Leadership from 'below'?

Clinical staff and public hospitals in South Africa

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This paper identifies the possibilities and challenges related to involving clinical staff in the leadership and management of district hospitals in South Africa. It couches findings and recommendations in terms that are applicable to other service sectors. This is because strengthening the leadership capacity of practitioners (as opposed to simply their line managers'), and facilitating participation in their organizations' decision-making processes, might be one mechanism to restore responsiveness and quality in public services in general. The study also speaks to how to strengthen the public sector along lines that preserve its 'publicness' and enable it to meet its social objectives more effectively, as an alternative to more market-based approaches.

Failures of public sector leadership, the declining quality of public sector services, and poor staff morale are common themes in the discourse around public services in South Africa today. Policy-makers, academics, unions and other civil society organizations are perplexed, and sometimes divided, as to how to address these multiple problems in a context of constrained resources. Many low- and middle-income countries face similar challenges.

Yet, at the same time, throughout the world there are examples of committed individuals and good-practice sites that manage to provide effective and efficient services, seemingly against the odds. The reasons for this are varied, but this paper hypothesizes that dynamic leadership by 'practitioners' – be they nurses, prison counsellors, educators, police women, agricultural

extension officers, social workers or prosecutors – plays a part. If this is so, strengthening the leadership capacity of practitioners (as opposed to simply their line managers'), and facilitating participation in their organizations' decision-making processes, might be one mechanism to restore responsiveness and quality in public services. An attractive aspect of this approach is that, in the short term, it could unleash the potential of existing staff and management systems, even ahead of the long term injection of resources and large-scale reform required to address the myriad failings of public systems.

This paper is predicated on the assumption, first, that strong, publicly owned and managed systems are essential to the delivery of services that address social objectives, including equity. In the health literature, at least, there is ample

evidence to support this case (e.g. see Gilson et al 2008), although many would argue that there is a role for private sector provision.

Second, large-scale, top-down interventions to improve the performance of public services run the risk of either over-bureaucratizing or over-commercializing the public sector (over-zealous implementation of quality standards and New Public Management initiatives in the UK's health system are cases in point, see Kirkpatrick et al 2008; Malby 2014). While elements of such overarching interventions are essential, this paper argues that they need to be balanced by local initiatives to transform the public service workplace.

This paper uses the example of leadership by clinical staff in district hospitals in South Africa to explore these issues further. It summarizes the findings of an exploratory study using a qualitative approach based on an extensive literature review, 14 semi-structured interviews with local and international experts, and feedback on the draft report from the initial interviewees and five additional experts (Doherty 2013, 2014). Interviewees were sampled purposively on the basis of their involvement in hospital management and clinical governance: the majority had a clinical background and had worked in a district hospital environment. Interview transcripts were coded and subjected to a thematic content analysis.

The study is limited because it is small and, in most part, reflects the perspective of clinical staff, especially doctors (although some interviewees came from other disciplines, including management). Further, although the paper attempts to demonstrate the relevance of the study of hospitals to other sectors, this needs to be tested. Nevertheless, the study serves to prompt research and debate on the neglected area of leadership by practitioners in health and other services. It also speaks to how to strengthen the public sector along lines that preserve its 'publicness' and enable it to meet its social objectives more effectively, as an alternative to more market-based approaches.

Why is clinical leadership important?

Internationally, the historical assumption has been that doctors, nurses and other clinical staff simply look after patients, while administrators look after the rest of the

organization. Reflecting this, the debate around public hospital management reform in South Africa tends to focus on the authority and capacity of the senior management team of the hospital, and how to strengthen general management processes. However, a growing international literature argues that, in the hospital setting, decision-making that directly affects the quality of care largely occurs at lower levels of the management hierarchy (Doherty 2013). Equally important, it is largely clinical staff, and not general managers, who make these decisions. "Clinical leadership" (see definition in Box 1), as argued in the literature, is therefore vital to improving hospital performance particularly with respect to the quality of care.

Drawing on Mintzberg (1993), the international literature explains that healthcare institutions are "professional bureaucracies" where a clinical health worker's authority does not derive from his/her position in the formal management hierarchy but from his/her specialist knowledge and linkage to professional networks. In hospitals, this means that most decision-making that affects clinical care (and even some aspects of organizational efficiency) is actually out of the hands of hospital managers: it occurs in the ward and operating theatre rather than in the boardroom or office.

