CHAPTER 1

Leaders, Managers and Administrators

Consider

- **What is in a name?**
- **Leadership and clinical leadership**
- **Understanding the added value of the 'clinical' element**

Leaders, managers and administrators are all terms in common use in the health service. Probably those using them are aware of what they mean but there is not a common understanding and agreed usage of the terms. Some have a discrete view of the definitions. A leader being a person with a vision who articulates it and aligns colleagues behind it and moves forward. A manager being one who creates a plan to fulfill the strategy and executes it within a performance management structure. The administrator being one who takes specific tasks and elements of the plan forward delegated by the manager and performance managed by them. The manager manages

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the administrator. The leader on the other hand is a non specific role and might be one of the executive team with responsibility for developing strategy.

I believe these definitions are quite purist and in practical terms are rarely as clear cut or clearly defined or separate from each other.

With no malice of forethought some use the terms interchangeably through ignorance of any difference or a lack of understanding of how the 'system' works. Yet others will use the terms interchangeably and dismissively of clinical colleagues who they believe have 'gone to the dark side' of management.

Thus there is complexity of definition, meaning and understanding not to mention perception.

Let us explore this a little. No health service in the modern age could function without an infra structure of management providing the context for clinical care and service delivery. The domestic and estates function and general housekeeping in relation to hospitals and complex health provision units needs to be managed. Buildings have to be provided and maintained fit for purpose even at a heating and lighting level. They have to be cleaned, modernised and replaced as appropriate. Meals have to be planned, cooked and served. Drugs, medical and surgical supplies have to be sourced, ordered and delivered timeously to ensure constant supply and avoid shortage at times of great and potentially unpredicted demand. Staff have to be employed. Healthcare institutions are multidisciplinary. All staff groups play an important role. Whilst it is perhaps intuitive that a surgeon is necessary to perform operations the whole smooth functioning of an operating theatre depends on the other team members including the anaesthetist, scrub nurse

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but also theatre nurses and porters who deliver patients from the ward to theatre at the appropriate time and fundamentally the cleaners who have a vital role.

Employment, recruitment and retention require planning, organisation and management. There are robust legal requirements around human resource functions and appropriate training for particular professions and roles. These must be confirmed at times of employment and reaccredidation. In short there are multiple professional roles to be discharged. These are specialised roles and very necessary to the functioning of any healthcare organisation.

It is likely that the need for a robust management infrastructure with finance, human resource, estate and domestic functionality would be agreed by conventional wisdom. The complexity is around the specifics of delivery of healthcare and the need for clinical involvement in that process. This is potentially hugely contentious and multiple constructs of appropriate arrangements are held.

If there is a pure management structure of educated, trained and skilled managers, with general management skills, delivering the functions they require clinical context and information to inform their work. How this is achieved is multifaceted and, at one extreme, there would be an advisory clinical input where advice can be given or be solicited in relation to specific issues with no accountability or responsibility upon the clinician for delivering the service. At the other extreme a pure medical or clinically trained individual would have responsibility and accountability for delivering the service. This is potentially challenging for the clinical manager who is basically operating outside his trained comfort zone of competence. However this

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model focuses on not just the idealism of pure clinical decision and the best for that patient or group of patients but the pragmatism of affordability and achievability come into the equation as do competing priorities. Medical and clinically trained individuals do not, typically, have the additional training and skill sets to discharge the business aspects of accountability.

There is the added tension of what is the correct decision for an individual patient, what the decision would be in relation to the patient population with a specific disease process or indeed the public at large. This reflects the challenges facing the clinician at the end of the patient's bed who is considering that individual patient and his specific circumstances and what is best for him as opposed to the public health doctor who considers patient populations, percentages and probabilities. The final context is the greater good to the wider public of a particular patient population balanced against other competing possibilities for funding for that disease process and finally in relation to all disease processes, screening and prevention programmes.

The current model of clinical leadership is one of a 'partnership' of an individual with general management skills and training and a clinician. This is deemed to be a useful team to discharge the function. Another model is of a team or executive group providing the wider functions and including clinical input.

Typically administrators and managers are appointed to posts with defined job descriptions around specific responsibilities and accountabilities. They have the authority of their role to discharge their duties.

Clinical leaders may be appointed to roles. In theory they have some status and authority. In practice this is not

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necessarily the case. Army personnel issue orders and expect obedience and delivery. The police service and typically the ambulance service have this 'command and control' model of management. This is not the ethos of healthcare delivery. Clinical leaders have to negotiate change with colleagues.

Formal appointment of clinical leaders is not the only type of leadership within the health service but rather an element of it. Leadership is a valid concept exhibited in many roles and indeed expected in large numbers of roles in healthcare.

A patient may look to the doctor to lead them through their care. The expectation of knowledge and understanding of the course of the disease and its complications being information the doctor has from experience and learning. He can support and lead the patient through his illness.

Clinicians often have to lead clinical teams and indeed multidisciplinary teams. Both junior staff and other team members, paramedical and allied health professionals, will look to the team leader to adopt that role.

In service change and development there must be leadership. Whilst typically there will be a formal leader appointed others will have to discharge elements of change through discussion, negotiation and adoption of a variety of devices.

In short we may all be called upon to exhibit leadership skills and roles although they are not formally designated as such. In fact they may not be remunerated as such. Some may not recognise they are providing this leadership and indeed might have shied away from applying for a formal leadership role rejecting the perceived burden of the responsibility and accountability.

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The focus is probably therefore on the function rather than the form. We should not get too hung up on definitions as it is unlikely we will achieve common agreement and by the way it probably does not matter! It is what we do and how we do it rather than what we call the roles that matters.

Process, structure and function do have their place and it is important to recognise that the above argument in no way denigrates their value. They are the infrastructure of support within which an organisation works. Without them everybody is doing their own thing, in good faith, but typically rather inefficiently. It is inconceivable that any country would function without laws of the land or a highway code. Chaos would ensue however well intentioned individuals were. The default in a large organisation must be known, articulated, documented process which the whole organisation adheres to.

What is at issue here is how to deliver leadership within the context of that framework without enormous bureaucracy and inefficiency. In other words making the system work for you!

Take Home Messages

- **Understand models of leadership**
- **Discover the importance of context, responsibility, expectation, form and function**

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