Clinical Leadership in Jordanian Hospitals: The Clinicians' Perspective

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Abstract

The main aim of this study is to explore the nature of leadership in Jordanian hospitals. This study consists of four objectives; the first objective is to identify the extent to which clinicians perform their role of managing and leading Jordanian hospitals .The second objective for this study is to explore the source of power and authority being adopted in Jordanian hospitals. Then the third objective is to differentiate between doctors and other clinicians from nurses and AHPS in practicing leadership. While the fourth objective to explore the obstacles in developing CL in Jordanian hospitals.

The methodology of a qualitative approach was adopted through analyzing the contents, thus, semi-structured interview was conducted with 38 participants from managers who have a clinical mission besides managerial and supervising ones. The study has found out that there is a lack of administrative qualifications for clinicians, and seems difficult to apply the transformational style in Jordanian hospitals due the fear of responsibility and bad distribution of power and authority among clinicians and doctors in particular. Furthermore, there is a lack cultural diversity and this weakens the provided medical services in matching globalization and international criteria. Communication channels in Jordanian hospitals are acceptable; because both technical and personal settings among clinicians are emerged. Unfortunately, there was no specific and clear agenda for both quality and ethical considerations .Doctors are dominated by the concept of bureaucracy and centralism. Accordingly, some obstacles have been revealed in Jordanian hospitals; doctors are the biggest obstacle because they are holding the whole power. Also, communication channels with other departments and among colleagues are weak. Furthermore, the clinical culture did not reach the creation of cultural system .This is due to the weak coordination among academic faculties and governmental departments to shape the meaningful concept of health care management and leadership.

The researcher recommends that both quality and ethical considerations should be involved in more practical sense and doctors need to be trained to carry out the administrative responsibilities by involving nurses and AHPS to ensure the distribution of power and diversity. This study has added the academic contribution by presenting a new mass of knowledge, and considering clinical team members in Jordanian hospitals as a uniform by creating the comprehensiveness of work culture. Finally, the study proved that both experience and knowledge are additional authorities beside position, law and work that may enrich performance.

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List of Abbreviations

Abbreviation	Terminology
AHPS	Allied Health Professionals
APS	Australian Public Service
CEOS	Chief Executive Officers
CL	Clinical Leadership
CPD	Continuing Professional Development
Dept	Department
DOS	Department of Statistics
EFQM	European Foundation for Quality Management
GNP	Gross National Product
GPS	General Practitioners
HFA	Health for All
HR	Human Resources
HRD	Human Resources Department
HRM	Human Resources Management
IC	Individualized Consideration
II	Idealized Influence
IM	Inspirational Motivation
IMR	Infant Mortality Rate
IS	Intellectual Stimulation
ISO	International Standards Organization
JD	Jordan Dinar
JNC	Jordanian Nursing Council
JOD	Jordan Dinar
JPH	Jordan Private Hospital

JUH	Jordan University Hospital
KAH	King Abdullah Hospital
LEO	Leading an Empowered Organization
LMX	Leader Member Exchange
MBA	Master of Business Administration
MCH	Maternity Care Home
MD	Medical
MDS	Medical Doctors
MLQ	Multifactor Leadership Questionnaire
MOH	Ministry of Health
N	Number
NHS	National Health Service
NQF	National Quality Framework
Nsg	Nursing
PBH	Princess Basma Hospital
PHC	Primary Health Care
PHCI	Primary Health Care Initiatives
PhD	Doctor of Philosophy
PPLS	Professional Practice Leaders
QA	Quality Assurance
RCN	Royal College of Nursing
RD	Research and Development
RMS	Royal Medical Services
TCM	Total Care Management
TQM	Total Quality Management
UK	United Kingdom
UNDR	United Nations Development Report

UNRWA	United Nations Relief and Works Agency
USA	United States of America
USAID	United States Aid for International Development
USD	United States Dollar

Chapter One

Introduction

1.1 Backgrounds and the Need for Study

The main objective of this study is to examine the reality of management and leadership in Jordanian hospitals and to find the appropriate answer to the following issue: Are the technical training, academic rehabilitation, and the powers (the role) granted to clinicians in hospitals considered significant factors in creating a concept of leadership with the formation of work experience and knowledge? Basically, the researcher means by clinicians, the health care providers who assist in health care services in Jordanian hospitals. This is an attempt to differentiate those workers from the ordinary employees working in several departments such as management, finance, IT, engineering, maintenance, guarding, etc.

To emphasise the importance of this study, Muasher (2005) suggested that health service management in Jordan is still need some developments regarding staff, sources and process as there is no obvious planning to promote human resources and management. In addition, co-operation between medical or clinical institutions with health care providers is still limited and needs much greater levels of support. Therefore, this thesis argues that classic, bureaucratic management structures are no longer suitable for huge organisations like hospitals health service providers who are attempting to match public demand and customer requirements.

Many authors, such as Preston and Clarke (2000), Heiberg and Hellijesen (2002), Schultz (2004) and Goodwin (1998), have stated that health service managers have often moved into management from a clinical background. They have very little experience of management and

in such cases it is a big responsibility for clinicians or chief executives to have managerial requirements, effectively balancing the demands of clinical and managerial responsibilities. Health services cannot be provided unless such institutions have successful management or leadership, with highly qualified staff who possess both clinical and administrative skills. By making clinicians primary decision makers in the hospital environment, as much money has been spent on leadership development, learning about leadership ideas and skills and learning about transition from administration to management; there must now be a transition from management to leadership, therefore change must occur in order for clinicians to become effective leaders (Lamb and Cox, 1999). There are common characteristics between leadership and management; for example, the topics of management and leadership are severely complex according to Kokkinen et al (2007). To emphasise this issue , Yukl (1981, p2) defines leadership as *"the behaviour of an individual when he is directing the activities of a group toward a shared goal, it is interpersonal influence, exercised in situation, and directed through the communication process toward the attainment of specific goal or goals".*

This thesis will explore and analyse the ways in which the current standards of health care can be maintained. It is increasingly important that specialised and ethical leadership must provide a source of enthusiasm for all levels of staff; for example, the UK Department of Health (2000) states that the health service will require first class leaders with both clinical and managerial backgrounds. Those leaders believe in shifting the balance of power in order to create a better health care system that tackles bureaucracy. Such a situation means clinicians will take the sole responsibility of managing one health team. Some managerial and leadership skills are needed to facilitate such a new style of leadership based on power .This type of power means visible supervisory roles embodied in knowledge, experience and position for all clinicians .

Unfortunately, clinicians usually have no managerial background as their university curriculum has been focused purely on clinical procedures regarding hospital administration, such as health planning, epidemiological statistics and some information about health communication skills. Instead, they get to practice their management skills throughout their training period under the supervision their supervisors. Clinical associations, such as medical and nursing, as well as clinical colleges, are now aware of the need to teach their clinical students some compulsory management modules in their curriculum. The knowledge they gain from this process enables them to lead their clinical departments more easily. Also, alleviate conflict with non-clinical managers and human resource officers, finance, quality departments, training and development sections, maintenance, engineering, and other departments.

It can be difficult for non-clinicians trickle their roles to clinicians instead of managerial individuals and administrative officers such as accountants, HR officers and others who are working in management. “This often causes a problem of communication for clinicians when passing their clinical information to administrative officers from a non-clinical team, because non-clinicians do not possess clinical knowledge. The opposite is the case when administrative officers pass managerial information to clinicians who have no management background.

To enable more successful communication it would be necessary for clinicians to share their goals and strategies (including those relating to human resources, budgetary, planning, vision and strategy) with their colleagues from a managerial background to a greater degree. Furthermore, top management groups in hospitals, such as chief medical staff, head nurses and clinical directors from allied health professionals (AHPS) should move to being operative

leaders .They are achieving a diverse team formulating CL, led by clinicians from all divisions, not only medical staff, and ignoring the classic understanding of doctors as ‘managers’ and ‘leaders’ of hospitals.

Doctors have no serious problems regarding practicing CL because they are usually awarded a high level of authority in their hospitals, being the most qualified of those with a clinical background. They are also considering themselves to possess decision making and managerial responsibilities within the hospital environment. For this reason they are often involved in health care management as policy makers in the strategic apex of government. My research demonstrates that physicians, as clinical members were involved in decisions during the development of strategy as they are very fast learners. This is one of the important reasons for health services naming doctors as health service management leaders. However, the increasing work-load of many doctors may affect the clinical side of their occupation negatively; the more they are heavily involved in the managerial process the greater the potential for this to impact on their original medical roles and responsibilities.

Therefore, it is frequently common for other clinicians, such as nurses, to hold highly advanced academic certificates of clinical setting and health service management. This is either in the form of completed training courses or separate administrative qualifications such as a diploma, masters or PhD. These qualifications enable lower level of clinicians to practice CL, however, in spite of holding qualifications and possessing a great deal of experience. Basically, lower level clinicians do not usually have the positional power to be decision makers in their hospitals, as doctors do. Furthermore, they are represented on hospital boards by one person while doctors have more than 3 or 4 members such as the chairman, clinical leaders and assistants for strategy, planning etc. The same situation applies to AHPS who, as a

separate group, do not have strong powers and are not strongly represented on hospital boards.

In spite of the country's good level of health care delivery and highly developed infrastructure, health service management in Jordan is still a relatively new concept. Increasing public expectations require wise management and leadership abilities in order to successfully establish a new culture aimed at promoting better health care quality. This research intends to fill some of the aforementioned gaps in knowledge surrounding Jordan's health care system. To this end variables have been formulated to explore the state of Jordanian CL. For example, in 1997 Jordan's Ministry of Health (MOH) drafted a strategy for advancing health care by 2010, which informs much of the fieldwork of my own study. The document suggested special measures to strengthen health management, professional standards and maintain Jordan's role as a centre for excellence in medical treatment in the Middle East. The strategy defined the role of the MOH in planning, training and continuing the education of health professionals. Also it is promoting and institutionalizing health research and technology development according to international standards by linking management performance to health economics principles.

