PART 1

THE INDIVIDUAL
1 THE NATURE OF LEADERSHIP

Learning Outcomes

Introduction
The Importance of Leadership in Patient and Client Care Outcomes
Relationships between Leadership and Followership
Defining Leadership
Health Care – A Changing Context
Global Leadership
How We See Ourselves and How Others See Us
Comparing Leadership and Management
The Art and Science of Leadership
Summary of Key Points
Further Reading

Learning Outcomes

By the end of this chapter you will have had the opportunity to:

• Discuss the notions of leadership and followership
• Define leadership
• Discuss the importance of the changing context related to health care
• Compare leadership and management
• Debate the art and science of leadership.
INTRODUCTION

So you want to find out about leadership, but what does this mean exactly? How do you know that you are not already a leader? You may be thinking that you have only just started your career in one of the many health care professions and that the leadership issue will not raise its head for some years, but you could assume some leadership roles early on. Similarly, you may have been a qualified practitioner for some time and are about to move into a position that has a formal, recognised leadership role. Whatever the reason, this chapter will allow you to start to think about leadership and its role in your life and career.

The concept and theories of leadership have evolved and are continuing to do so, but how can a book on leadership help you to be a better leader? Daft (2008: 24) reminds us that it is important to bear in mind that leadership is both an art and a science. Leadership is an art because many of the leadership skills and qualities required cannot be learned and a science because there is a growing body of knowledge that describes the leadership process. By keeping this in mind we can understand how a variety of leadership skills can be used to attain the best possible care for our patients. Jeffrey (2013) talked of the term ‘nurse leader’ as being a misnomer because in the English language we place adjectives in front of nouns (e.g. blue car, not the car blue); the term nurse leader would therefore imply that this person is a leader who just happens to be a nurse. I am convinced that this is not the case; nurse leaders are certainly nurses at their core and become nurses who lead.

When first thinking about leaders in health care, we may identify people like Florence Nightingale (1820–1910), famous for her work at Scutari Hospital in the Crimea, collecting data (the beginnings of research in nursing) in order to improve practice. Mary Seacole (1805–1881), another nurse, was refused an interview to go to the Crimea. Such was her belief that there was a real need for her talents there, she paid for herself to go and went on to be known as ‘Mother Seacole’. She is now held up as one of the first black women leaders. Dr E.L.M. Millar highlighted the need for effective training within the Ambulance Service of the 1960s, which ultimately led to the current technician training and paramedic degree (Kilner, 2004). These people did much for caring, through their pursuit of improved standards and acting as role models in the health care work they did. In today’s society you might think of John F. Kennedy (1917–1963), Nelson Mandela (1918–2014), Barack Obama (1961–), Benazir Bhutto (1953–2007), Indira Gandhi (1917–1984) or even Tony Blair (1953–) as being renowned leaders. Beverley Malone (1948–) is currently the chief executive officer of the National League for Nursing in the United States. Prior to assuming this position in February 2007 she served as general secretary of the Royal College of Nursing for six years. I heard her speak at a National Association of Theatre Nurses conference – she was inspirational and so enthusiastic about nursing today that everyone left with the intention of being a nurse who has the power to strongly advocate for their patients. Whoever you think of as an influential leader, they must be enthusiastic and love their chosen profession in order to command such respect and to be able to infuse others with energy and enthusiasm. Leadership involves people...
being led, so there must be those who are happy to be followers. We must, therefore, remember that effective leaders and effective followers may sometimes be the same people playing different roles at different times. This book will try to engender this verve for effective leadership. In order to address the identified learning outcomes, this chapter will introduce the nature of leadership, comparing management and leadership, and the art and science of leadership.

