the literature is saying with the results of the recently completed project. Leadership theory has grown exponentially in the last two decades (Dinh, Lord, Gardner, Meuser, Liden & Hu, 2014) and induces some vigorous discussion within the literature. Here, we discuss how the most prominent of these views are applicable in contemporary healthcare and offer an integrated theoretical perspective on the mediators of communication and leadership which have come to light from the current investigation.

2.0 INVESTIGATING TERTIARY PUBLIC HOSPITAL LEADERSHIP-A PROPOSITION

Perhaps the most salient influences on communication between leaders are embedded within professional boundaries and expectations, and the imposition of governance structures of tertiary hospitals. Within the literature these two implications for leadership are not progressed to the extent that other emergent influences have been. Locating communication practices within the restrictions of professional practice or the demands of governance structures needs further enquiry. Building on the foregoing discussion, we suggests some propositions to investigate communication and leadership action in the tertiary sector, specifically within a professional and structural boundaries focus. Specific research questions to be addressed include:

2.1 Research Questions

1. *In what ways do the communication pathways of the clinical directorate structure of hospitals support effective diffusion of information between executive and senior staff?*

More specifically:

a) *How are communication pathways currently implemented in the clinical directorate of the case study hospital?*
b) *Why does the clinical directorate structure impact on effective operation of these systems from the perspective of staff?*

c) *What aspects of structural arrangements specifically impact effective communication and how does staff overcome these barriers?*

3.0 THE PROPOSED STUDY

The proposed study is focused on communication and leadership in contemporary healthcare centres. A mixed method approach is employed. Qualitative data was extracted from semi-structured interviews and used to not only understand the personal nuances of individual communication practices and leadership styles, but to support and corroborate the quantitative social network analysis (SNA). SNA can be applied to define the participant's involvement within a network and in this instance will generate some understanding about their communication practices as leaders. The first aim is to establish the level of interaction between professions by investigating the various types of communication relationships that have been formed. The second aim of the study is to understand how staff enact communication within their leadership in the clinical directorate. Of interest will be the influence of structure on the communication style and how this preference varies across the organisation in relation to executive members of staff within the organisation. The third aim of the study is to understand how preferred leadership styles and preferred communication pathways impact on activities. Particularly those activities in which cross directorate boundaries or are shared between teams causing complexity in task progress and communication.

3.1 Method

The study is undertaken at a large healthcare facility in Melbourne. The executive staff of this single site are the focus of the inquiry. Rather than comparing leadership styles between the consenting participants, this study aims to reveal the types of leadership found and to understand how structure impacts on individual's choices of communicating within their leadership styles. The researcher intends to address bias in interpretation of the results by choosing a data analysis mechanism which responds to the voices of the participants. Structural analysis serves this purpose through aligning responses directly to

the research question. A deeper analysis is also obtained using In Vivo analysis which again uses the participant's responses verbatim (Saldana 2018). Together these two methods will be used to produce a metasynthesis; a narrative built directly from the participant's words. Data analysis is also complimented by a team approach to analysis which is supported by the guidelines of a code book.

3.2 Integrated theoretical perspective

We advance three organisational behaviour theories to understand the context and conduct of communication in this executive network. Elbasha and Wright (2017) posit that "empirical research has failed to effectively account for how macro structures are recursively interrelated with micro practices" (p. 107) and places emphasis on the need to understand the interplay between these two boundaries. The employment of Structuration theory (ToS), Third generation activity theory (TGAT) and Distributed leadership theory provides a framework in which to apply both an individual (micro), individuals as team members (meso) and individuals as leaders of teams (macro) view of the interplay respectively.

Theory of Structuration (ToS) facilitates discussion about individual behaviour or agency. This theory accounts for the agentive behaviour and the structure of the agent's world. Giddens (1973) proposes that individual behaviour is recursively perpetuated by the structure in which the individual resides and is in response to maintaining and propelling towards one's own goals. Agentive behaviour contributes towards complexity in the workplace when the agent designs and maintains aberrant methods of work to achieve goals. Agentive behaviour is also apparent in leadership where managing staff is preferential and commensurate with the managers own agenda.