For this reason, many commissions, such as the Primary Health Care Initiative (PHCI) and United States Aids for International Development (USAID), have established significant roles in CL working to promote quality services at the MOH. Furthermore, these commissions were named also to introduce and sustain a quality assurance programme, train staff, strengthen health communication and conduct research (PHCI, 2002). Moreover, they enhance the relationship between lower level employees and those of the upper levels. In this approach, Jordanian clinical faculties are increasingly aiming to introduce their students to management

and leadership concepts, preparing them to manage care, make appropriate decisions related to clients and utilise the knowledge in planning health care (Abu-Mughli and Zu'mut, 2006:a).Also, it is important to remember the vital role that health care organizations in Jordan can play in adjusting the quality of the health service to meet the international standards, including organisational structure, communication systems, administration recruitment, staffing, expertise and qualified personnel, quality assurance, code of ethics, nursing administration and management and leadership (JNC, 2006:a).

Interestingly, Jordan began to establish a good, solid base for CL and hospitals started to prepare their clinical followers, such as doctors, nurses and AHP, to be leaders in their hospital believing they are the most appropriate people to make clinical decisions concerning health strategy and planning. This system is generally regarded as being more appropriate than managers with an MBA with no medical training. However, it would be easy for clinicians to make decisions due to having the benefit of both clinical and managerial background at the same time

Currently, Jordanian hospitals (which constitute the fieldwork of this study) are looking for international accreditation. Yet they are struggling to meet the requirements regarding the standardisation of health care quality and the adoption of highly developed management and leadership. Furthermore, health service delivery is now measured by the demanding standards of ethics, criteria and international standardisation in participation with clinical institutions, such as medical and nursing faculties and professional associations.

My reasons for initiating this study are numerous and include an acknowledgement that health as a concept does not refer only to pathological and physical considerations, but also healthy management and leadership. Indeed, the health service, as a large, multifaceted organization,

should be at the forefront of progressive administrative methods (Goodwin: 2000). For example, clinicians, especially doctors, nurses and HPS are required to be involved in the managerial process by providing them with suitable training to overcome misunderstandings which may arise with non-clinical administrative .In other words, fostering highly cooperative behaviour instead of conflict. Because the medical sector has shown such a high level of development in recent years regarding highly complicated medical surgeries and procedures, clinicians are the best who can assess their own needs and hospitals non-clinical bodies.

In order to conduct this study, qualitative method was applied to gather data from doctors, nurses and AHPS in different medical departments in four Jordanian hospitals from the public and private sector. This was also including the academic ones to achieve diversity. The purposive sample were interviewed to extend the data and to give a comprehensive picture about the study concepts and the most important obstacles faced by clinicians regarding CL and their views to the general philosophy and strategy of the hospital. The open ended interviews have an obvious role in describing the panoramic view; which helps to draw out the findings, recommendations and obstacles that stand in the way of achieving such objectives. In addition, the result of this study will have a strong impact in the academic, managerial, and clinical contributions that could be taken in future when conducting similar studies to identify the managerial reality of the health sector. The use of the contents analysis for qualitative analysis is to support all manner of other ways in order to facilitate generalization.

Accordingly, the objectives described in the next part of the thesis are attempts to detail all of the relevant issues regarding the clinical environment and the important role clinicians have in

improving clinical and managerial approaches to a level in line with those of more successful international and western countries.

1.2 Research Objectives

This first objective of this thesis can be summarised as follows: to identify the extent to which clinicians perform their role of managing and leading Jordanian hospitals according to their clinical background. For this reason, it will be surmised that clinical knowledge is not enough for clinicians to be managers and leaders. The second objective for this study is to explore the source of power and authority that clinicians have in practicing CL, and linked to this point, to consider if it might be possible and indeed beneficial for all clinicians (not only doctors) to perform CL in order to secure the diversity of the clinical system? To highlight this issue, the third objective in this project will be to differentiate between doctors and other allied health professionals, in terms of leadership effectiveness. Finally, in order to evaluate the effectiveness of current CL and potential means of improvement, the fourth objective will be to explore the obstacles in developing CL in Jordanian hospitals.

1.3 Organization of the Study

This thesis comprises eight chapters. Chapter two, entitled leadership as a concept, explores the importance of leadership concepts and multiple styles of leadership; it also details the necessary combination of many factors that are needed in order to be successful in leadership professions. Chapter three contains a discussion of CL in terms of clinical professions, such as the group of leaders, doctors as leaders and nurses as leaders, health quality, clinical and managerial ethics and communication, among health professionals. Chapter four, the Jordanian experience in CL, documents the situation of leadership in Jordanian hospitals and its health service sector in terms of the health status in Jordan, the background of Jordanian

CL, USAID participation in Jordanian CL, CL in Jordanian curriculum, standardisations of Jordanian CL and clinicians' attitudes towards CL in Jordan. Chapter five provides the research methodology. Chapter six is a discussion of the qualitative data analysis. In Chapter seven, the research findings are discussed and, finally, Chapter eight provides the conclusions and implications of this study.

Chapter Two

Leadership as a Concept

2.1 Introduction

This chapter aims to discuss the nature of leadership, focusing on transformational leadership. This kind of leadership is influenced by many factors, including the leader and his characteristics, the team and their beliefs, the organizational culture and its contribution to shaping the ideal leadership, as well as relationships and types of communications amongst the different hierarchical levels. In order to reflect this multiplicity, this chapter is structured as follows: section 2.1 presents the introduction, section 2.2 details leadership and professions while section 2.3 and 2.4 explain the definitions of leadership as a concept and differing theories of leadership. Characteristics of leaders and power are discussed in section 2.5. In section 2.6 leadership style and culture is discussed. Following this discussion, sections 2.7 and 2.8 explore the concepts of the team and communication as important features of leadership.

2.2 Leadership and Professionalism

Creating climates of constructive cooperation and organisational learning mean achieving a certain level of professionalization (Glover and Hughes, 2000). In this context, Ollila (2008) also emphasizes that management is now considered as a system of methodical support. A managers' basic task is to reduce work overload and add to the wellbeing and welfare of the team; providing comprehensive support systems and ensuring competence. However, Englmaier et al (2010) stated that manager with a free hand means poor decision-making within unproductive project .

In this sense, Abbot (1988) concentrates on the movement from an individualistic to a systematic view of professions, which is “healing our body and measuring our profit” (Abbot, 1988, p.1). To emphasise this idea, Freidson (1986, p.21) defines professionals by saying that they are *“intelligentsia, intellectuals, technicians and experts”. Professions are addressed in management training and business education to create vocational post experience management to teach something useful such as accountancy, marketing and personnel management”.* Abbot has also concentrated on the knowledge involved in professions, stating that the organizational formalities of professions are meaningless unless we understand their context. The term "professional employee" here refers to any employee engaged in work which should be varied in character as opposed to routine mental, manual, mechanical or physical work, over which they should have some judgement and specialised knowledge (Freidson, 1986).

Cooper and Palmer (2000) emphasized that work needs a type of supervision exploring the practitioners’ mission where the supervisor is expected to have some responsibility for work and identify problems . This also means that team members have a mutual responsibility to succeed in their leaders’ or supervisor's mission sharing their organisation’s aims and vision. For example, Freidson (1986) stated that, in bureaucracy, subordinates are expected to obey their officials by virtue of their formal position as officials.

It can be concluded that being a professional means possessing a distinct set of characteristics, often believing in the importance of knowledge, experience and education, combined with strong trust with followers and open channels communication. Dynamic organisations believe in such professionalism and try to encourage it where possible. That means professionalism setting is a complete concept consisting of individuals, experience and process by matching the organisation goals and employees interests Arguably, current management and bureaucratically systems are no

longer suitable in achieving organisational goals, instead a leadership style based on professionalism; applying a distinct style of supervision depending on consultation, training and delegation, may be a more successful solution in creating potential leaders from team members. In other words professionalism according to above discussion means that as sense of life could be given to organisations while considering the source of power for both leaders and followers embodies in experience , knowledge and some ethical considerations as well as the situation need .

2.3 Definitions of Leadership

The topics of management and leadership are profoundly complex; as a result management and leadership overlap in the field of personnel management (Kokkinen et al, 2007). We should not ignore the fact that leadership is an important concept, with many linked definitions. In this Yukl (1981, p2) defines leadership as *"the behaviour of an individual when he is directing the activities of a group toward a shared goal, it is interpersonal influence, exercised in situation, and directed through the communication process toward the attainment of specific goal or goals".* Decades of academic study of leadership have reported more than 850 definitions (Bennis and Nanus, 1985). Many authors, such as Fiedler (1967), Riseborough and Walter (1988), Drucker (1947), Shackleton (1995) and Yudelowitz et al. (2002), have argued that it would be useful to have a clear logic behind why this concept is important in any organization in spite of the lack of leadership practiced in these organizations. Both Dexter and Prince (2007) have introduced leadership in the public sector as an accountability and performance management .In this approach, Senioret al (2011) argued that the psychological of leadership is a huge topic understanding the psychological factors driving leadership behaviours within socio-biology which can may facilitate and enhance leadership effectiveness.

By using these studies as a basis of leadership, we can say that “leadership is the power and characteristic of a person to influence groups to achieve goals after a systematic process starting with selecting the team, sharing ideas, inspiration, communication, decision making, motivations empowerment and delegation ending with power for subordinates”. Furthermore, Cole et al (2011) say that leaders or managers transmit their belief to team members through role modelling by providing guidance and reinforcing behaviour that supports a leader's favoured achievement orientation. In other words, leadership means sometimes a charisma which the followers can detect the behaviour of their leaders according to their perceptions (Levay, 2010).

Accordingly, leadership means that there are some factors and a suitable atmosphere for work environment such as an appropriate behaviour for both subordinates and leaders. These factors are embodied in open communication and transmitting information smoothly thorough the different managerial levels. So, sense of power for leaders is a need to direct their followers in order to achieve goals. In other words, the charismatic setting is not enough for leaders to have their power and strength on team members, but sharing their interest seems important for success. It seems also that the definition of leadership does not mean only managerial approach but also social and psychological as well as biological. Furthermore, leading personnel needs qualified leaders and followers to build such concrete concept; this could be valid for leadership approach which means that management concept becomes narrow besides leadership indications.