**THE IMPORTANCE OF LEADERSHIP IN PATIENT AND CLIENT CARE OUTCOMES**

Recently there have been a number of high profile system failures where patient/client care has been affected through poor and ineffective leadership. Following the Francis Report (2013) the Prime Minister David Cameron asked Professor Don Berwick, a leading expert in patient safety, to look at what needs to be done ‘to make zero harm a reality in our NHS’. The Berwick Report (2013) ‘A promise to learn – a commitment to act’ identified a number of existing problems such as a lack of leadership in risk management systems. The executive summary made ten recommendations which are:

1. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.
2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.
3. Patients and their carers should be present, powerful and involved at all levels of health care organisations from wards to the boards of Trusts.
4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS’s needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.
5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.
6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.
7. Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.
8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

The need for quality in the delivery of care is vital, and failings were highlighted in a variety of instances where this has clearly not been the case e.g. Bristol Royal Infirmary (2001), Baby P (2007), the Mid-Staffordshire NHS Foundation Trust scandal (2013), and Gosport Hospital (2013) to name a few; this will be further discussed in Chapter 12. All these events have changed the landscape of how we look at the duty of care; in all these situations the failure of effective leadership and management strategies were shown to be complicit in the failure of care provision and workers seemed to have become complacent about their roles. They have reminded us of the importance of raising concerns and acting on them before it is too late, and of developing a workplace culture which enables staff to have the confidence to speak out (UNISON, 2011). All is not doom and gloom though; the Royal Colleges, National Institute of Clinical Excellence (NICE) and Care Quality Commission (CQC) highlight areas of good care provision and there are lessons to be learned from those papers in order to ensure high quality care for all.

In the light of the findings from the various reports it can be seen that the need for effective leadership is vital. These leaders, whatever their background, must demonstrate ‘best practice’ in their clinical areas and dedicate themselves to supporting, marketing, and ‘driving through’ an innovation (Greenhalgh et al. 2004: 182). They have become known as Champion Nurses and practise at a level that encourages others to better themselves to ensure all patients receive first class, evidence-based care at all times. Stoddart et al. (2014) highlighted a project that suggested systematic ‘Care Comfort Rounds’ for ‘in-patients’ whether this be in hospital or care/nursing homes; the project led to proactive rather than reactive nursing care delivery and the number of falls and the use of all buzzers were reduced. Active nursing rounds – variously known as ‘intentional’ or ‘care and comfort’ rounds – are still relatively new in their present format; what is important is that it is patient- rather than task-focused: every hour, a nurse checks in with the patient, not to ‘do something’ but to find out if s/he is comfortable and if there is anything s/he needs. Whilst this might be thought to be a regressive move (in that it was commonplace in the 1950s, 1960s and 1970s) it means that the patients’ health and welfare are assessed at regular (hourly) intervals during the day so leading to safer, effective patient-centred practice. The current notion of care comfort rounds started in the United States and has been adopted in some UK hospitals, including some hospital Trusts participating in The Kings Fund Hospital Pathways Programme (Kings Fund, 2012). In acute settings key aspects that are usually checked during Care Comfort/ Active Nursing/Intentional rounds include the ‘Four Ps’:
i. Positioning: Making sure the patient is comfortable and assessing the risk of pressure ulcers.
ii. Personal needs: Scheduling patient trips to the bathroom to avoid risk of falls.
iii. Pain: Asking patients to describe their pain level on a scale of 0–10.
iv. Placement: Making sure the items a patient needs are within easy reach.

During each round the following behaviours (which may be summarised on a prompt card) are undertaken by the nurse:

- Use an opening phrase to introduce themselves and put the patient at ease
- Perform scheduled tasks
- Ask about the ‘Four P’s’ (described above)
- Assess the care environment (e.g. fall hazards, temperature of the room)
- Use closing key words e.g. ‘is there anything else I can do for you before I go?’
- Explain when the patient will be checked on again
- Document the round

Structured methods of intentional rounding are underpinned by leadership support, e.g. regular staff meetings to review activities and progress. Staff training and accountability structures are used to ‘hardwire’ the required behaviours and competencies into routine practice (Studer Group, 2007). In the USA it is deemed part of the daily care to conduct a full health assessment on all patients by the registered nurse. In order to ensure that this is not just a paper exercise, NHS Trusts need to identify suitable registered nurses whose responsibility it is to implement this systematic care standard as a change in practice. These leaders need to ensure an effective implementation of this strategy (both day, night, and at weekends, i.e. 24 hours a day, 7 days a week) in order to improve patient outcomes.