Activity theory, in particular Third Generation Activity theory (TGAT) as detailed by Engestrom (2000) contributes toward understanding complex interactions in overlapping activities. These complex interactions involve actions of agents, or groups of agents that have an impact on other agents or agent groups. This theory is inclusive of boundary spanning and involves 'knotworking', an instrument used to maximize the skills of staff for the work at hand. Knotworking requires that the most skilled member of

staff take a leadership role for the current task, and when completed, step back from this role to allow another team member to take leadership responsibilities (Avis 2009). Leadership roles change depending on current requirements. TGAT is also useful to visualise the current position of each team involved in a cross- boundary interaction and to provide generally acceptable solutions.

Distributed Leadership theory (DL) (Gronn 2002) is chosen as a response to the devolved structure of the CD. Within the central hospital the healthcare streams present as individual units, hospitals also have satellite centres of care which are physically separated from the central hospital site. This separation incurs an absent leader model which suggests that there may be some distribution of responsibilities occurring. This articulates with ToS when managers must make decisions around who to share responsibility with, and indeed whether to share the responsibility at all. How much responsibility to share and how this will impact on the managers own agenda to achieve targets are also issues to be resolved? Agentive practice may include choosing delegates who share the same profession, who are friends or who are recommended by friends. Further, the absent manager at satellite sites empowers the person to whom leadership is distributed to then have their own agenda to succeed and become involved in complex activities as the managers representative. DL also articulates with TGAT when designing workloads for teams and the interaction of teams to complete complex tasks. Thorpe, Lawler & Gold (2011) suggest that DL is a response to the rapidly changing 'operational, strategic or technological' (p.239) landscape where the actions of groups are more responsive than the single heroic style leadership of the past. Thorpe et al. (2011) acknowledge the contribution of Engestrom's activity theory to the alignment of tasks with the organisations goals and the collective unity required to achieve outcomes of these tasks.

4.0 A REVIEW OF THE LITERATURE

Leadership styles have been examined in many ways over decades. An underlying theme within the literature is to place leadership in the continuum of achieving service improvements. This traditional focus still excites leadership theorists (Fitzgerald, Ferlie, McGivern & Buchanan, 2013). Contemporary

leadership theory involves the consideration of more than just achieving service improvements. Theory around leadership incorporates a functional, contextual and relational collectively enacted work (Bolden 2011,Fitzsimons, Turnbull James & Denyer 2011) that is the consequence of social interactions, as well as the structural influences of organisational mandates and social identities within organisations (Sparrowe, Liden, Wayne & Kramer, 2001). Leadership also incorporates expertise, knowledge transfers and collaboration (Friedrich, Vessey, Schuelke, Ruark & Mumford, 2009). Together these elements have not been extensively reported within the context of the CD structure. Evidence from the literature suggests leadership opportunities to facilitate service key improvements are supported when there is "good pre-existing relationships" (Fitzgerald, Ferlie, McGivern & Buchanan 2013, p. 227). Braithwaite (2006) challenged the lack of empirically based inquiry into the relationship changes as a result of the structural rearrangement of healthcare organisations. Friedrich et al. (2009) nominate communication within their key collective constructs and cite modes of communication as an important factor within their framework for understanding collective leadership. Friedrich et al. (2009) discuss the importance of understanding the two-way communication of leaders and individuals with a focus within the distributed leadership setting. Their conclusion identifies the benefits of collective leadership, but suggest this relies on team members and leaders to "foster and facilitate the process" (p.95). The following discussion attempts to illustrate the lived experience of the problems of fostering and facilitating a network within the CD structure which not only supports interdisciplinary and multi-team communication, but the advancement of a distributed leadership style. The void in the literature concerns the inseparable link between communication and leadership and the mediating effects of the clinical directorate structure.