In addition, the clinical process is extraordinarily complex and unpredictable in nature. No one patient entering the health system is the same as another, conditions progress from day to day, and treatments vary according to an array of individual, family and contextual features. This means that it is difficult to standardize the approach to care, while the management of resources – at the ward, theatre, unit and departmental levels – needs to adapt to changing circumstances. A high degree of discretion is required of health professionals, and clinical decision-making needs to be individualized and responsive, as explained by Lipsky's (1980) theory of "street-level bureaucrats." As one interviewee put it in this study:

> "At places where there is good care, people are not working to the rule. Where there is good care there is good leadership and the leadership usually is something … quite ephemeral in some ways, on some levels. On other levels I think it's something very, very visible and very concrete."

Leadership versus management: Leadership – especially transformational leadership – is about developing a values-based vision and direction for an organization, motivating and inspiring members to implement this vision, aligning the efforts of various members, guiding the organization through periods of change and instability, and developing and empowering followers. Management, on the other hand, is more about achieving stability through planning and operational problem-solving, including developing concrete plans and budgets, setting targets, and marshalling and organizing resources.
Clinician/clinical staff: Any health professional who is directly involved in diagnosing a patient's health problem, deciding upon the treatment required, overseeing and participating in the care of the patient, including conducting procedures.
Clinical governance: An integrated system for leading, managing and monitoring the clinical process that promotes a productive culture in which clinical excellence can thrive, while ensuring transparency and accountability on behalf of leaders, managers and clinicians.
Clinical leadership: The transformational leadership provided by practising clinicians who drive improvements in the quality of care, either through formal participation in clinical governance activities or through informal role modelling and mentorship.

Sources: Doherty 2013, 2014.

The conventional approach to managing a government bureaucracy through hierarchical, rule-governed relationships is therefore not entirely applicable to public hospitals, at least with respect to the clinical process. In order to be effective managers of change – or even to meet regular financial and other targets – hospital managers have to bring clinical leaders into management processes, actively facilitating clinical leadership and encouraging managers and clinical staff to understand one another's viewpoints and experiences.

Leadership also has to penetrate into all parts of the organization: this need for "distributed" leadership means that a large number of clinical leaders need to be involved as part of teams working on specific clinical areas or "clinical micro-systems." This must happen together with a new approach to leadership that is shared and collaborative, extending across both organizational and professional boundaries (Doherty 2013).

The international literature also shows that effective clinical staff have specific attributes, apart from their expert knowledge, to contribute to this new approach to clinical governance (Doherty 2013). Because of the nature of their training, their roles within the clinical setting, and their socialization within their professional groupings, clinical staff tend to deploy a different leadership style to general managers. They have a micro-level viewpoint and use persuasion and evidence to bring about change, often acting as opinion formers who shape the tone of the hospital in an integral way. Good clinical staff are trained to take responsibility for decision-making and to prioritize patient care. Because material incentives to become clinical leaders are poor, clinical leaders tend to take up leadership positions not so much for personal advancement as to improve their clinical area (Doherty 2013).

In combination, these characteristics make clinical staff good candidates for bringing about organizational change in support of patient care, and recent international research evidence is strong for clinician engagement as an essential strategy for improving clinical governance. For example, quality improvement strategies in the UK have had more success when "done in a way that made sense to staff and that engaged doctors fully in its implementation" (Ham and Dickinson 2008), with one study finding that "hospitals with the greatest clinician participation in management scored about 50 percent higher on important drivers of performance" (Mountford and Webb 2009, 3). Looking at primary care practice in Australia, Phillips et al. (2010, 606) also found that "the evidence is strongest for improvements that are driven by health professionals at the practice level." Bohmer (2012, 7) concludes that "[l]eaders at the lowest levels of delivery organisations, where clinical staff and patients interact, have control over a set of organisational levers that have been shown to have a meaningful impact on both intermediate medical outcomes (e.g. error rates) and terminal outcomes (e.g. readmission and mortality rates)."