**Activity**

- In your experience, have you observed a similar activity to Care Comfort Rounds?
- Consider your clinical environment and list the pros and cons in implementing a system such as Care Comfort Rounds.

You might have thought of the time consuming element of filling in yet another form but Stoddart’s project has shown that not only was all-round patient care improved but staff satisfaction in care delivery was also increased (Stoddart et al., 2014: 22); as with any change the implementation of a ‘new’ work practice has to be considered with a great deal of communication, planning and education for it to succeed (Chapter 13).
Employees have rights just as patients and patient/clients have rights, similarly employers have a duty of care (Department of Health (DH), 1974, 1999a, 2005b); under the Management of Health and Safety at Work Regulations (Department of Health, 1999b) employers are obliged to assess the nature and scale of risks to health and safety in the workplace and base their control measures on it. We have to accept that as humans we are all able to make mistakes but learning from the failure of others is imperative; the Department of Health (2000b) paper An Organisation with Memory highlights that failure is almost always unintentional and comes about through a variety of small omissions/errors rather than via a single colossal one. It set out to understand what was known about the scale and nature of serious failures in the United Kingdom’s National Health Service (NHS) system, examine how the NHS might learn from those failures, and recommend methods to minimise future failures. Despite the valuable information contained within the document the NHS continues to struggle with implementation of the recommendations.

RELATIONSHIPS BETWEEN LEADERSHIP AND FOLLOWERSHIP

Owen (2011: xvii) postulates that one barrier in the definition of leadership is the belief that leadership is related to seniority. However, he goes on to state that leadership is not about position but about behaviour. Think about the following situation in relation to leadership:

Sue Potter is a third year student on placement in the clinical area. During the course of the day, she notices that a second year student in the same placement area often comes to ask her for advice related to patient/client care for a given situation. Sue happily explains the procedure to the other student, highlighting the current research supporting the action. A qualified member of staff also approaches Sue for information related to the research, as it was an area of care he had not been involved with for some time. Sue was happy to tell the qualified person what she knew and then started to reflect on her own abilities in leading and teaching. She then started to examine why people felt that they could come to her for information and support.

Although Sue was not yet qualified, she was clearly seen as a leader within that situation. The skills Sue demonstrated – being approachable and teaching others willingly – are those of leadership. Sue’s example of supporting and sharing her knowledge can be applied to any field of health care provision.

It is important, then, to examine some of the variety of definitions of leadership available. Daft (2005: 4) states that: ‘scholars and other writers have offered more than 350 definitions of the term leadership’ and concludes that leadership ‘is one of the most observed and least understood phenomena on earth’.

Tappen et al. (2004: 5) suggest that there are a number of primary tasks involved with being a leader:
THE NATURE OF LEADERSHIP

1. Set direction: mission, goals, vision and purpose
2. Build commitment: motivation, spirit, teamwork
3. Confront challenges: innovation, change, and turbulence.

So leadership would appear to be a people activity and occurs within group life; it is not something done to people. Leaders are seen to be effective because they have charisma which allows them to articulate a vision for a given group of followers and generate enthusiasm for that vision (Haslam and Reicher, 2011: 5). Without followers there cannot be leaders and without leaders there cannot be followers, so being an effective follower is as important to the health care professional as being an effective leader.

Activity
Can you identify situations when you have been a leader and when you have been a follower?

You might have been a leader during your time at school, as a prefect, sports team captain; or outside school as a Girl Guide, Boy Scout, youth club leader; or even a member of a parent–teacher association. Conversely, you might also have identified those same situations as being times when you were a follower. Similarly, there may be times in your clinical area when you were a follower due to being unsure of yourself; but other times when you were a leader like Sue. ‘Followership’ is not a passive, unthinking activity. On the contrary, the most valuable follower is a skilled, self-directed team member who participates actively in setting the team direction; invests his/her time and energy in the work of the team; thinks critically and advocates for new ideas (Grossman and Valiga, 2012). Tappen et al. (2004: 5–6) suggest that there are a number of things you can do to become a better follower:

1. If you discover a problem, clearly you would inform your team leader of the problem but you might also offer a suggestion as to how it might be rectified
2. Freely invest your interest and energy in your work
3. Be supportive of new ideas and new directions suggested by others
4. When you disagree with the ideas explain why
5. Listen carefully and reflect on what your leader or manager says
6. Continue to learn as much as you can about your speciality area
7. Share what you learn with others.