It can be detected that leadership is a comprehensive term of organisational care concentrating on the behaviour of both leaders and followers. It can also achieve the vision and mission by using the talents and abilities of individuals to be involved in decision-making and goals. Theories given next might explain and answer this questionable issue.

2.4 Theories of Leadership

There are several fields of leadership theories, these theories spread throughout the twentieth and twenty first centuries. It was based on the characteristics of leaders, individuals, organizations and elements that constituted the concept of leadership. For example, Trait theory, at the highest of its fame till 1940, focused on individuals' characteristics. After that theory, style theory spread throughout 1940s and 1960s, concerned with behavioural aspects and respecting the followers' needs. Then the contingency theory came into existence during the late sixties and continued till the early eighties, it focuses its attention on the general atmosphere that governs organizations and companies. Later on, contemporary theories emerged throughout the 1980s and beyond, these include the transformational, charismatic, visionary and transactional theories. (Sullivan and Williams: 2007).

Trait theory has been discussed by many authors such as Armandi et al. (2003), Sullivan, (1990), Yukl (1981), Mc Arevery et al. (2001) and Metclafe and Metcalfe (2007). Such authors believe that Trait theory can be used to differentiate leaders from non-leaders, with the theory focusing on characteristics such as the desire to lead honestly and with integrity, self-confidence and intelligence and job relevant knowledge as signifiers of leadership potential. This is also called the Great Man Theory. The style approach, according to Ohio State University and the University of Michigan refers to the belief that there are two general types of leader behaviours. The first concerns interpersonal relationships between leaders and subordinates, whilst the second relates to the initiating of structures or achieving of goals (Armandi et al., 2003).The third theory, contingency suggests that the degree to which the situation allows the leader to control and influence is important **(**Armandi et al , 2003). In this vein, Schneider and Littrel (2003), Grint (1997) and Sullivan (1990) explain that contingency theory opens the door for the possibility that successful leadership could differ given the situation and as such is dependent on two factors: the personality of the leader (leadership style) and the situation itself in terms of size, structure and the

purpose of the setting as well as the climate (the atmosphere of the organization, supportive or non-supportive).

Hernandez et al (2011) added that contingency theories consider the situational factors such as leader-member relations, task structure and position power for leader which is high. This means that leaders cannot manage the situation without considering the additional sources of power coming from the leader himself, the follower's experience and the consistency of task. Under these circumstances, a leader is supported by the situation because he has some influence and potential power on followers. He also emphasised that the path-goal theory is a situational theory will lead to a valued outcome. For example, the effective leader, according to path-goal theory, classifies employee's paths to work goals and the link between work goals and valued personal outcomes.

Interestingly, Bedeian (1986) notes that these theories overlook or ignore the possibility that the followers have an active role to play in the success of the leader in achieving ideal decisions and desired goals. However, both Armandi et al (2003) and Bedeian (1986) have discussed the importance of suitable forms of communication, ethical frameworks, follower's motivational levels and work place quality as crucial factors in achieving good leadership. Bryman (1986) agrees with Hernandez et al (2011) that path goal theory is to shape leadership style according to leaders' characteristics. He mentions five styles being embodied in.

1- Directive desired leader: telling subordinates what to do.

2- Negotiating leader: developing bargaining to achieve goals.

3- Consultative leader: discussing with subordinates before making a decision.

4- Participative leader: subordinates take a part in decision - making process.

5- Delegating leader: subordinates are left free to make their own decision**.**

Furthermore, Hernandez et al (2011) has pointed out that situational leadership theory depends on the followers' level of maturity and the leaders should match their behaviours with the followers' maturity level by moving through the phases of telling, selling, participating, and delegating to correspond and increase follower readiness.

So, these styles of leadership can be summarised as a mutual contract between the leader and his/her team members made because there is much more support of the leader in technicalities and consultation. The authors, Kelloway and Barling (2000) and Yukl (1989) stated that transformational theory elevates the interests of followers in an attempt to generate awareness and acceptance of the purpose and the mission. In contrast, Bass (1985) explains that transactional leadership as the clarification of goals, work standards and task assignments which focuses on task completion and engendering compliance based on incentives and rewards to appeal to the self-interest of followers.

Most of the researchers on transformational leadership have used the multifactor leadership questionnaire (MLQ) developed by Bass Avolio (1994), which emphasised that transformational leadership is composed of four dimensions. First, *idealized influence (II)*, which refers to extraordinary leaders who usually emerge in the context of crises or major change. Secondly, *individualized consideration (IC)* means the extent to which the leader cares about the individual followers' concerns and development needs. Third, *intellectual stimulation (IS)* means the degree to which the leader provides followers with interesting and challenging tasks and encourages them to solve problems in their own way. The fourth dimension is *inspirational motivation (IM)* based on the communication of expectation and followers' confidence in their leaders' vision and values as well as challenging the old ways of thinking in addition to personal attention, mentoring, listening and empowering (Gillespie and Mann ,2004 and Stone et al, 2004).

In fact, the authors Gaughan (2001), McAreavey et al (2001), Horner (1997), Monica (1990), and Jabnoun and Al-Rasasi (2005) have added that, being either positive or negative transformational can be seen as an expansion of transactional leadership. In their further discussion of leadership styles, the authors Godiwalla et al. (1997), Cooney et al. (2002), Manning and Robertson (2002) and Brazier (2005) have proposed that transformational leadership definitely creates the culture and climate of the organization and enables its workers to participate in a shared vision and strategy, where the vision is a vital factor in providing leadership with a real strategy to improve employee satisfaction through efficient management. Consequently Hancock (2005) argues that the transformational leader will provide the skills for the profession to stretch its boundaries and be innovative in the way in which its problems are viewed and solved.

To summarise transformational leadership, Utley et al (2011) discussed transformational leadership by revealing the meanings of its components. For example individualized consideration means knowing employees and showing concern for employee's needs. While intellectual stimulation is encouraging employee creativity and problem solving as well as learning., in addition to providing opportunities for creativity. Inspirational motivation means doing best and recognizing quality work performance. Finally, idealized influence is acting as a role model and demonstrating desirable behaviours

Again, Hernandez et al (2011) has also added that there are some theories are emerging with leadership such as value driven concentrating on ethics and values. These theories called ethical, spiritual and authentic leadership. For example, ethical leadership is demonstration of appropriate conduct through personal actions and interpersonal relationships by focusing on two-way communication, reinforcement, and decision-making. While Spiritual leadership theory is focusing on the leader's spirituality and the followers' spiritual needs. Authentic leadership theory interacts

with social identification by increasing the followers' levels of hope, trust, positive emotions, and optimism because it is cross-cultural leadership. Moreover, Zhu et al (2011) identify how authentic transformational leadership develops group ethical climate and follower moral identity to enable individuals to create ethical complexity and behave fairly. Also, Simola et al (2010) stated that equality and fairness assume moral decision making and sharing of societal norms and respect for laws. In this approach, Wright and Quick (2011) clarified that values-based or ethical leadership also focuses on moral qualities leading to better society embodied in being courageous, forgiving and self-controlled. Generally speaking, DeChurch et al (2010) have emphasised that a phenomenon is emergent that leadership affects four types of emergent constructs: cognitive, behavioural, affective and motivational and there are some interaction and similarities amongst leadership theories.

Many authors a such as Fitzsimons et al (2011) revealed further theories called distributed leadership by acknowledging that multiple individuals are involved in the leadership mission not only leaders by exploring the interactions between individuals and situation in which leadership is enacted .Interestingly, Edwards,G, (2011), emphasised that this kind of leadership also appears to have other labels such as dispersed leadership, institutional leadership, co-leadership, shared leadership, multidirectional leadership and rotated leadership, all these names are similar. Therefore, Thorpe et al (2011) have seen distributed leadership within a social phenomenon with constitutive of the practice of leadership, concerned with thinking and actions in situation focusing on actions rather than role or position. Thus, co-leadership, shared leadership; and self-managed teams are considered to shape this type of leadership. In this vein, Boldon,R, (2011), consider that distributed leadership is a notion that has seen a rapid growth since the year 2000 which is a group activity that works within relationships rather than individual action. Accordingly, Currie and Lockett (2011) argued that this style of leadership is appropriate to be practiced in health sector for

many reasons. First, health and social care are a pattern of how contextual influences linked to professional hierarchy and policy impact. Second, health and social care is a fast mover in policy reform. Third, it is an ethical practice associated with lack of power by those positioned as followers. Therefore this kind of leadership is a super leadership is the emphasis placed on leading others to lead themselves.

In conclusion, we can say that the transformational style of leadership involves a belief in the culture and vision of the organisation; in breaking down the bureaucracy as well as expanding the definition of environmental factors to serve communities. Transformational leadership is an attempt to change the organizational culture and stretch its boundaries to move from management to leadership and to create leaders believing in consultation, direction, negotiation, direction and participation. To emphasize this Wang et al (2011) pointed out that the favourable effects of transformational leadership behaviour on followers include strengthening followers' confidence in the leader, making followers feel good in the leader's presence by obtaining respect from employees. So, both transformational and transactional leadership involve two types of behaviour, one the firm, such as planning, vision or goals and the second on the followers by proving support technical assistance. In this approach Menges et al (2011) have added that transformational leadership is a positive and affective climate with high trust providing high levels of performance in followers due to strong interaction between leaders and followers. Furthermore, the transformational leadership framework assumes transformational leader behaviours to create a meaning for organizational change and creating followers to be leaders by working together to meet organizational requirements and enhance its performance (Wallis et al, 2011).In other words, there is a positive relationship between transformational leadership and effectiveness according to Cho and Dansereau (2010).