5.0 THE INSIDERS PERSPECTIVE

The insider's perspective dwells on the influence of hospital structures as an important mediator in particular professional communication relationships. These professional relationships incorporate elements identified within the literature and are elevated to a higher abstraction by identifying the appearance of certain relationship styles in relation to differing roles within the healthcare organisation's

structure. To do this we place a focus on those leadership types which are best described as personalised forms of leadership, in particular the charismatic, ideological and pragmatic leader models. This perspective also challenges the notion of collective leadership types, such as distributed leadership, as relevant in contemporary healthcare. The insider perspective suggests distributed leadership in healthcare is constrained citing restrictions of time and professional boundaries as limiting this type of activity.

5.1 Personalised leadership styles

Charismatic leaders are considered to be strategically more advanced in terms of leader-follower relationships than the ideologue or pragmatic leader. Key characteristics are the ability to identify needs of others, develop an environment where each leader can work with others and develop relationships or alliances to move forward to a common goal (Bedell-Avers et al. 2009). The strategy used by the charismatic leader is to remove traditional barriers and enable people to work together. Doing so also enables work to progress through anticipating the needs of workers and encouraging alliances to share workload or increase the amount of expertise to be applied to work. This leadership style may be illustrated by a nurse unit manager or senior nursing personnel within a unit who are not formal managers but are able to influence others to work together for mutual benefit. The charismatic medical leader may be one who manages junior doctors or be a senior medical administrator who does not have direct influence over colleagues but has to inspire them to a shared way of working within the organization when the doctors may work for other institutions and also in private practice unlike the nurses or other clinical staff. The charismatic leader is evident within the CD structure, particularly within disciplines. Leaders and members of discipline do display team work qualities, however in critical or definitive situations, the role of the professional is embedded within traditional reporting and hierarchical boundaries.

Nominating the ideological leader within tertiary hospitals presents an interesting challenge if the description offered by Bedell-Avers et al. (2009) is accepted. “Ideological leaders most often maintain strong group boundaries, demonstrate an oppositional character, and maintain a rigid commitment to their beliefs and values in a manner that precludes their acceptance of alternative leadership strategies” (Bedell-Avers et al., 2009, p. 312). This description aligns the style of the ideological leader with those qualities which may be more common among medical staff as a result of their training and professional roles. Socialisation to the medical profession may make it unnatural to take a social interactional approach to their role. Functionally, this leadership style does not encourage alliances with others, nor does it encourage collaboration with those who hold different values and beliefs. Followers of this leader find strength in the approach where goals and aims are shared. Similar professional status will also find supporters of this person.

The pragmatic leader may be prominent in healthcare. Bedell-Avers and her co-authors (2009) suggest these leaders, as many found in healthcare, focus on the functional needs of followers and the subsequent performance as a result of investment in providing these needs. This type of leadership practice acknowledges the experience and seniority of others; however such leaders selectively denigrate or celebrate the actions of others according to their own values and beliefs. “They appear to capitalise on the strengths and weaknesses of other leaders in a manner that better serves their goals” (p. 313). The pragmatic leader may be best illustrated as middle management and mentors within the nursing hierarchy. The middle management of doctors could also be included in this group due to the value placed on their own beliefs, the challenge of the integration of professions at the bedside (interdisciplinary teamwork)and the distance from the power base (their managers) to their own positions as major providers of care.

This middle management and mentor group undertake a great deal of responsibility, but are without autonomous input into the policies and procedures under which they work. Their outputs are mostly practical but requiring investment in others to maintain these outputs. These leaders demonstrate varying degrees of control which suggests their approach to any problem is one of assessing the situation, controlling threats and finding opportunities (Mumford, Antes, Caughron & Friedrich 2008). The pragmatic leader appears to be one who responds to the situations as they arise. Mumford et al. (2008) suggest this type of leadership as a response to situation and threats is also one which contributes to innovation; pragmatic leaders are exposed to opportunities to be challenged in complex situations giving rise to emergent practice which challenges and innovates old practices.