If you are to be an effective leader, it is vital that you recognise the opportunities for leadership all around you and that in these situations you act like a leader, influencing others in order to bring about change for a better quality of care provision. Leaders have to face some hard decisions in their work, remembering at all times that
managing scarce resources – such as equipment, pharmaceuticals and transport – may not be easy, and that managing people is much more complex.

**DEFINING LEADERSHIP**

Leadership can be defined in a number of ways but it is still an elusive concept. Indeed, key authors cannot agree on the nature or essential characteristics of leadership but offer a variety of perspectives. This indicates that leadership is thought to be about relationships. Leadership is a discipline that is evolving, indeed Alvesson and Spicer (2010: 4) note the understanding, interpretation and response to leadership is variable and complex. On the one hand, distrust and control are seen as features while, on the other, support and close contact may be dominant. Alongside this, on a more positive note, Rafferty (1993: 3–4) offers up the leadership notion that:

> vision is driven from an emotional front with some practical ability to achieve that vision; leaders inspire you, and others will follow and trust you. They will trust in your integrity. Leaders care for the people they are leading/serving. Leaders try to strengthen and promote these people. They facilitate and help and encourage and praise.

However, Bernhard and Walsh (1995: 17) identify leadership as a process that is ‘used to move a group towards goal setting and goal achievement ... and can be learned’. Stewart (1996: 3) recognises leadership as discovering the way ahead and encouraging and inspiring others to follow. She agrees with the idea that leadership involves ‘... the spirit, personality and vision’. Rafferty (1993: 3–4) thinks of leaders as people who ‘have that combination of conceptual ability’ whilst Daft (2008) expands on this by indicating that leaders allow room for others to grow and change themselves in the process; they also act as facilitators, coachers and servants. Sayle (1993 in Sadler 2003: 33) takes a less dramatic view of leadership – the working leader. A case for the working leader is presented; that is the person who makes the organisation work to the maximum effect. Leadership skills are needed to overcome the bureaucratic contradictions of organisational life.

**Activity**

Can you find a definition that fits in with clinical leadership?

Clinical leadership is a relatively recent term and is seen as being about facilitating evidence-based practice and improved patient outcomes through local care (Millward and Bryan, 2005: xv; Stanley and Sherratt, 2010: 115–121; Anonson et al. 2014: 127–136). Working with common definitions can lead into concept analysis: a deeper
THE NATURE OF LEADERSHIP

process involving antecedents, attributes and consequences being unpacked (Walker and Avant, 2010). At a deeper level, leadership could be seen from various perspectives as being:

- A characteristic trait – based in trait theory
- A position – based in the functional approach
- A quality – based in trait theory
- A process – based in functional approaches
- A power relationship – style, or the effect on group behaviour.

These perspectives will be developed further in Chapter 4. How you view leadership will influence your clinical beliefs, values and behaviours. Leadership must be a part of caring. Patients and patient/clients deserve care that is well led at all levels of the NHS or health industry organisations.

HEALTH CARE – A CHANGING CONTEXT

Due to the driving technological forces and rising expectations, our health service has expanded to encompass a much greater provision than that envisaged when the NHS was set up in 1948. The NHS has its history in a liberal socialist ideology of health being a right for all, regardless of ability to pay. Its current complexity and philosophy has put great emphasis on leadership at all levels. It could also be said that the health service of today is seen by the public almost as a religion or a system of belief. This may be due to the expectation that the health service can cure all ills. The view that health is a much more sought after and accessible commodity is stronger than it was in the past. Sofarelli and Brown (1998) conducted a leadership literature review and then strongly argued for the need to move from the previous bureaucratic NHS management model to a model of a leadership-focused health service. This new model is useful in order to cope with the apparent dramatic change and uncertainty in the health service today. Bishop (2009: xii) noted the emergence of significant policy changes. The Darzi ‘Next Stage Review’ (DH, 2008a) highlighted the emergence of more clinician-led services, and the critical and main leadership role of clinicians drawn from nursing and allied health professionals. In 2010 the Coalition Government NHS Policy supported this continued perspective (DH, 2010a, 2010b, 2010c). Storey and Holti (2013: 8) advocate a new NHS leadership model that encourages high staff involvement and engagement focusing on meeting service user needs. They highlight the need to manage and improve care with openness to a variety of perspectives including ‘soft’ intelligence rather than the narrow range of hierarchical imposed targets.