2.5 Leader and power

One of the most important facts of studies into leaders and leadership is the attempt to identify the characteristics that enable an individual to successfully lead others with sense and vision. Consequently, Kelloway and Barling (2000) ask the question: Who stands out as the best leader you have had? As if to answer this theoretical question, both Bennis and Nanus (1985) replied that the leadership of Winston Churchill, Mahatma Gandi, Golda Meir, Franklin D, Roosvelt, Tom Watson, Edwin Land and Alfred P. Solan stood out for them as suggesting they would be able to build great organizations.

It is important to note here, the difference between being a manager and being a successful leader. It may be possible to surmise that anyone can be a manager but very few people embody leadership qualities. When you talk about a successful leader you are often in reality talking about someone who is both heroic and charismatic. Dexter and Prince (2007) address this issue, stating that leadership can be only learned, not taught. They go on to suggest that the leader often tends to use a narrow view of teaching which fails to recognize the roles of a range of pedagogic methods that can develop certain skills and attributes. The leader is often a unique person who is normally bigger than others, not in age but in what he is doing (Damiani, 1998). In a similar vein, the authors Bass (1960), Tapeen (2001), Oni (1995) and Guo (2003) argue that a leader becomes a father and that the most important attribute for leadership is the desire to lead. All of this discussion points to the belief that the extraordinary leader will be someone who claims authority, knows the weaknesses and strengths of his subordinates, and is able to develop the deficient areas and promote the competencies of his workforce. Role conflicts arise from intangible differences in values, about the content or importance of required job tasks, between workers and various supervisors, (Michael, 2009).

In a slightly different take on the notion of the leader, Towsend and Gebhardt (1997, p.136) mention that the representative of the US House, Sam Rayburn, has said "*You cannot be a leader and ask other people to follow you, unless you know how to follow, too. He added that it is his responsibility to create new leaders"*. Furthermore, both Dierendonck (2002) and Thacker (1997) illustrate that LMX, (Leader Member Exchange Theory) describes how leaders use their positional power to develop and exchange relationships with different subordinates.

Sydow et al (2011) pointed out that leaders are influencing the social activities and relationships towards the production, reproduction or transformation of a social order due to their (powerful) situation known as knowledgeable agents enabling them to monitor organisation **.** The leader should be productive and valuable in their handling of both production and people, developing cooperation more than competition with a low level of productivity that may discourage employees, making them feel un-rewarded and poorly coordinated as well as frustrated (Liu et al., 2002). In this approach, Subasicet al (2011) pointed out that there is shared psychological sense between leaders and followers called power tools strengthening the leader's influence and authorities by rewarding certain behaviours and sanctioning other. Additionally, Fisher et al (2011) indicate that the absence of power has negative effect on social behaviours because when people are powerless they feel uncertain increasing interpersonal conflict and reducing procedural justice. In the same vein, Mourali and Nagpal (2011) stated that power is not only material resources such as money, food, and jobs, but also social resources like knowledge, respect and psychological state. For example the cumulative evidence according to Rucker et al (2011), suggested that power is an omnipresent force shaping and guiding human behaviour. Moreover, Fast et al (2011) said that over-confident power makes people to feel subjectively and powerful in decision making. The same thing, People in high power are more likely to see themselves as autonomous rather than connected to others (Cazaet al,

2011). To emphasise the importance of powerful leaders Ruset al (2011) suggest that holding powerful leaders means powerful tool to prevent potential self-serving actions on their part.

Definitions of what it means to be a leader are numerous and most focus on the leader's personality more than their physical state. For example, Durbin (1988) pays attention to the leader's ability to inspire others and their intelligence, particularly in terms of self-confidence and managing crises. Another slightly different definition sees a leader as "*a person who has ability to get the other people to do what they don't want to do and like it*" (Manske: 1990, p1). Perhaps the most important characteristic for a leader is a defined set of morals as in Krishnan's perspective (2003). Krishnan believes that the moral leader should work towards the enduring benefit and growth of their followers. As a result, Yang et al (2011) emphasised that leaders have a complexity in their characteristics and emotional intelligence such as self-awareness, self-regulation, motivation, empathy, and social skill. They added that there are six categories embodies in physiological characteristics, social background, intelligence, personality and social interpersonal.

It is evident that a leader is an important element of the teamwork concept as he is often considered the father and boss of any organisation due to his high levels of experience and training and strong work ethic. He must also listen to his subordinates when it is necessary, a process which enables him to lead others more easily, taking care of their respective ethical considerations.

2.6 Leadership and Culture

Different situations of employees are needed in organisations. In this sense, Park and Tim (2009) have given a particular attention to the idea that organizational culture should embrace belief

ideology, custom, norm, tradition, knowledge, and technology; it influences the behaviour of an organization and its members. In this sense, Bonoet al (2011) emphasised that cultural characteristics is the extent to which leaders and others agree in ratings of leadership behaviour.

Both Millward (2005) and Brooks (1997) have argued that a suitable culture is needed to provide a framework for behaviour. They added that structure and culture might be experienced as one state. Following this approach, Block and Manning (2007) indicated that the long term success of a leadership development initiative requires an organizational culture that considers developing future leaders as a long term strategic priority. Similarly, a positive organizational culture is co-created by leaders and their followers as they mutually engage in the process of sense making.

As discussed earlier, Loo (1997) has pointed out that many organizations went from the 1980s to the 1990s concentrating on culture, leadership and vision because an emphasis on structure and systems did not produce the expected organizational results. Lok and Crawford (2001) highlight the functional relationship between leadership and organizational culture by saying that the leader has an improvement role in managing shared values, which are considered the core of organizational culture. Accordingly, Schein (1985, p595) defines culture as *"a pattern of basic assumptions that a given group has invented, discovered or developed in learning to cope with its problem of external adaptation and internal integration, and have worked enough to be considered valid"*. Additionally, Mackenzie (1995) has added to this discussion that *"it is common held beliefs, attitudes and values which give meaning to the organization for its members and provide them with roles for behaviours".*

The authors Wright (1986), Bettinger (1989), Allen (1995) and Gordon (1985) discuss several of the aspects that a successful organizational culture must be aware of, these include human resource orientation, conflict resolution, attitudes and beliefs, innovation, employee commitment, clarifying of organization direction, management styles, attitudes ,mistakes, leadership, communication style and customer orientation. In this sense Senior et al (2011) pointed out that the transformational leader motivates followers and encourages them to transcend self need for the favour of organisation by supporting the concept of culture for change.

Culture should be linked strongly with the vision of the organisation because an emphasis on structure alone will produce results. Similarly, regarding the clinical sense, Park and et al. (2009) has declared that education of clinical and administrative staff is an important precursor prior to the implementation of any new information system.

2.7 Leadership and Team

Being part of a team, according to Landsberg (2000) , Bezzina et al. (2001) and Storey and Buchanan(2008) means giving individuals and teams some power might take management support out of the system, and acting as a partnership in order to achieve a mutual goal together under the direction of a leader. In this sense, leadership requires team members to understand and respect the role of each other when implementing and evaluating decisions. One of significant reasons to organize work in group's teams because group performance means different and several knowledge and perspectives of group members in which distributed knowledge is exchanged, discussed, and integrated to establish decision making with distributed information (Van et al, 2011).

Stones and Granthan, (2009) suggested that corporate social responsibility has favourably translated equity, employee satisfaction, reputation, team building, and community relations into a

solid reputation. In this vein, Ayoko and Callan (2010) emphasised that the team task has a social by improving the quality of working life of members. In the same vein, Carmeli et al (2011) emphasised that the team behavioural integration believes in the process of quality of information exchange among team members and collaborative behaviour among the team members. Furthermore, according to Yang et al (2011) that teamwork is statically significant by influencing the project performance and there is a visible relationship between teamwork and overall project success. Additionally, Monica (1990) indicates that the team can create a positive group dynamic by achieving the following things: greater sensitivity to follower needs and desires.

In this sense, Schippers et al. (2008) pointed out that transformational leadership attempts to transform followers by stimulating them to go beyond self –interest. It does this by changing their morals, values and ideals, and motivating them to perform above expectations. Furthermore, Schippers et al. (2008) added that leadership for the team means having a shared, overarching goal or vision of the future. In the same vein, individual's identification – internalization of the organization's goals and values in addition to involvement measure the individual's sense of belonging towards the employing organization, (Michael, 2009).

The importance of teamwork factors such as those outlined above can be seen in the study of the UK NHS by Bamford and Griffin (2008), who note that the NHS regarded the following factors as essential in teamwork development: purpose; organization; leadership; climate; interpersonal relations; communications and composition. The authors Millward (2005), Greenberg and Barcon (2003), Gillespie and Mann (2004) and Akhlaghi and Mahony, (1997) all argue that it is critically important for those in frontline leadership to make the team process visible and actively manageable in order to successfully develop the idea of integrated teamwork. They added when people are multi

skilled they tend to be more interested in their jobs, similarly when they feel happy and satisfied their performance in terms of quality and problem solving is likely to improve.

A recent study by Gillespie and Mann (2004), entitled Transformational Leadership and Shared Values: the Building Blocks of Trust, investigated the relationship between a set of leadership practices (transformational, transactional and consultative) and members' trust in their leader in a research and development (RD) team. In conclusion, the study found that the behaviour of team leaders who have the task of managing teams are highly educated, committed and often individualistic scientists and technologists who work together .Schippers, (2009) declares that transformational leadership enhances team collectiveness; it develops team reflexivity by focusing on the role of leader behaviour, enhances a common goal and mutual vision in the team that will enhance its abilities, the thing that shall have a strong impact upon the team objectives, strategies and collectiveness.

Moreover, setting and sharing common values with team members using a set of inter-related leadership techniques based on consultative decision and modelling a collective and value -driven vision. Both Townsend and Gebhardt (1997) have established guidelines for the followers such as seeking self-improvement and getting more practice.

