Management and Leadership in the Health Services

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Introduction

Organisations require leadership and successful management if they are to succeed. Traditionally leaders have been romanticised in the literature within the health care industry. This paper will examine the concept of leadership is a romanticised position, and examine the differences between management and leadership. Clinical leadership will be explored along with perspectives of leadership perspectives from medical, nursing and allied health. The paper will conclude with a discussion of the move from dominant medical management of patient care to multidisciplinary team management in the context of how these views interact with the overall performance of a group, service or organisation.

Leadership and management in contemporary health care

Many authors have explored the theory that leadership holds a romanticised position in management literature is has been explored by many authors over the decades. In this context leadership qualities are depicted as being central to organisational process, with leaders held in high esteem, having prestige, charisma and a kind of heroism which has contributed to this perception (Meindl, Sanford & Dukerich 1985; Bohoris, G & Vorria 2007). This romanticised position is reflective of those leaders that are highly successful. Leaders that are not perceived as contributing to organisational performance are more likely to be held responsible and made scapegoats (Meindl, Sanford & Dukerich 1985).

Are leadership and management the same thing? Although these terms are often used interchangeably some authors argue that they are in fact different (Capowski 1994). Daly, Speedy & Jackson (2007) believe that management is an appointed position which tends to have total control of the organisation or department. This control includes the formulation of policies and procedures, strategic planning, staffing levels, skill mix, and coordinating. Management in its self is seen to be rigid in structure, appearing unapproachable to employees. Management tends to work by set guidelines, rules and certain deadlines which is where it differs from leadership (Daly et al 2007).

Capowski (1994) believes that there are many definitions of a leader and that leadership and management are often considered overlapping concepts. Meindl, Sanford & Dukerich (1985); Bohoris & Vorria (2007) argued that a leader is not necessarily an appointed position but they have certain traits which can be seen in a manager, these include vision, integrity, trust and commitment and this is how they attract followers. Kotter (1998) believes that a leader will lead by example, and it is essential to effectively communicate a vision. A good leader should have a quest for knowledge and learning and effective leaders invest a great deal of talent, energy and caring in their change efforts (Kotter 1998).

There is debate over whether management and leadership can be separated, as it is believed by some that in reality they are entwined (Daly et al, 2007). Perhaps an efficient distinction can be seen from a structural perspective. Management is more often seen at the top levels of an organisation where leadership can be seen at any level (Daly et al, 2007). This view is also supported by Scanlan (2005) who believes that an individual doesn’t need to hold a position of power in an organisational
hierarchy to be a leader. Scanlon further believes that people who possess a passion for service and have been informal difference makers within their organisation are also leaders. Clinical leadership, for example, must occur at all levels of the organisation and become an intrinsic practice throughout the organisation. Clinical leadership improves the performance of health care organisations from the bottom up.

Today’s health care leaders face increasing demands, fluid priorities, restricted resources, health care professional workforce shortages, increasing consumer demand, ownership in their care, increasing use of technology and often a dysfunctional health care system. With the variety of health professions including but not limited to nursing, allied health, general management and medicine involved in patient care at any one time, all professions are seen to have leaders within their respective profession. These leaders all bring individuality and differing perspectives with them.

Within nursing a leader is seen as a visionary who can look externally and internally at how the organisation / department or profession can move forward (Daly, Speedy & Jackson 2007). Unlike other health professionals, nurses form the single largest group of health care workers, which gives them the opportunity to influence the health care system (Daly, Speedy & Jackson 2007). In the past the medical profession has dominated patient care decisions and provision and nurses operated within bureaucratic structures requiring conformity and regimentation resulting in nurses being seen as ground floor care givers and not traditionally being involved in the decision making (Daly, Speedy & Jackson 2007). With the shift of nursing education to the university sector in the 1980’s, the nursing profession achieved some legitimacy and standing as a profession (Chiarella 2002). With the modernisation of health care, nurses are seizing leadership opportunities at all levels within health care fields. Nursing leaders with the support of members are influencing government health care policy, introducing extended scopes of practice such as Nurse Practitioners in Australia and changing the public’s perception of the nursing role.