Of course, there are many clinical staff who have performed very badly as managers. It is important to acknowledge that not all individuals are suited for – or interested in – clinical leadership. One interviewee in this study noted that:

> "Some people are very good clinicians but make shocking managers, and other people are good managers and make shocking clinicians, and sometimes you're lucky enough to get both."

The literature acknowledges, too, that an increased influence for clinical staff needs to be balanced by greater accountability, recognition of funding constraints and adherence to national norms and standards. Nonetheless, many clinical staff play a pivotal role in sustaining hospital services in South Africa. This is especially so in poorly resourced areas: thus, in rural district hospitals, clinical staff shoulder enormous responsibility, not just for managing the care of individual patients, but also for developing staff and services at primary and hospital levels, and contributing to wider decision-making around healthcare priorities and resource allocation. Often these staff work under very difficult circumstances.

Good clinical leadership systems

An understanding of the important role clinical leadership could play in clinical governance has given rise to attempts to develop more productive relations between clinical staff and management, with most formally documented examples emanating from Australia, Europe, the United Kingdom and the United States (Doherty 2013). Over the past decade there has been considerable progress in moving toward distributed clinical leadership in the countries mentioned above. In bigger hospitals, an important change from traditional approaches is that clinical leaders assume much greater responsibility for overseeing all the functions falling under their team, including managing the budget, human resources and procurement, as well as taking responsibility for meeting targets.

In this study of South Africa, however, interviewees did not feel this was necessary, given the small size of district hospitals and, especially in rural areas, the multiple daily opportunities for informal networking between different types of health professionals, some of whom live on the hospital grounds. One interviewee expanded on this:

> "There is much less of a hierarchy in district hospitals than regional or tertiary hospitals. All the clinicians are faced with more or less the same range of clinical challenges. They can relate directly to each other's experience."

Within this context, good clinical leaders are involved in a range of leadership roles, both formal and informal (see Box 2 for examples). These clinical leadership opportunities exist at many levels of the hospital and provide an opportunity for junior staff to gradually take on more demanding roles.

Many of these roles could be filled by staff from any clinical discipline, but doctors have predominated in some roles historically. Interviewees felt that different disciplinary backgrounds confer different advantages and disadvantages as leaders, and that the role of nurses in particular could be developed further. Not all individuals are suited to senior leadership positions, however, and interviewees emphasized that leaders have to have appropriate personality traits, training and experience.

Further, successful examples of clinical leadership internationally and locally are based on open and inclusive communication as well as collaborative leadership styles that rely on influence and mediation (sometimes called "influence-ship") rather than "command and control" (Doherty 2013). Participants in this study added that collaborative leadership styles need to be founded on multidisciplinary teamwork and backed up by frequent, purposeful meetings of clinical teams as well as between clinical staff and management.

The international and local examples show that, in order to restore mutual respect and a sense of shared purpose between clinical staff and managers, a "crossing over" of perspectives is required: clinical

Examples of leadership roles for clinical staff in South Africa

- running a ward or clinical unit
- participating in ward rounds
- mentoring other clinical staff at the bedside
- developing clinical guidelines and standard operating procedures
- participating in or leading a variety of permanent and ad hoc committees, such as:
  - meetings of multi-disciplinary clinical teams
  - meetings between clinical staff and managers
  - meetings of clinical staff with administrative personnel (human resources development, finance, supply chain, cash flow, transport and maintenance, etc.)
  - meetings to review indicators and progress reports
- training undergraduate and postgraduate students
- taking line management responsibility for particular types of clinical staff
- overseeing clinical governance
- ensuring the recruitment and appointment of clinical staff
- solving daily non-clinical problems that impinge on the quality of care (e.g. acquiring supplies, sorting out sewerage problems)
- running the hospital as hospital manager
- providing outreach support to primary health care clinics

Source: Doherty 2014.

staff must contribute to organizational transformation, traditionally the preserve of general managers, while managers must shift their focus to achieving the main purpose of hospitals, good quality clinical care (Doherty 2013). This leads to a greater willingness on the part of both clinical staff and managers to share responsibility for change, re-alignment of priorities, a dove-tailing of clinical and resource management decision-making, and a greater likelihood for innovation in service delivery. This requires a mind-shift on the part of clinical staff and managers, changes in their respective behaviours and training, the incorporation of clinical staff into management teams at different levels within the organization, and greater recognition of clinical staff's informal leadership contributions as role models and mentors. One interviewee reflected that providing clinical leaders with adequate support can make an important difference to the quality of their leadership:

> *"Freeing up time for middle-level medical leadership to engage with colleagues, other clinical professionals and hospital management can be achieved by providing them with adequate administrative support – adequate both in terms of the skill-levels of such people (which engenders trust) and the salaries attached. Both require significant investment."*

Involving clinical leaders facilitates their understanding of the strategic direction of the health service. This reconciles professional aspirations with resource availability, facilitates and supports clinical self-management, achieves change through motivating clinical staff, and promotes a move away from a custodial role – where they focus on protecting their clinical practice – to creating a greater alignment between the managerial and clinical objectives of the organization (Doherty 2013). Interestingly, interviewees in this study emphasized that effective clinical leaders play a crucial role in re-orienting the hospital toward meeting patient needs as a counter-weight to bureaucratizing tendencies. In doing so, they manage to strike a balance between caring for individual patients and strengthening the health system as a whole.

Importantly, both the literature review and the majority of the interviewees noted that even senior clinical leaders should maintain their involvement in clinical work: this is what allows them to keep patient care at the heart of management and understand what is needed to protect service quality. Once they take up formal leadership positions, continuing clinical work preserves clinical leaders' credibility with other clinical staff. As one medical manager highlighted, if one continues to practise one:

> *"... can understand what is important and what is not so important in terms of delivering the service in the ward. But I think also . . . if you're still practising, you have a degree of sympathy for the frailty of humanity. You understand under [certain] situations that people don't always achieve their best and that it doesn't necessarily mean that they're useless."*

Barriers to effective clinical leadership

There are many barriers to strong clinical leadership. Internationally, and as reported by the South African interviewees, clinical staff are often poorly prepared for leadership (Doherty 2013). Organizational support is often weak: clinical leaders report encountering resistance from their clinical colleagues who sometimes judge them for having gone over to "the dark side" by participating in management processes; there are few financial incentives to take up leadership positions; and career pathways are limited (Doherty 2013). Clinical leaders' attempts to institute effective clinical governance may also be stymied by persistent management hierarchies that do not recognize clinical staff's contributions, or maintain silos that fragment the efforts of doctors, nurses and general managers or administrators.

Historically there have also been poor relationships between clinical staff (especially doctors) and managers due to different backgrounds, training, social status and perspectives. Internationally, management reforms since the 1980s have sometimes aggravated these poor relationships by elevating concerns of efficiency and financial soundness over the demands of patient care (Doherty 2013). Clinical staff have resented managers and "managerialism" for compromising the quality of their clinical practice. Managers, on the other hand, have been frustrated by the insistence of clinical staff on the primacy of their individual clinical autonomy, sometimes at the expense of the wider hospital community.

Apart from these general problems, clinical leaders working in district hospitals in South Africa grapple

with poorly resourced and managed systems, especially in rural areas. As put by one of the interviewees who had been identified as particularly effective in the district hospitals where he had worked:

> *"Despite having often that passion and that drive, it means you have some success but sometimes that success is only limited to keeping that team together and you're still putting out fires, but some of the more high quality issues, or some of the ... deeper issues of clinical governance, you're not necessarily getting to those even though you've got a good team."*

Interviewees identified the problems that give rise to this situation, some of which are specific to the health sector and others which may ring true for other sectors:

- the inability of district and provincial offices to provide an enabling environment for quality healthcare provision
- hospital managers distracted from their duties in the hospital by constant meetings with district and provincial managers
- a disjuncture between the identification of problems affecting clinical care and action taken by the management team
- alienation of district hospitals from the primary care services in the district
- poor human resource management that slows the appointment of clinical staff and places enormous administrative loads on clinical leaders who are compelled to intervene to recruit staff
- the selection of clinical staff into leadership positions on the basis of length of service rather than leadership skills

- lack of leadership and management training for all types of health professional, at undergraduate and postgraduate level, as well as insufficient mentoring
- burdensome and ineffectual monitoring systems that create administrative loads on clinical staff without addressing the root causes of poor quality of care

Finally, participants in this study, working in contexts of severe resource shortages, noted that it is difficult to achieve progress as clinical leaders without a critical mass of skilled clinical staff. All these problems contribute to the failure of clinical governance systems in South Africa, even where there might be skilled and motivated clinical leaders working at facilities.