In their study on a similar subject, Konu and Viitanen (2008) point out that the philosophy of shared leadership involves decentralization and creating an empowering environment. Accordingly, transformational leaders can influence a team environment by influencing the followers' values in an attempt to achieve the organisation goals (Hur et al 2011),

In many ways team members can be seen as the leaders of the future as they have the same interests as their leaders concerning achieving the organisation's goals and strategies. They are often technically proficient which enables them to emphasise that knowledge and experience are considered powerful characteristics, and qualifies them to be decision-makers .The successful team member should believe in coordinating, evaluating, directly educating and sharing knowledge with others. They should be able to take the initiative and not need to be spoon-fed by leaders or directors. In this manner, transformational leadership is dependant not only on the characteristics of leaders but also team members, who will be qualified to be leaders one day.

2.8 Leadership and Communication

The word communication comes from the Latin, *communico* meaning to share (Damiani: 1998. p117). While Greenberg and Barcon (2003, p.318) define it as a "*process by which a person, a group organization (the sender) transmit some type of information (the message) to another person, group or organization (the receiver)*". Though traditional communication is a formal and rigid process (Seiftre, 2001) it can be a useful means through which to increase teamwork productivity. Communication is also an important component of providing a work atmosphere in which employees can feel appropriately motivated and creative, as Thacker (1997) argues. In his study (Bell, 2007) explores how the ability to communicate successfully requires specific training among managers and team members. The supportive communication style is more likely to foster creativity than control while the controlling style may decrease individual motivation and does not allow for creativity. Therefore, the team with a directive/assertive leader reported that the leader's communication style had a negative impact on the creative processes of the group, while the team with a consultative team oriented leader reported that the team leader's communication style had a positive impact on the creative process. In the same vein, both Tourish and Hargie (1996) clearly illustrate that in a major survey of over 300 organizations during the late 1980s, most employees

still felt that senior managers did not understand the pressures of their job and did not invest enough effort in improving communication, particularly on a face-to-face basis.

The authors Daft (1999), Miles and Mangold (2002), Wilson et al. (1996), Tourish and Hargie (1996) state that an open communication climate involves sharing types of information across functional and hierarchal levels in order for individuals to work more easily. They emphasize that the use of open questions enables subordinates to generate solutions for problems .The same thing is important when using open communication, which can enable respondents to feel free to express their own opinions and thoughts. In this sense, Yang et al (2011) has added that team communication is the uniform of team members and make the team more effective making critical team performance.

Kelloway and Barling (2000), Sullivan, (1990) and Smith (2004) also focus on the message ('I know you can do it') as a powerful way of raising the employee's sense of efficiency and inspiring the individual to try harder. They added that communication could be upward from subordinates to supervisors or downward from supervisors to subordinates and lateral between colleagues or departments on the same level in order to build better relationships and develop more awareness of problems.

It can be suggested that communication and leadership are twinned, that is to say that successful leadership cannot be achieved as a concept with closed and formal channels of communication. Instead it involves the gaining and sharing of knowledge and experience among employees. Open and descending communication enables employees to reflect on the organisation's goals more easily, because they are the main power as an operational core and every change has to be started from them, not a strategic apex. The purpose of communication has been studied by Cranwell and Maakie (2002) and Gent et al. (1998) who explain the purposes of communication such as

informing, gaining support and trust, sharing others to improve continually and generate creativity. Furthermore, communication can create openness, resolve conflict, optimise resources and improve relations in order to resolve problems and gain approval or authorization to perform tasks. Generally speaking, Leurer et al (2007) emphasize that dissatisfaction regarding a perceived lack of communication usually means lower levels of effectiveness in terms of HR and organisational activities.

To summarise, organisations will find it difficult to develop successfully without open forms of communication (such as bilateral and upward communication) and a strong relationship between all levels and departments. Open communication can enhance the quality of care, culture and structure of the teamwork concept. In many ways professionals are the people most in need of open communication, which serve to break down negative ideas of bureaucracy, creating positive concepts such as friendship, support, consultation and problem solving through the use of mutual decision making. Therefore, organisations have to set special courses on communication skills for their members to enable them to become effective mediators with top management in reflecting public and customers' needs.

It can be concluded from he mentioned literature according to Table 2.1 (page 31-33) coming next that professionalism means ensuring competency and intellectual technicians within open communication. This could be emphasised by theories of leadership. For example, trait theory means characteristics of leaders, while the style approach believes in leaders’ behaviours and interpersonal relationships between leaders and subordinates. Then contingency is dependent on two factors: the personality of the leader and atmosphere of the organization. Path-goal theory, classifies employee's paths to work goals and the link between work goals and valued personal outcomes. The most popular theory which can absorb the demands of professional setting as a comprehensive approach is transformational theory which elevates the interests of followers in an attempt to generate awareness and acceptance of purpose leading to achieve goals and development.

This type of theory is focusing on open channels and challenging tasks by encouraging problem solving with high expectations of confidence and values .There are some different names of theories give unique meanings of interpersonal relationships between leaders and followers such as ethical leadership, spiritual, dispersed leadership and institutional leadership as well as co-leadership. Additionally, shared leadership and multidirectional leadership as well as rotated leadership, all these names are similar.

The authors emphasised that the extraordinary leader who holds authority and knows the weaknesses and strengths of his subordinates, but they have no particular demands regarding the most required leaders valid for leadership They only added six categories embodies in physiological characteristics, social background, intelligence, personality and social interpersonal as a general approach. Basically, the ideology culture is focusing on beliefs, customs, norms, traditions and knowledge as well as technology. It seems that it is a mutually engaged in the process of development in addition to achieve external adaptation and internal integration .In other words it means leadership and customer orientation.

Team is also playing as partnership in order to achieve a mutual goal which requires team members holding different and several knowledge and perspectives .But this type of knowledge should be exchanged, discussed, and integrated in order to get highly rational decision .Also positive and dynamic group is required to achieve greater sensitivity on organisation needs through multi skilled members . Transformational leadership enhances team collectiveness which can develops team reflexivity by focusing on the role of leader behaviour, enhances a common goal and mutual vision. The same importance is for communication which increase teamwork productivity and facilitate a work atmosphere in which employees can feel appropriately motivated and creative. This issue could not be specific without training and sharing types of information across functional and hierarchal levels. The authors point to the type of communication which also gains support and trust

Table 2.1: The Indications of Leadership Literature and its Concepts.

Factors	Sub factors	Categories and Indications
Professionalism		Comprehensive support and competence
		Intellectual and experimental setting
		Knowledge, experience and education
		Open channels communication
Theories of Leadership	Trait theory	Individuals' characteristics
	The style approach theory	Two general types of leader behaviours: interpersonal relationships between leaders and subordinates and achieving of goals
	Contingency theory	Personality of leaders and situation or climate
	Path-goal theory	Link between work goals and valued personal outcomes to produce directive leader, negotiating leader, consultative leader , participative leader and delegating leader
	Transformational theory	Idealized influence context of crises or major change
		Individualized consideration: individual followers' concerns
		Intellectual stimulation means providing followers with interesting and challenging tasks
		Inspirational motivation means expectation and followers' confidence
		Team reflexivity and strategic

		collectiveness.
Theories of Leadership	Ethical leadership theory	Appropriate conduct of personal actions and interpersonal relationships by focusing on two-way communication, reinforcement, and decision-making
	Spiritual leadership theory	Spiritual needs
	Dispersed leadership, Institutional leadership, Co-leadership, Shared leadership, Multidirectional leadership and Rotated leadership theories	Cooperating and sharing
Leader and Power		Knowing the weaknesses and strengths as well as knowing how to follow. Developing cooperation more than competition. Focusing on personality more than physical. Having six categories embodies in physiological characteristics, social background, intelligence, personality and social interpersonal.
Culture		Ideology of custom, norm, tradition, knowledge, and technology
		External adaptation and internal integration
		Common beliefs, attitudes, values and employee commitment.
		Management and leadership styles; attitudes mistakes, communication style and customer orientation.

Team	Partnership and a mutual goal
	Understanding and respecting the role of each other and evaluating decisions with common goal and mutual vision
	Exchanging decision with distributed information. Positive dynamic and multi-skills group as well as sensitive to members' interests
Communication	It is an important component of providing a work atmosphere means sharing types of information across functional and hierarchal levels in order for individuals to work more easily. In order to gain support and trust

Chapter Three:

Clinical Leadership

3.1 Introduction

The technology demand and international norms of management mean that leadership in different organisations is becoming specific and more specialised. In clinical terms, doctors, nurses and AHPS have vast experience in clinical settings and patient care. It is impossible to discuss effective CL without taking into account factors such as government legislation, individual power and authority combined with clinicians' professional experiences and knowledge. In many ways doctors already hold these responsibilities, due to classical norms and their professional demands, in spite of the presence of others from clinical bodies that are able to carry out such procedures, such as: nurses, pharmacists, radiographers, laboratory technicians and clinical researchers. It is crucial to create a fair balance of power distribution in the health care system so that all employees can be decision makers,

Buchanan et al (2007) stated that leadership appears to be a novel concept; better leadership means better patient care by putting that process at a premium. However the potential causal linkages between leadership practice and patient outcomes depend upon what the term leadership transmission means in operation. The aim of this chapter is to discuss CL within health service management (hospitals in particular), and to identify the

experience of clinical managers or clinicians such as doctors, nurses and AHPS, how clinical quality is achieved and such individual's engagement with clinical ethics.

This chapter consists of eleven sections. Section 3.1 contains the introduction; section 3.2 gives the background to CL and associated professions. Section 3.3 discusses the background of CL, while the issue of clinicians and power is discussed in section 3.4. Sections 3.5 and 3.6 explain the importance of clinicians, doctors and nurses as leaders. Health quality is explored in section 3.7. Section 3.8 contains a discussion of the impact of clinical ethics on CL. The combination between transformational and CL, and the interaction of CL factors are discussed in 3.9 and 3.10. Finally, the summary is presented in section 3.11.

3.2 Clinical Leadership and Professions

The World Health Organisation (WHO) has a comprehensive definition of health which covers multiple aspects: "health is not merely the absence of disease, but the complete physical function, social function, role function, mental health and general health perceptions". This definition was evaluated and a move to the development of patient centred measures (O'Connor, 2004, p.2). It is no longer enough to discuss health as an abstract concept away from health care individuals and the social, mental, cultural and administrative issues surrounding them. That means according to (WHO) that the health concept means clinical and managerial approaches as well as individual considerations for both patients and staff at the same time.