Each of these personalised leadership forms present barriers to fostering and facilitating team work and thereby a distributed model of leadership. While representing ego centric models of leadership; it is the structural barriers evident in the discussion which contribute to an ineffective communication network. Discipline silos also limit the diffusion of communication. The leaders described above have the social capacity to develop effective communication relationships however are constrained by hierarchy or discipline expectations and communication only occurs when necessary; forgoing the development of social relationship and more fluid communication pathways.

6.0 THE PARTICIPANTS PERSPECTIVE

The participant's perspective is drawn from the results of the data analysis and is compared to the findings of the literature review. From the outset the project results allude to a healthcare organisation which struggles to meet the needs of the Victorian community. Unprecedented growth within the service corridor of this organisation presents the greatest challenge to executive staff. There is also a recent

history of major management issues which continue to impact on the relationships between executives. These burdens are highlighted in the responses of the participants and present new considerations for management theorists. Participants failed to nominate functional, contextual and relational aspects highlighted within the literature review as a consideration in maintaining their communication relationships. Specifically expertise sharing, knowledge transfers and collaboration along with the establishment of long standing relationships. The lack of these social and professional engagements have a significant negative influence on the interaction between executives and are perpetuated by profession boundaries and structural instability. Leadership is a tightly controlled prerogative which incorporates little, if any of the ideals offered through the insider's perspective nor the literature review. This tight control over leadership responsibilities challenges the idea of distributed leadership within contemporary healthcare. Participants nominated limited tenure, a lack of time and professional expectations as important in their management responsibilities and implicit in their choices of leadership style and communication pathways. This ego-centric approach to leadership does little to contribute to growing teams who foster and facilitate team work and relationships with other teams and contributes to complexity where teams overlap with the activities of other teams. Overwhelmingly participants nominated establishing trust relationships with fellow executives as the most important aspect to facilitate their communication. This requirement of trust extends beyond Giddens concept of "power as a means of getting things done" (1984, p.283), and so dominates the considerations of leadership. Participants nominated trust as imperative in allocating of tasks, securing and giving resources and consulting others outside their disciplines for their expertise. Participants also said the lack of trust contributes to a cautiousness and reticence to develop good communication relationships, or to distribute tasks. This appears to be directly related to the structural and professional limitations of the organisation at this time. This project supports the view that there is an inseparable link between structure and communication and that structure is an important mediator recursively situated within in the development of effective communication pathways.

7.0 CONCLUSION

The study addresses issues that the insider perceives to be embedded within the clinical directorate structure from its inception. Through the years since the structure was introduced, several tertiary hospitals have reconciled their governance structures and added or removed levels according to their needs. There is little evidence that the issue of relationships between staff has received attention. Professional connectivity and embeddedness appears crucial in the leadership preferences of staff in tertiary hospitals. Tribal alliances influence leadership types where the choice is pre-determined and mandated by previous generations. Governance structures also influence the types of leadership in healthcare by restricting the implementation of some of the most innovative leadership styles favored by management theorists. The bureaucratic ego-centric style leader still lives within the echelons of hospital management despite efforts by theorists and innovative staff to adapt leadership styles to the current hospital structures. There is no doubt that informal networks play a significant role in the professional judgements made by leaders in healthcare. Leaders who follow the styles mandated by their professions, stifle experimentation and growth in exemplary leadership. This project has highlighted the incongruent nature of related, yet separated disciplines and the unresolved issues around consistent and appropriate leadership models within tertiary Australian hospitals. The governance structure changes now yield little debate within healthcare scholarship. Future efforts by researchers could focus on the role of limited tenure of executives which appears to be prevalent in contemporary healthcare organisations. Participants suggest this limited tenure model means executives do not have the trust relationships which come from long standing relationships. This, in turn, impacts on stability on organisations and for executives to have enough time to invest in teams who will foster and facilitate relationships.

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