In support of this, nurses and health care practitioners today need specific leadership skills and clinical development in order to help them deal with this rapidly changing situation in clinical care (Barr and Dowding, 2012; Gopee and Galloway, 2014). Indeed, this can relate to all health care professionals as changes are occurring rapidly everywhere. Rippon (2001), however, argued that leadership training per se
will not produce the quality of leaders required to bring through change. A more sustainable solution lies with the development of what he terms ‘growth cultures’ in order to develop leaders with emotional intelligence (Chapter 10). It is emphasised that leaders need to focus on inward rather than outward bound experiences, enabling a spiritual growth based on relationships and awareness (Wright, 2000). ‘Inward’ could mean greater self-awareness and need for learning whereas ‘outward’ could relate to expected behaviours. The notion of growth cultures, emotional intelligence and change will be discussed further in Chapters 10, 11 and 13.

GLOBAL LEADERSHIP

The notion of global leadership is a relatively new term which developed in the 1990s (Lobel, 1990; Kets de Vries and Mead, 1992; Pucik et al., 1992; Rhinesmith, 1993; Moran and Riesenberger, 1994; Brake, 1997). The term global encompasses more than simple geographic reach in terms of business operations; it can be about the world but is generally thought to be about having ‘helicopter vision’, or being ‘across’ a number of areas i.e. when a helicopter is on the ground, if the pilot looks down s/he can see only a small circular surface area below the helicopter and has virtually little or no information about the surroundings. The more it goes up the more surface it covers, meaning that the pilot gradually starts to get a clear picture of the ground and surroundings; s/he can see every detail of the area s/he is covering at this stage. The further up it goes, the more information the pilot can get about the area.

Global leadership also includes the notion of cultural reach in terms of people and intellectual reach in the development of a global mindset (Osland et al., 2006). It can be suggested that it is concerned with the interaction of people and ideas among cultures rather than the efficacy of particular leadership styles demonstrated by particular leaders in their home countries. Global leadership differs from domestic leadership in terms of issues related to connectedness; boundary spanning; complexity; ethical challenges; dealing with tensions and paradoxes; pattern recognition; building learning environments in towns and communities; and leading large scale efforts – across diverse cultures (Osland et al., 2006). You may think of the World Health Organization (WHO) as one organisation that leads on health globally.

Activity

Can you think of any situations where a leader might have had a global effect within health care provision?

In terms of world influence you might have thought of Gandhi (political influence), Alexander the Great (military influence), Mother Theresa (spiritual influence) or within health care there are many to consider – Waterlow (2005) and the development
of the pressure sore risk assessment tool that is used globally; Roper, Logan and Tierney (1980; 2000) who identified the activities of daily living used for the basis of assessment within the majority of health care provision in the acute sector; or further back in nursing history Florence Nightingale, who worked so hard to get basic nursing practice recognised for the good it did. Within the ambulance service it could have been Dr Millar who introduced the standardisation of training, which again is the foundation for all training within the service and is an idea used to underpin training throughout the world. Today, global health leaders may not be famous but locally there may be Unit Leaders you can think of who have helped generate better practice by ‘borrowing’ ideas from other areas in the world to implement in their own practice. Sharing best practice is a very global health activity.

Freshwater (2014: 93–7) distinguishes that leaders need to anticipate challenges, contest the status quo, work towards creativity and diversity, make decisions and learn through reflection and feedback. However ‘a really formidable leader is the person who can balance and integrate the caring heart with the global mind’. This perspective highlights that leaders need to attune or resonate with patients and clients who ultimately will be able to receive the outcome of good leadership.