Professionals in all sectors (Glover and Hughes, 2000) are increasingly expected to follow the norms of commercial and managerial professionalization. For example, in the National Health Service (NHS), doctors are increasingly expected to be competent managers. In addition to this, it would be helpful for all employees, professionals and managers to have social, educational, occupational, professional and sectoral backgrounds in order to enhance their skills and training. Clark and Armit(2008) indicate that historically, the medical profession has not particularly encouraged doctors to attain competency in management and leadership, but some attempts to get individual doctors involved with voluntary management training and development have been made. They added that the royal college of physicians now defines the medical profession as a set of values, behaviours and relationships. Regarding nursing, Leigh et al (2012) argued that health care policy clearly identifies the need for a healthcare workforce demonstrating creative approaches to work through complex leadership and management in an attempt to develop the sense of flexibility and confidence in health care industry .This needs nurses to join postgraduate programmes to investigate the gap between theory and practice

In terms of clinical supervision, Cultiffe et al, (2001) have argued that clinicians are focussing on organisational and management issues, clinical work, professional development, educational support and interpersonal problems. As a result of this complex situation, the management of health care sectors such as hospitals has become a difficult job, as candidates need both clinical awareness and some experience of environmental and cultural dimensions. Cultiffe et al, (2000) showed that, in multi- professional teams,

self-respect, mutual appreciation of colleagues, and the level of support provided by fellow employees makes management a very challenging job. Furthermore, Kunzle et al (2010) explain ensuring patient safety is critical need to be introduced by care teams, and leadership skills are increasingly recognized the concept of patient's safety. Thus, effective leaders play an essential role in promoting team performance to be adaptable to situational demands and shared between team members

That is why there are strict criteria for hospitals to obtain accreditation not only in terms of health or disease protection but also with regards to developing management and creating successful leadership. This does not just refer to those professionals who do the everyday work of teaching and doctoring, but also members of the profession with supervisory and managerial positions such as physicians, dentists, chiropractors, optometrists, pharmacists, podiatrists, veterinaries, registered nurses, dieticians, health technologists, dental hygienists, health record technologists, radiological technicians and therapy assistants. Health care institutions have become interested in training their professionals in management as well as different subjects besides the health care service in order to meet public demands and customer needs. Therefore, their followers are requested to enhance their professional abilities, improving their skills at solving problems and making rational decisions.

There is a need to construct a language of understanding in the health care service. For example, Jones and Hughes (1995) and Seedhouse (1988) emphasised that the expert is expected to communicate effectively with clients, colleagues and families, to listen as

well as to explain, educate and negotiate, and to use language that is appropriate to the people and situation. Involved professionals are expected to communicate effectively across language, cultural and situational barriers. Basically, there is lack of communication among clinical departments and poor practice of the two- way communication style. Andersson et al (2002), Kruijver et al (2000) and Smith and Preston (1996) recommended that communication be informal in order to minimize the stressfulness of the situation and minimise conflict between doctors and nurses.

Abbot (1988) pointed out that professionals should be trusted and guaranteed by various institutional forms, associations, and licensure and ethics codes. Since the 1960s an unparalleled amount of growth has occurred in the number of professional codes of practice, conducts and ethics. This has been due to a range of factors, including growth in the number of professions, a growing interest in the field of business, professional and administrative ethics and increasing public and political criticism of some professions (Glover and Hughes, 2000). For example, it could be argued that physicians are becoming more marginalized, with less power and control over their own work, at the same time external factors are exerting a growing influence on the working conditions of physicians and other professions are heading for management positions (Vultee et al, 2007).

Glover and Hughes, (2000) note that doctors, who have traditionally been very highly qualified super health technicians rather than true medical technocrats capable of managing all aspects of the health care profession, have begun to fight back against the

threats of commercialism and encroaching management by taking a much more active interest in the non-medical aspects of health care. Glover and Hughes added that the power of doctors influenced their professional associations, health authorities and general practice.

In the same hospital environment, nurses are struggling to gain a role in managing the health sector. Johnson (1997) has emphasized that nurses are insufficiently assertive and experience substantial stress in achieving their goals of care in the context of emotional labour. However, Jones and Higgs (1995) argued that clinical reasoning is important for nursing practice because the nursing health profession is becoming increasingly more complex and difficult. In this sense, Senn, B, (2010), stated that the oncology nurses provide clinical management and leadership at all levels of clinical practice by discussing the context of social, cultural context.

Based on these arguments, quality of clinical services is necessary to enable individual practitioners to develop knowledge and competence in complex clinical situations (Cutcliffe et al, 2001). For this reason, Freidson (1986) states that statutory certifications is a need for professions, creating an exclusive right to use a particular title not establishing an exclusive right to practice in order to work in a particular occupation. To summarise the purpose of organisational quality, Manjunath et al (2007) addressed the different criteria of quality in the health service industry, including leadership, strategic planning, customer and market focus, measurement, analysis and knowledge management, human resource focus, process management and business results.

Accordingly, clinical and academic institutions, as well as professional associations, began to include health service management in university modules for clinical professionals, such as doctors, nurses and AHPS. These modules teach the principles and theories of clinical supervision, communication styles, guidelines, and specifications of health care quality, and ethical considerations. Furthermore, clinical procedures, staff, patients as well as managing the health industry are also needed. Doctors with much more power and knowledge have had some conflicts with management. However, nurses practice their management role but do not have enough power to make decisions affecting health care futures, while other health professionals from AHPS such as pharmacies, radiographers, medical lab technologists, clinical technicians have little power and little impact on health care strategy and health management.

Bamford and Griffin (2008) have done some work into operational objectives in promoting team work as a means of raising productivity and encouraging innovation through engaging the talents and experience of all. To put this issue in a functional manner, Buchanan et al (2007) pointed out that it is important to conceptualize the impact of leadership in health care, as one set of processes influencing organizational change and service improvement. This complexity gives rise to a great deal of diversity which is of growing interest to health organizations. Social interaction between doctors, nurses and managers is increasingly being encouraged to ensure shared understanding of issues. In this sense, Bergman (2009) argues that a successful leader must have a high degree of emotional maturity and stability. However, Sullivan and Williams (2007) emphasized

that transformational leadership is becoming more and more sort of moral as it raises the level of human conduct and ethical aspiration of both leader and follower. The transformational leader has to be charismatic, offering guidance and encouragement.

To summarize, it would be difficult for clinicians to manage health organizations alone, instead a level of coordination with administrative managers from non -clinical bodies is required. For example, training on decision making and strategies such as those related to financial and HR settings are useful. In addition to this, clinicians themselves, especially doctors, cannot ignore the significant role of managers or businessmen in constructing the general philosophy of hospital environments. In this manner, the health team is not the only members who serve the patient, as others from the non- clinical staff can aide with processes such as finance, maintenance and records. Furthermore, even though power in hospitals tends to be concentrated around doctors, they should appreciate the experience and knowledge of other clinical and non clinical experts in order to make for better CL.

3.3 Background to Clinical Leadership.

Increasingly hospitals can only be effective if they combine good health service management with successful health care, consequently there is a growing need for health professionals or clinicians such as doctors, nurses and AHPS to serve their sector managerially and clinically, as those professionals have more awareness of their hospitals in terms of the hospital's needs, goals, strategy and patient requirements. They are the

individuals who are best able to diagnose health problems and concerns more so than ordinary managers or businessmen who only hold management and administrative certificates. In contrast, clinicians can perform clinical services and be involved in management, sharing in its strategy and vision.

Similarly, Goodwin (1998) suggested that changes to the UK National Health Service (NHS) from the 1980s onwards should be practiced regarding developing good inter-personal and inter-organization as well as leadership. In order to examine health service culture, Merali (2003) indicates that clinicians should share their knowledge and experiences in order to contribute positively towards the successful development of the hospital.

The effectiveness of CL styles among clinicians have been discussed by many authors, such as Jackson (1998), Gaughan (2001), Hewison and Griffiths (2004), Preston and Clarke (2000), Salauroo and Burnes (1998), Thorne (1997), Walker and Morgan (1996), Gent et al. (1998), and Jackson (1998). Some of these studies concentrate on the organizational effectiveness of hospitals in comparison with clinical effectiveness in order to determine whether levels of overall effectiveness were a result of the management process, the people involved, or a combination of both.

Jackson (1998) has noted that in order to be effective organizations needs visible leadership. In addition to this, Gaughan (2001) determined that the development of

leadership skills in the health care industry is derived from the interaction between the leader and his followers within transformational leadership theories, as developed by Bass and Avolio, and as discussed earlier in chapter two (Leadership as a Concept).

In this sense, Both Hewison and Griffiths (2004) argued that leadership is only one element in the changes that need to be applied in health care. In the same vein, Preston and Clarke (2000) investigated more about health care managers and their experiences. The two found that managers have a high level of awareness of the largely negative perceptions surrounding them and accepted this as an integral part of their role. Thorne (1997) reviewed the role of clinical directors, concluding that they perceived their roles in terms of leadership rather than management.

It can be concluded that at present the clinical sector has a number of and clinical managers practicing in managerial responsibilities who really need training in how to achieve leadership properly. Gent et al. (1998) have explained how hospital administrators often create cross-functional teams, including clinical and non-clinical staff drawn from different functional areas, to face the increasing competition and raise hospital revenues.

Quality of health can be linked to the quality of management and human resources working in hospitals. Health teamwork was reviewed by Wilson (1987) and Smith and Preston (1996), whose work showed the necessity for effective multidisciplinary teamwork within increasingly complex health and social care environments. They

emphasized that good teamwork makes a critical contribution towards the effectiveness of health care delivery. Furthermore, they suggested that the agenda of quality improvement through clinical governance can be delivered illustrating how team coaches have used their clinical experiences to facilitate effective change in health care organizations. From the results of these studies we can see that CL needs serious cooperation between all responsible governmental and private departments and institutions. These organizations need to introduce useful managerial training and support for clinical staff to enable them to deliver a high standard of health care.