The reformation and amalgamation of health services has had a significant impact on the role and voice of allied health professionals in patient management (Swaby 2003). In the past patient care was decided on by the medical profession, now there is a shift in decision making and the traditionally silent groups such as nurses and allied health have a far greater input into the patient care journey (Swaby 2003). Swaby believes that leadership within allied health is a process that an individual can intentionally influence, motivate or inspire others to accomplish their goals within an environment that fosters trust and respect. Swaby elaborates further to say that leadership in allied health can be divided into organisational leadership which establishes direction and aligns people to the organisational direction; and clinical leadership which utilises clinical expertise to enhance the clinical knowledge and skills of other people within the team.

Wearing (2004) considers that medical dominance has become a major threat to health in that they practice medical science and research without looking at the contributions of other professions such as nursing, allied health and that this constricted focus influences policy in a narrow way (Palmer and Short 2007). Dowton (2004) believes that over recent decades, the nature of the medical profession has changed from the long standing legislative canons and deeply entrenched cultural systems, to external influences having altered a doctor’s autonomy and hierarchies in which they practice. The transformation or merging of smaller healthcare organisations into larger organisations has seen management / leadership emphasis move from local clinical bodies e.g. doctors in medical clinics
having admitting rights, to more distant control bodies such as organisational employed medical
officers and / or a medical director. There is increasing pressure within organisations to form
management systems by multidisciplinary teams (Dowton 2004). Dowton believes that capable
leaders in medicine are needed to create a shift in emphasis of control back from the multidisciplinary
team management theory to the medical fraternity which is not appropriate when aiming for optimal
patient care.

Most organisations operate within rigidly defined power structures and systems of authority. This rigid
hierarchy of power and influence, characteristic of most hospitals and health care facilities is still
dominated by the medical profession (Black & Westwood 2004). The medical profession over the
decades have positioned themselves in such a way that they hold great power within government and
healthcare in general. They in effect had created a uni-disciplinary health team, where all the members
were from the same profession and here is seen that there are fewer struggles over power and
leadership (Harris 2006). Walker et al (2004) believe that one of the main challenges for health service
leaders is to break down barriers between different professional silo groups with the aim of improving
interprofessional working relationships.

Black and Westwood (2004) suggest that true multidisciplinary team leadership is rare in most health
care facilities. Multidisciplinary teams, however, take longer to form, and there is a period of cohesion
building that may prove difficult because of the differences in values of the differing groups (Harris
2006). This is where the multidisciplinary team leadership and interdisciplinary learning transcends the
traditional, power relationships in the medical profession (Black & Westwood 2004). Walker et al
(2004) believe that interprofessional communications must be effective for an organisation to be
competitive. The transformation of an organisation is the ultimate test for any leader, but it is imperative
that the change process is understood. Organisations need to be able to work as a team with common
goals, interests and not just as a collection of individuals (Kotter, 1998).

Most managers’ roles are dependent on the activities of a variety of other people due to the division of
labour and resource constraints (Kotter 2003). Because organisations are divided into specialised
divisions, departments and jobs, managers are dependent on others for information and cooperation if
they are to successfully manage. In the managers role they are reliant on the dependants, within their
team performing their role. If the people within the department don’t act in a manner that the manager
wants the goals of the organisation will not be met (Kotter 2003). Individual personalities, preformed
agendas, individual goals or beliefs can make people uncooperative (Kotter 2003). Past experiences
such as past success and failure shapes the future decisions of an organization (Rubin de Celis &
Lipinski 2007), thus, the greater the positive experience of the organisation or department, the more
likely it is to adapt to new conditions.

**Conclusion**

This paper has identified the romanticised qualities of leaders in the literature and explored the
relationship of these to the successful leader. It must be recognised that in order for an organisation to
be successful, there has to be high importance placed on quality clinical leadership in a context where
there is a move to the multidisciplinary team management of patients in the health care organisation.

**Reference**


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