HOW WE SEE OURSELVES AND HOW OTHERS SEE US

In order to move forward in considering our readiness for leadership it might be useful to consider how we see ourselves and more importantly how others see us. The ‘Johari Window’ (Luft and Ingham, 1955) allows us to see how much the perceptions and knowledge we have about ourselves are also seen by others. The ‘Window’ has four areas:

<table>
<thead>
<tr>
<th>Known to self/known to others (Arena)</th>
<th>Not known to self/known to others (Blind Spot)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known to self/not known to others (Facade)</td>
<td>Not known to self/not known to others (Unknown)</td>
</tr>
</tbody>
</table>

**Figure 1.1** Johari Window – the four areas

What is interesting about this is that if you ask your friends or colleagues what they think your characteristics are they often see differing elements to you. By understanding who we are and how others see us we can begin to adapt our behaviours at work to get the best from our teams. Remember this is about you and so there are no correct answers. As we receive feedback from friends we might be able to change any negative elements and also recognise the positive elements of our personalities and adapt to meet the role of leadership, so improving relationships with others within the team.
Recently I met with a student who displayed a lovely disposition, a keenness to learn, who engaged well with reflection but presented with a constant frown on her face, portraying her anxiety to her team and clients. On discussing this perception, which may be seen as her blind spot, the student thought about it and noted that it had come as no surprise; she relayed her daughter had commented on her ‘scary face’ in the past. This arena then enabled her to attempt to adjust her persona.

An example of the façade could be that I am basically quite shy but because my role as a leader requires me to speak at meetings, conferences and in class I can overcome the shyness so that the world at large sees me as an ebullient, jovial person. Often when a person puts on their uniform or work clothes they also ‘put on’ their altered persona.

**COMPARING LEADERSHIP AND MANAGEMENT**

There appears to be some ambiguity between the notions of leadership and management. Currently the terms *leadership* and *management* may be used interchangeably because the differences between them may not always be straightforward. Most of us think we can recognise leadership but we may not find it easy to find in ourselves.

**Activity**

Jot down your ideas of the differences between a manager and leader in health care.

Current thinking indicates that managers have formal authority to direct the work of a given set of employees; they are formally responsible for the quality of that work and what it costs to achieve it. Neither of these elements is necessary to be a leader. Leaders are an essential part of management but the reverse is not true; you do not have to be a manager to be a leader but you do need to be a good leader to be an effective manager. Table 1.1 reflects the differences between leadership and management.

**Table 1.1  Differences between leadership and management**

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Based on influence and sharing</td>
<td>• Based on authority and influence</td>
</tr>
<tr>
<td>• An informal role</td>
<td>• A formally designated role</td>
</tr>
<tr>
<td>• An achieved position</td>
<td>• An assigned position</td>
</tr>
<tr>
<td>• Part of every health care professional’s responsibility</td>
<td>• Usually responsible for budgets, hiring and firing people</td>
</tr>
<tr>
<td>• Initiative</td>
<td>• Improved by the use of effective leadership skills</td>
</tr>
<tr>
<td>• Independent thinking</td>
<td></td>
</tr>
</tbody>
</table>
The amount of time taken up in leadership activities might differ from person to person (Sadler, 2003). Cunningham (1986, in Sadler, 2003) noted that leadership is an ‘integral part’ of the management role and as such may not be seen as a separate entity (Figure 1.2). However, Bennis and Nanus (2004) indicate that there are two other models to be considered. They are where leadership is seen as half-and-half of the same concept (Figure 1.3) and where there is partial overlap (Figure 1.4).

**Figure 1.2** Leadership within management  
*Source: Adapted from Sadler, 2003*

**Figure 1.3** Leadership alongside management  
*Source: Adapted from Sadler, 2003*

**Figure 1.4** Leadership overlapping with management  
*Source: Adapted from Sadler, 2003*
In each case the time taken up by leadership functions will differ. Overall, management is defined in relation to the achievement of organisational goals in an effective and efficient way. This means that planning, vision, staffing, direction and resources are the main concerns that need to be managed. Managers often seem to have a bad press as ‘us and them’ with the ‘them’ controlling the ‘us’. It should be remembered that management and leadership should work together to achieve a common aim of effective quality patient care. Dowding and Barr (2002) discuss the potential effects of a wide variety of management approaches on practice. Examining these individually – or in some detail – is not the remit of this book. However, if you consider the history of management approaches, it is evident that the way in which leaders and managers function within the health care system is greatly influenced by the overall management philosophy in place. Miner (2005) suggested that organisational knowledge goes hand in hand with effective management.