It can be concluded from the previous discussion that the preparation of clinicians to be leaders should be a cooperative mission between health service organisations and other business, academic and training agencies, involving not only top managers but also frontline, group leaders, supervisors and ordinary employees. In order for these processes to work health care professionals must build strong relationships with those in the external environment in order to gain more experience regarding management and leadership.

3.4 Clinicians and Power

This section will examine which type of people should operate health management and what type of qualifications and power such managers should have, in order to enhance health care delivery.

Preston and Clarke (2000) have noted that many NHS managers have moved into management from clinical backgrounds. Thus, successful hospital chief executive

officers (CEOs), as Papadimos and Machiavells (2000: p.17) argue, have fostered links between management and clinicians: *" clinical leaders have enhanced relationship with physicians, developed operational focuses, understood finance and debt management, known their board, bosses leadership presence, being team leaders and builders. They do not surround themselves with Yes Men but should conduct themselves with their advisors"*. Health care managers need to balance their responsibility to the public with their accountability to political policy makers effectively dealing with any conflicts which might emerge in health care management (Palfrey et al, 2006).

It is a big responsibility for clinical managers or hospital chief executives to have these managerial requirements; they may believe that a clinical background is not enough to lead their staff. Forbes et al (2004) have noted that the clinical managerial combination still poses some difficulties. They have argued that there has been very little attempt to examine this development from the perspective of the individual clinicians entering management and their attitudes towards management. In the same vein, Markens and Spencer (1998) have supported this analysis and tried to solve this dilemma, arguing that, in health services leadership, executive leaders have to facilitate their teams, support their decisions, coordinate their efforts and become coordinators instead of only being supervisors. Heiberg and Helljesen (2002), (Hancock 2005): Buchanan et al (1997) appear to share Markens's opinion that the top management in hospitals such as the head nurse, chief medical staff, and directors of the organization, should move to become leaders.

Now, the question is: Can clinicians and doctors perform CL with their current qualifications in clinical settings? And how will managerial effectiveness in health care be achieved using their current abilities? To answer this question Schultz (2004) diagnosed the qualifications which clinicians need to be effective leaders: to lead health care organization as MDs (medical doctors) or MBAs (business administration). The study revealed that no significant differences exist between medically educated and managerially educated people so far as making strategic decisions or improve the quality of health care organisation are concerned. The characteristics of the individual, rather than their educational degree, appear to have a stronger influence on the CEOs' ability to make successful strategic decisions. Therefore, an educational background should not necessarily be a requirement. Both clinical and chief executives can combine to focus on the improvement of patient care as a first priority (Roland et al, 2001).

Any discussion about the management within the health service would not be complete without some mention of doctors' power. According to Goodwin (1998) stated that doctors have powerful pressure group as national associations and also powerful individually in hospitals as members of health authorities. That means doctors have the strongest power in hospitals while others, from nurses to AHPS, have very little power.

A study by Forbes et al (2004) suggested that clinicians are trained within narrow professional limits. Also, they do not have enough managerial experience to fulfil this role in the health service. For example, there are no wider inter-professional and

organisational factors within their employing organisations. Therefore, there is a tension between professional values encapsulated within clinical autonomy and managerial demands.

Power can be defined as "*the ability to influence behaviour, to overcome resistance, and to get people to do things that they would not otherwise do*" (Krishnan: 2003. p.346). Authority has been defined in the following manner: "*authority means the probability that a specific command will be obeyed*" (Etzioni: 1962. p.4). Fiedler and Chemers (1984. p.100) have a different perspective on the concept of power and authority, suggesting that we should: "*remember that power and authority are not simply given to the leader. No leader has absolute authority, and all authority and power derives from the willingness of subordinates to accept the leaders' right to lead*".

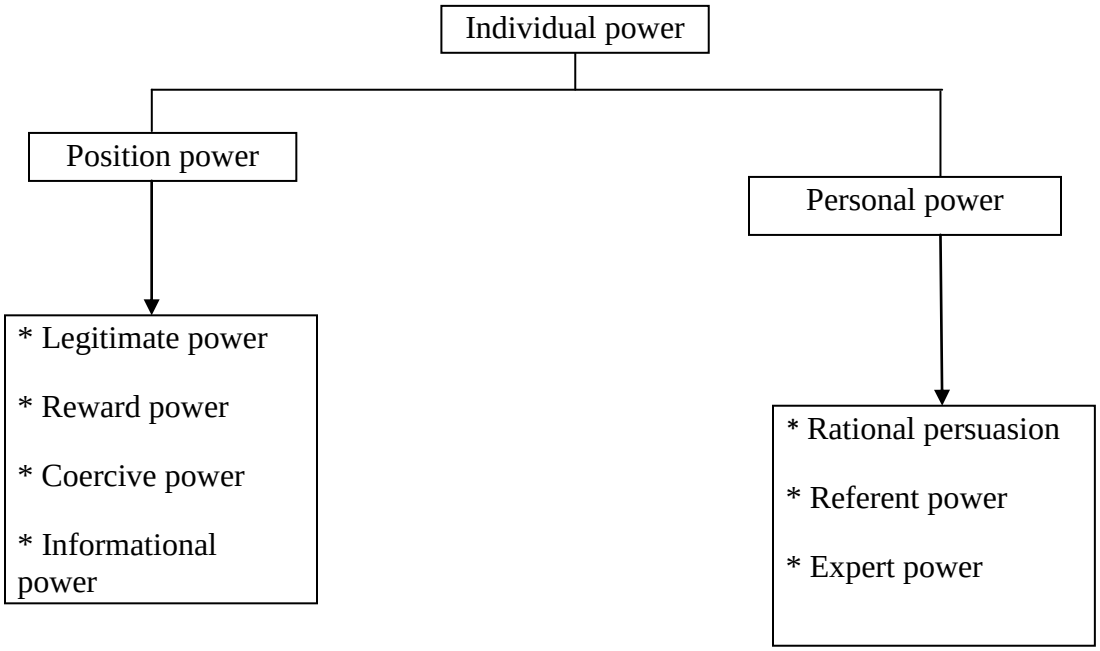
In hospitals, Scholten and Grinten (1998) have argued, there is no room for either unlimited professional autonomy or unlimited professional management because "*each individual in the organization has their own interests, beliefs, values, preferences, perspective and perception and their effectiveness will depend on how far their power oriented skills are acquired from personality and experience*" (Willcocks, 1998, p.130).

Brazier (2005) has argued that it is important for leaders to focus on increasing their expertise. Supervisors should make subordinates feel that they are valued, accepted and important to the supervisor (referent power), sharing their technical expertise, experience and knowledge with subordinates (expert power). He added that doctors are the clinicians

who have most experience and knowledge; therefore, their experiential authority will give them strong power to lead.

To summarise, Greenberg (2003) has introduced individual power, as shown in figure (3.1), subdivided into two sections: position power such as legitimate power, reward power, coercive power and informational power; whereas, personal power includes rational persuasion, referent power and expert power.

Figure 3.1 Types of Power



Source: Greenberg et al (2003).

This figure (3.1) indicates that power of clinicians, especially doctors, is more likely to take the form/s of informational power, rational persuasion and expert power. There is usually a balance between the power afforded by an individual's position and the power that someone can wield because of that individual's personality. Similarly, other clinical managers who perform both clinical and managerial duties have the same powers. Thus, power is not only for executives but also for others involved in leadership using their experience, knowledge and personal power.

In conclusion, power is an integral part of health care work. In hospitals and health care services we need a combination of all types of power; an ideal leader will possess knowledge and a strong personality Doctors usually tend to have the greatest amount of power in health service delivery. However, it must be noted that even doctors' qualifications are not, by themselves, enough for them to be successful at management and leadership. It is necessary for clinicians, such as doctors, nurses and other AHPS, to be charismatic alongside their experience and knowledge in order to enable them to achieve their goals with the cooperation of their followers from other clinical and managerial staff.

3.5 Doctors as Leaders

In many ways doctors are committed to being leaders due to their levels of experience and knowledge. However, does this qualify them to be leaders and physicians at the same

time? CL is reviewed by Smith et al, (2004) who suggests that CL is of paramount importance to doctors, perhaps more so than hospital facilities such as buildings, equipment, x -ray department, wards, reception area, hospitalised services and hotel luxuries. To emphasise the effectiveness of doctors' being leaders, Brightman (2007) argued that once a physician decides to practice management, such as assessment and planning processes, this enables them to generate options and take action more efficiently.

Kumpusalo et al. (2003) argued that physicians are often involved in health care management whether they like it or not. Surprisingly little attention has been paid in medical schools to the way physicians learn about administration, management and leadership. Forbes et al (2004) have pointed out that UK government reform and the reorganisation of the NHS in recent years has had many objectives, such as the involvement of hospital doctors in the management process in order to increase management and strategic practises. Aluise et al, (1989) have argued that there has been a growing demand for the inclusion of management skills in the medical curriculum. These elements are related to the role of the physician to be a medical expert, a communicator, collaborative in approach, a health advocate, a learner, a manager, a scholar and a physician. These studies indicate that doctors have a great level of power in their hospitals, which is why they are required to perform CL more than others from AHPS. They are likely to face many conflicts with administrative managers due to the prominence of centralisation in CL. In conclusion, doctors consider that all employees in hospitals are working towards improving patient care.

Other authors, such as Letour (2004), Chrispin (1996), and Anderson (1994), have emphasized that physicians are mostly resistant to organizational change because they do not consider themselves to be ordinary employees. Physicians consider that the implementation of decisions is a vital part of clinical management and that they are in the ideal position to determine strategy. This provides a good point at which to discuss the relationship between physicians and management, exploring the rights and requirements that need to be satisfied in management and leadership.

