

ORIGINAL ARTICLES

Developing healthcare leaders and managers: course-based or practice-based?

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ABSTRACT

The paper explores two different underlying assumptions about healthcare organisations, from which emerge two related views of where leadership and management are located. It considers the nature of healthcare problems as a means of distinguishing between leadership and management. Emphasising the importance of local context and social capital, the paper describes two UK-based approaches to healthcare leadership and management development which exemplify these differences.

Key Words: Leadership, Course-based, Practice-based

1. INTRODUCTION

There is a growing divergence of opinion with regard to the most effective means of developing leaders and managers within healthcare systems. Two quite different approaches have developed, based upon very different underlying assumptions regarding healthcare organisations; the nature of the problems which they face; the distinctions between healthcare management and leadership and the most useful methods of developing such key people. This paper aims to outline the major issues associated with this debate.

2. UNDERLYING ASSUMPTIONS ABOUT ORGANISATIONS

There are two different underlying major assumptions held about organisations and how they function.^[1] One viewpoint is identified as unitary and emphasises a single source and locus of organisational control (senior healthcare leaders and managers), a single identity and loyalty focus (the employing

healthcare organisation, such as a hospital) and adherence to a single set of common organisational objectives (goals, targets). Conflict within this approach is seen as a rare and transient phenomenon, typically attributed to the activities of organisational troublemakers and deviants. The managerial prerogative is emphasised and this perspective exemplifies what has been termed the “command-and-control” approach to running organisations, which sees them as top-down hierarchies, where work is designed in functions, leaders and managers make key decisions and workers simply do the work.^[2] It is founded on the metaphor of the organisation as a machine.^[3,4]

The alternative, pluralist, view sees healthcare organisations as loose alliances or coalitions, where some degree of conflict is inherent and ineradicable (and may indeed even be positive and functional). From this perspective, rather than a monolithic entity, a healthcare organisation is best seen as a diverse plurality of power-holders drawing their power from differ-

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ent sources, including, for example, the status derived from the level of professional education (doctors) and from staff numbers (nurses). Effective healthcare leaders and managers recognise that sustainable clinical and organisational change comes from a process of debate, challenge, persuasion and negotiation.^[5] This pluralist view seems closer to the actual practice of leadership and management in healthcare.^[6]

3. LEADERSHIP AND MANAGEMENT – WITHIN PEOPLE OR BETWEEN PEOPLE?

From the underlying unitary and pluralist assumptions flow two very different views of where leadership and management is located. Linked to the unitary view is the notion that leadership and management is simply located inside people – their personal knowledge, skills and attitudes – in short, their competence. Leadership and management competence is conceived as something associated with the leader or manager alone and so disassociated from the organisational setting in which it occurs, such as the hospital or primary care or mental health services, and therefore easily transferable to a different context. Focusing on developing such personal characteristics is seen as the means of improving overall organisational learning and should therefore be the aim of healthcare leadership and management development. By contrast, the pluralist viewpoint sees leadership and management as operating in the relationships between people within a specific local and idiosyncratic setting. Leadership and management is therefore concerned with fostering dialogue through engaging conversation and the building of relationships with others.^[7]

3.1 Different problems

Perennial (and sometimes sterile) discussions often take place concerning the differences between leadership and management in healthcare. One useful way of addressing this is to consider the different types of problems which are faced. Some problems are “tame” (or benign) and are characterised by predictability, certainty and clarity of the desired endpoint or solution. Other problems are “wicked” – they interact with other problems and are part of a set of inter-related problems which cannot be addressed in isolation.^[8] They sit outside single professional hierarchies and across organisational systems. Typically incomplete and contradictory, they have none of the clarity of a tame problem. They cannot be removed from their context, solved and returned without affecting that context. Where some form of resolution is possible it may, in turn, even create another problem. Examples of tame problems include writing a business plan for a clinical service or moving services from one location to another – they have been done repeatedly before and there will typically be “standard operating procedures” to be fol-

lowed. Examples of wicked problems include alcoholism, drug addiction and obesity – all of which are linked to larger social problems and which cannot be addressed by healthcare organisations alone. Largely speaking, therefore, healthcare management is concerned with tackling tame problems but healthcare leadership is concerned with wicked problems, although there is a major temptation to ignore the latter or to over-simplify them and so pretend that they are tame.^[9]

3.2 The importance of setting

Assumptions that leadership and management are “universal” qualities which are easily transferable from one setting to another grow out of the unitarist model, which implies that it is entirely possible (and indeed desirable) to develop and improve healthcare leadership and management without giving due consideration to the setting or context (social, cultural, historical and economic) within which it occurs. Yet that setting is a prime influence on what is (and is not) possible within healthcare organisations. Generic learning and the development of universal qualities run into what has bedevilled the entire education and training field for generations – the learning transfer problem, *i.e.* the challenge of translating learning acquired from off-site education and training experiences into practical action in the workplace. Applying generic learning to specific local contexts is challenging without a deep understanding of those contexts garnered from long (and sometimes painful) experience.