Therefore, it is necessary to view the different elements of an organisation in order to understand why it functions in a specific manner (Chapter 11). It can also help to clarify or structure how you might be expected to behave in a given situation in order to uphold the reputation of that organisation. Similarly, it may help us to adopt management practices which, while considered ‘old’, might be the most appropriate for a given situation.

THE ART AND SCIENCE OF LEADERSHIP

Donahue (2011) indicated that nursing has been called the oldest of the arts and the youngest of the professions. Stewart (1918, in Donahue, 2011) goes further to state that the science, spirit and skill of nursing was beginning to develop as it became apparent that love and caring alone could not ensure health or overcome disease.
Nursing education, in the past, has concentrated on the science element or ‘medical model’, whereby nurses were told what to learn and when to learn it in relation to the disease and the disease process. More recently, it was recognised that the patient is unique and not just a collection of symptoms. Nursing then became more ‘art’ focused concentrating on holism rather than being medical/science focused, concentrating on the disease process. This has now changed to include a holistic approach, not only to deliver care in relation to a specific condition but also to include the family and regular carers. However, health care professionals need to recognise the strength of their medical knowledge as health technology advances in order to provide health education to the patients and their families. For leadership, the notion of science and art must go hand in hand in order to respect the uniqueness of the patient and their health condition.

The concept of leadership has evolved over the last century and continues to change. That isn’t to say that the old ways of doing things are not good but that in today’s health business society there are different ways of getting things done; ways that enable ‘management’ and ‘leadership’ to work together. Leadership is both an art and a science. It is an art because of the many skills and qualities that cannot be learned via a textbook; a science because of the growing body of knowledge that describes the leadership process, leadership skills and the application of these elements within a given practice area. Knowing about leadership theories allows us to analyse situations from a variety of perspectives, to understand the importance of leading an organisation to success and to suggest well-thought-out alternatives to enhance a quality practice. Studying leadership gives you skills that can be applied not only within the workplace but also in your everyday life. This book will lead you through a variety of situations as an individual and a member of a corporate body.

Summary of Key Points

This chapter has briefly looked at various aspects of leadership in order to meet the identified learning outcomes. These were:

- **Discuss the notions of leadership and followership** This was achieved by examining how you might already be a leader in some situations and a follower in others. Also, we examined how a variety of writers have described leadership, so that you can select the definition that comes closest to your own perception of the role. The use of the Johari Window will help you to recognise your attributes and weaknesses so making you a better leader.

- **Define leadership** By selecting and understanding the multifaceted nature of leadership the benefits of effective leadership were examined: as Daft (2005: 4–5) said, ‘leadership is an emerging discipline that will evolve’. Don’t expect to get it right

(Continued)
every time but with knowledge of the leadership theory you might get it right some
of the time.
• **Discuss the importance of the changing context related to health care** The National
Health Service (NHS) emerged due to a socialist ideology of health being a right for
all, regardless of ability to pay. Leadership within the health service has always been
seen as important because of the size of the NHS and the changing policy and
practices. Global leadership as a notion has also been explored.
• **Compare leadership and management** This perennial argument related to the dif-
ferences (or not) between leaders and managers. Much of the problem in under-
standing the concepts relates to the fact that the two philosophies are so closely
linked and the words used are interchangeable, hence the possible lack of differen-
tiation when we think and speak of leaders.
• **Debate the art and science of leadership** Stewart (1918) highlights that the science,
spirit and skill of health practice was beginning to develop as it became apparent
that love and caring alone could not ensure health or overcome disease.

**FURTHER READING**

WB Saunders Company.

Visit the companion website at https://study.sagepub.com/barr3e for more resources.