Recommendations for action

This section suggests actions to strengthen clinical leadership, couching recommendations in general terms so that their applicability to other sectors might become more obvious (using the term 'practitioner' to include professionals from other sectors who are directly engaged in delivering a service to individual clients and are therefore equivalent to clinical staff). The recommendations attempt to shift the focus and style of conventional management transformation efforts toward empowering practitioners and reorienting services toward quality concerns. The recruitment and retention of skilled practitioners is obviously a starting point for improving the quality of services and some recommendations are designed to address this as well.

Universities
1. Strengthen research on practitioner-leaders, including identifying the capabilities, training, mentorship, and management support they require, as well as successful leadership practices. It is also essential to understand how senior managers could facilitate decision-making by practitioners while still holding them accountable to the wider objectives of the facility.

2. Introduce or reinforce leadership and management training for all practitioners. Practitioners need

leadership training and mentorship, starting at the undergraduate level and persisting late into their careers. Importantly, this training should build on, but also shift from, conventional business management approaches to respond to the unique features and values of the public sector, reflecting a philosophy of shared, multi-disciplinary and transformational leadership. Postgraduate learning opportunities in particular should use innovative and reflective training approaches and be supplemented by on-the-job mentoring and support. In relation to the health sector, problem-solving skills need to be promoted for all clinical disciplines: these skills were identified by interviewees as a prerequisite for clinical leaders.

National departments or ministries
1. Acknowledge practitioner-based leadership as a key driver of facility performance and, in the health sector, support provincial hospital systems in formulating clinical leadership development strategies as part of effective clinical governance. Strategies also need to be developed to incentivize good clinical staff to become involved in leadership roles, including adequate financial rewards and administrative support, and career paths that allow them to combine management with direct service provision as well as move in and out of leadership positions.

2. Monitor the impact of different quality monitoring mechanisms, not only on fundamental aspects of the quality of services but also on the morale, workload and commitment of staff: this is because when resources are scarce and management systems are weak, inappropriately designed or implemented assessments can alienate practitioners, at least in the health sector.

Provincial and district offices
1. Review the demands placed on facility managers by district and provincial head offices, and create effectual delegations, so that facility managers are not called away from their facilities too frequently and can concentrate on transformative leadership. Adopt a supportive rather than 'policing' role in relation to clinical leaders.

2. Galvanize human resource management at provincial, district and facility levels, with an emphasis

in district hospitals on rapid appointment and timely payment of clinical staff, as well as effective labour relations and disciplinary support. In the health sector this would facilitate growing the numbers of good clinical staff and relieve medical managers of what is presently a large human resource management burden.

3. Review structures and processes for joint planning and supervision of district health services, with a view to integrating district hospital and primary health care more effectively. This should include developing a comprehensive clinical governance strategy and specialist support to district hospitals.

4. In the health sector, make clinical governance a key function of the senior hospital management teams as well as hospital boards, in order to re-orient the focus of the hospital toward patient care and create a stronger impetus for improving clinical governance. This does not need to be inconsistent with maintaining financial sustainability and efficiency.

Facility managers

1. Clarify the roles of different types of practitioners, especially those in leadership positions, with a focus on building collaborative teams. In the district hospital setting, particularly important relationships are those between: the hospital, medical and nursing services managers; as well as the nurse and doctor in charge of a ward.

2. The support of top-level management is critical to the development of practitioner-based leadership. Facility managers need to be willing to delegate power and responsibility to these leaders and nurture productive relations between them and management, creating an enabling environment for leaders to function well and to assist the facility in achieving its objectives. For this to happen adequately, facility managers themselves need to receive appropriate delegations.