4. LEADER AND MANAGER DEVELOPMENT VS. LEADERSHIP AND MANAGEMENT DEVELOPMENT

The belief that leadership and management abilities lie within people rather than in the relationships between them leads inevitably to leadership and management development programmes which seek to enhance those individual abilities further. This emphasis embodies what has been called the “fundamental attribution error”^[10] – the tendency to overvalue personality-based explanations of behaviour, while undervaluing situational or contextual explanations. Investment in individual leaders and managers, either through qualification-based or non-qualification-based programmes certainly does wonders for the career progression of those leaders and managers, and thus the enhancement of individual “human capital”. Yet there is no certainty that the reinforcement of individual human capital leads to improved “social capital” – defined as the “networks together with shared norms, values and understandings that facilitate cooperation within or among groups”.^[11]

Such social capital is collective capacity or efficacy – the quantity and quality of connections and relationships in a

system^[12] which are reflected in the acuteness of the social perceptions of individuals and the network of their social ties.^[13] It is thus embodied in the dynamic connections among people where trust, mutual understanding, shared values and behaviours act as links making cooperative action possible.^[14] The key question should therefore not be “How do we make better leaders?” but “How do we improve leadership in the system?”

Two models of leadership and management development

There are therefore two major models emerging for the development of healthcare leaders and managers which reflect these differences. They can be described as course-based or practice-based. They are epitomised by the divergent approaches adopted within the United Kingdom by the different healthcare systems in England and Scotland. England embodies the course-based approach. A national NHS Leadership Academy has commissioned about £60 million worth of programmes focused at Masters level in programmes run by consortia of Higher Education institutions and international management consultancies. This is described as a “professionalised and standardised” approach to leadership and management development, based on the acquisition of academic qualifications and the intention is that possession of such qualifications will become essential criteria for those applying for future leadership and management roles.

The course-based approach can be characterised by the following assumptions:

- Leadership and management is a generic activity, common to all organisations.
- Leadership and management are grounded in a technical-rational view of practice.^[15]
- Leadership and management can be taught using educational and training means.
- Leadership and management development is best delivered by experts (academics and/or management consultants).
- An academic “benchmark” is required to ensure a standardised approach.
- A competency-based approach is helpful in ensuring standardisation.^[16]

Such an approach is helpful in enabling agreement on core leadership and management desiderata and providing a common language about which to speak of leadership and management activity,^[17] but the approach also:

- Supports and reinforces a personality-based view of leadership and management.
- Tends to diminish leadership and management to a reductionist set of fragmented skills.

- Focuses on past or current performance and so has little predictive value.
- Struggles to take account of complex organisational factors.^[18]

In the NHS in Scotland the National Leadership Unit has taken a different, practice-based approach, based upon the nostrum that “Leadership is a contact sport, not virtual reality”.^[19] The basic assumption is that leadership and management is essentially a practice-based activity and that theory is useful only insofar as it contributes to improving leadership and management practice – what has been described as the “extraordinisation of the mundane”.^[20] Development programmes therefore make great use of “context-sensitive methods” such as coaching, mentoring and action learning, together with service improvement projects^[21,22] and with examples of good practice and relevant theory being delivered through short “masterclasses”. For senior clinical leaders, for example, an annual 18-month programme for 24 different mixed clinical professionals has proved highly successful.^[23,24]

The practice-based approach can be characterised by the assumptions below:

- Leadership and management is both context-dependent and historically-situated.^[21,25]
- Leadership and management are grounded in a professional-artistry view of practice.^[15]
- Leadership and management are best learned by reflection on personal experience and revised action.^[26]
- Leadership and management development are best enabled by skilled facilitators and coaches.
- Leaders and managers will inevitably vary in the speed, breadth and depth of their learning.
- Rather than seeking standardisation, leadership and management development should seek to foster diversity, creativity and flexibility.^[27]

It also goes without saying that the relative costs of the two approaches are starkly different. The costs of funding leaders and managers through Masters-level programmes inevitably limits the numbers who can be “processed” through such programmes. Because limited funding means that programmes are targeted at those at the “top” of healthcare organisations – and therefore serves to reinforce hierarchy and “command-and-control”.^[28] Practice-based approaches offer a potential means of dealing with larger numbers of leaders and managers at a significantly lower cost – they are therefore necessarily more cost-effective and also serve to model a more distributed or shared approach to leadership and management,^[29] emphasising such features as multi-professional team-working.^[30]

5. CONCLUSION

Most leadership and management development activity in healthcare seems to be based on a set of unitary assumptions, emphasising hierarchy and control. Such programmes typically seek to develop tools and techniques suitable for addressing tame organisational problems or to pretend that wicked problems are capable of resolution through application of these methods. Focused as it is on relatively small numbers of people at senior levels in organisational hierar-

chies, it is both expensive and tends to replicate the status quo. The alternative pluralist approach recognises the existence of diversity and conflicting interests and highlights the importance of the skills of “making and mending” relationships as best-fitted for addressing wicked problems, which are typically multi-professional and multi-agency in nature. This latter approach seems much more relevant to a world of “polyarchy” which sees leadership and management as a complex dynamic system rather than just a personal attribute or something which only assigned leaders do.^[31]

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