3. Acknowledge the key roles played by senior practitioner-leaders (such as medical and operational managers in district hospitals). Appoint credible professionals into these positions based on leadership and management prowess rather than simply on the

number of years they have served. It is very important to ensure that appropriate people fill these positions – with the necessary leadership traits and skills, and the ability to adapt their leadership styles and focus to the contingencies of local circumstances.

4. Encourage practitioner-leaders to remain highly visible and accessible to the rest of the organization through such strategies as, in the case of district hospitals, ongoing engagement in clinical work, the physical location of offices near clinical areas, an open door policy and frequent visits to clinical spaces.

5. Strengthen the position of the senior administrative manager (sometimes known in district hospitals in South Africa as the systems or non-clinical services manager), so that the administrative loads of practitioner-leaders are lightened, enabling them to make stronger leadership contributions. Also ensure that there are functioning computers, internet connections, e-mail, fax machines and photocopiers to minimize administrative chores for managers.

Senior leader-practitioners

1. Implement a practitioner leadership development strategy that could include:

- strengthening multi-disciplinary teams (especially, in district hospitals, at the level of the ward)
- exploring the leadership roles that different types of practitioner could play along the junior to senior continuum, and creating incentives for them to participate in leadership (with, in district hospitals, a focus on enhancing the role of nurses)
- providing supportive supervision and on-the-job leadership training and mentorship for leaders throughout their careers
- promoting joint appointments with universities for key staff in order to give them support and stimulation, especially for those working in rural areas
- finding a mechanism (such as a quality committee) to take

structured action on issues affecting the quality of care that may be identified by other committees and individual practitioners

- balancing collegial leadership with measures to ensure that practitioners are fulfilling their roles adequately and remain accountable

2. Develop clear, frequent and multi-faceted strategies for communication within and between practitioner groups, and between practitioners and administrative staff. Use both formal and informal opportunities for face-to-face interaction. Make strategic use of e-mail communication so that senior staff are not drawn away from practice to discuss trivial issues. The focus of communication strategies should be on identifying and addressing obstacles to good clinical care and taking accountability for agreed actions.

Conclusion

The sustainability of South Africa's draft policy on National Health Insurance (the country's financing policy for achieving universal health coverage) rests on the delivery of good quality care in the public sector. While the current introduction of national hospital standards and the deployment of more competent senior hospital managers are vital interventions to strengthen public hospitals, it is at the level of the ward and clinical section that quality improvements need to be generated on a daily basis. This paper argues that strengthening clinical leadership has potential in this regard and that the concept could be extended to practitioners in other sectors, although this needs to be investigated further.

Strengthening clinical leadership does not simply mean putting in place a set of structures, standards and systems to oversee the quality of care: it is about a new way of conceptualizing leadership in the hospital setting. The international literature finds that clinical leadership has the potential to address the structural cause of inefficient and poor quality care, namely, overly centralized, bureaucratic and unresponsive decision-making and organizational cultures. It has the potential to transform underlying values

and management processes by placing the provision of good quality care at the heart of management efforts, creating an organization-wide shift in management culture. It helps to build management systems that support the clinical process actively, drawing on the leadership potential of clinical staff, stimulating potential innovation through unifying the efforts of managers and clinical staff, and strengthening the accountability of the whole organization to delivering good quality care.

Exactly how to strengthen clinical leadership in the South African context needs further investigation and debate. The international literature on this subject has only emerged in the last decade and the degree to which useful comparisons can be drawn with South Africa are not yet known. Obviously in South Africa there are fewer resources than in high-income countries and staff shortages are particularly stark, but there are more subtle factors – such as differences in the level of decentralization and organizational culture – that might be equally important considerations.

District hospitals in particular seem to play much more extensive roles than their high-income counterparts, responsible as they often are for developing and supporting the surrounding primary care services. Further exploration of these issues is required while managing the sensitivities of different professional groupings as well as policy-makers' concerns about decentralization in the context of weak capacity.

ABOUT THE AUTHOR

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ABOUT THE PROJECT

The Municipal Services Project (MSP) explores alternatives to the privatization and commercialization of service provision in the electricity, health, water and sanitation sectors. The MSP studies progressive models deemed successful in an effort to understand the conditions required for their sustainability and reproducibility. The project is led by academics, NGO representatives, labour leaders and activists from different sectors and regions who believe in strong research for social change.