In contrast to the above discussion, Willcocks (1998) indicates that there are tensions between different post structures such as hospital boards and clinical directorates; problems of centralization or conflict between central control and budgetary services. Furthermore, poor relationships among clinical director and clinical peers and nursing staff may enhance these concerns. It seems from Willcocks' findings that it can be difficult for doctors to become managers due to past and current conflicts with business managers (non-clinicians), which can form an obstacle to achieving results.

In order to summarize the function of medical management Mark (1994) has proposed that it should maintain efficiency through the removal of stress about the mechanics of the management process. Yet, there are many questions, which need to be answered in terms of medical management. How will management be perceived in those organizations where being the clinical director is necessary but not seen as really desirable? What messages are received by the professionals and managers when those

doctors are involved in management? What support is provided for those doctors who find themselves alienated both professionally and socially from their clinical colleagues because of full participation in the management role? What are the implications of managing on a part time basis? To resolve these problems, Mulec (2005) has argued that the combination of managerial and physician roles has shown itself to strengthen the position and agenda of the physician, promoting their professional interests. The non-medical manager is unable to deal with the work of a clinician. Instead, he should handle operational issues, leaving time for the medical managers to practice clinical work and focus only on strategic managerial issues related to medical practice.

It would also appear that doctors believe that they should be involved in clinical management due to their high levels of experience and knowledge. Their lack of managerial awareness can cause conflict with managers, because those with a managerial background often see themselves as being more skilled in management. Furthermore, doctors often find it difficult to combine their clinical duties with their managerial responsibilities; it is a real challenge for them to be given two missions at the same time. However, it would be impossible for managers or administrators to perform clinical functions.

The next section will examine the extent to which nurses have fewer opportunities than doctors to be involved in managerial responsibilities and the leadership process.

3.6 Nurses as Leaders

It is well known that nurses constitute the majority of the clinical body. It is usual for the majority body of an organization to have the legislative right to take the responsibility of management. To highlight this issue, Millward (2005) noted that nurses and midwives deliver 80% of all health care and should therefore play a critical role in implementing the new NHS. The British Royal College of Nursing (RCN) is perceived, in the national nursing leadership programme, as a vehicle for leading the process of change, involving the introduction of bigger nursing roles.

There is strong evidence to suggest that nurses also have an important role to play in health care besides doctors. Obviously, nurses have more awareness of the patient's condition, as nobody is closer to patient care delivery than nurses. They strongly reflect patients' needs to the top-level management, this would facilitate health care delivery and help to minimise health risk (Preston and Clarke, 2000).Both Hancock (2005) and Burke (2004) suggest that CL is recognised as a potential cornerstone for the development of nursing and health care, with CL.

Conant and Kleiner (1998) have argued that increasing job satisfaction for nurses is one of the key challenges for those in the health care industry. One of the means by which satisfaction could be improved is by those with authority giving nurses a real role in terms of leadership. To enhance the nursing role of management, the RCN took up the call for nurses to become more involved in the management and leadership programme

and become transformational leaders (Bolton, 2003). For example, in 1994 RCN CL in Britain started to help clinical nurses (Hewison and Griffiths, 2004) in organized leadership positions to improve the quality of care through managing staff, managing the team, patient- centred care, net working and becoming more politically aware. In this approach, Both Stewart (1989) and McPhail (2002) have argued there is a correlation between the level of education, number of years practice, place of employment and personality type. It is often the case that nurses have an appropriate personality with high levels of professionalism.

Moreover, Utley et al (2011) emphasised that CL leadership is necessary for nurses to get job satisfaction and positive work environment, and that's why nurses are learning to be leaders to apply the concept of transformational leadership by improving the quality of health care. They added that nurses were taught process of inspiring followers to collaborate and work toward common goals to achieve success. The same for Cummingset al (2010) argued that leadership within the nursing workforce doesn’t mean only a task completion but developing transformational and relational leadership are needed to enhance nurse satisfaction, recruitment, retention, and health work environments. In this vein, Macleod (2010) emphasised that nurses can make a hospital’s culture by promoting positive attitudes and ethical considerations. Macleod has added that having a nurse leader as an active participant in hospital governance sends an important message to the hospital board in its highest level demonstrating a respect and value for their essential role in leadership. Furthermore, Lekan et al (2011) according to their paper entitled: Clinical Leadership Development in Accelerated Baccalaureate Nursing Students: An Education Innovation, they argued that there are some gaps

between the modules in nursing schools and the actual requirements of clinical practice. Therefore, the responsibility is getting serious for nursing students to deliver safe and effective patient care which needs severe concerns towards clinical leadership skills to the seniors by establishing effective communication, delegation of tasks and supervision skills. Accordingly, Walker et al (2011) defines clinical leadership in nursing setting by saying that it is *"a multifaceted process of identifying a goal or a target, motivating other people to act, and providing support and motivation to achieve mutually negotiated goals"*.

While we have established that nurse's form the majority of the clinical body and are very qualified in clinical settings and managing their followers. Also, it is important to note that they are also frequently qualified in the academic field. Many nurses hold postgraduate degrees, which enable them to be researchers and to gain their associations' trust in performing CL. Such nurses can easily maintain health care quality and improve health delivery due to their mature awareness of all clinical, social and psychological issues relating to patient care. Nurses have been given wide range of authority, as they are qualified and sufficiently trained in management and leadership during their association's training programmes. There is logic behind giving them more power, as they represent the majority of health care professionals and are the closest to patients' concerns.

At this point it is necessary to link clinicians' management and the level of health care quality in terms of clinical and managerial issues because, finally, management means a comprehensive field of quality in all aspects, not only those relating to health.

3.7 Clinical Leadership and Quality

There is a connection between the behaviour of leaders and quality concept . It seems that the quality as an overall concept is not only the quality of products or industry, but extends beyond the overall quality of management, quality of processes, training and quality of communication. Of course, all of that are elements to the concept of high leadership. In this sense, Lee (2007) agrees with the transformational style in leadership, as he discusses the leadership in quality of communication, training, preparing managers and individuals. Furthermore, Camilleri and Ocalloghan (1998) said that quality of management is embodied within the quality of procedures, techniques and personnel. In the same approach, Rasasi and Harris (2007) said that quality of management means the actual leadership adopted the principles of process and rehabilitation which reflects on the achievement of the organization objectives. Health care delivery and health service management should not be reviewed without criteria and parameters to measure the performance of the clinical work in both the clinical setting and the managerial aspect.

There are many definitions of quality regarding the managerial process, qualification of staff, techniques, procedures, production, customer care and personnel. Jabnoun and Al-Rasasi (2005) and Harris et al (2007) have suggested that to implement quality in health

care organisations, some HRM practices are necessary in order to achieve their star rating. Malek et al have also pointed out that the British Standard Institute (BSI) defines quality as "*meeting customer requirements"*, However, Ovretveit (1992. p2) views the term in a more abstract manner, stating that "*it is an umbrella for contentious staff and organization development using new methods*".

According to the European Foundation for Quality Management (EFQM) founded in 1988, Naylor (1999) suggests that customer satisfaction through leadership, driving policy and strategy leads ultimately to excellence in business results. Brown et al (2007) and Block and Manning (2007) emphasized that the goal of health care and education agencies is to promote the pattern of leadership in both sectors. In the health services, this means for example, adapting care services to ensure they are more patient focused.

As a result of this ethos, teaching, learning and assessment strategies are increasingly designed to help students become effective leaders and agents for change. Leadership development is not achieved by a curriculum, but instead by a comprehensive network of processes designed to support the continuing development of leaders outside the classroom.

However, the authors Bradley et al (2003), Hansson (2000), Davies and Walley (2002), White (1993) and Wilson (1987) have highlighted that total quality management (TQM) requires a partnership of doctors, managers and other AHPS to be effective. It is important that CL and quality are linked, as it will be impossible for clinicians to perform leadership without raising the quality of health care. The aforementioned authors believe

that matching international standards and criteria in both clinical and managerial arenas are the first steps to improving health care quality.

As a result, health service quality refers not only to the extent of health care but also the quality of the professionals' involved and their capacity for rational management and leadership. Therefore, many parameters and standardisation agencies focus on clinical quality as a strict and concrete process making quality the real factor of competition. Quality in the health service is more important than it is in other sectors, such as those of education, industry and commerce, because medical or clinical errors are often irreversible. CL means clinicians and personnel being trained in clinical settings and management at the same level. To emphasise the complexities of clinical and managerial quality, the next section will examine the role that ethical considerations play in CL.

3.8 Clinical Leadership and Ethics

Basically, ethics is integral to transformational leadership as codes of ethics should not be separated from leadership style, because ethics as Cohen and Kol (2009) say eliminate disputes and disagreements among individuals at work. Furthermore, Siebens (1998) argues that ethics can be described as a system of religious, linguistic, legal and more general beliefs which individual workers can each subscribe to. The authors Carter (2001), Gangon (1999) and Peterson (2004) concentrated on this and argued that ethics turns leaders into wise men who dedicate themselves to achieving the highest levels of

satisfaction and professional behaviour among employees, in regard to honesty, trustworthiness, friendship and confidentiality.

Banerji and Krishnan (2000), state that ethics are an important element of hospitals because a shared code of ethics ensures an effective working atmosphere. For instance, Millward, (2005) emphasized that the British NHS seeks to provide high-class medical services through ethical principles, spread among clinicians at British hospitals. Additionally, Vera (2009) says that obeying the Hippocratic Oath means that the individual should adhere to the medical profession's rules and managerial duties.

Health quality programmes are not only focused on the service itself or the specification of clinical performance and diagnostic evaluation, but also on the effectiveness management. Cohen and Kol (2004) have argued that the relationship between professionals and their organisations should be recognised as complex because of the supposedly hidden conflict between the organisation and the values of the professionals. Quality cannot be divorced from ethics, rather the two are integral parts of the same whole; the meaning of quality care would not be complete without paying attention to total care management (TCM) because ethics are intrinsically linked to quality care.

Ethics is derived from Greek and Latin words *(ethikos and moralis) to behave in one-way rather than another* (Bem, 2001, p.20). It is usually closely related to concepts of family, religion, friends, culture and the ethical codes of professional associations (Bedeian,

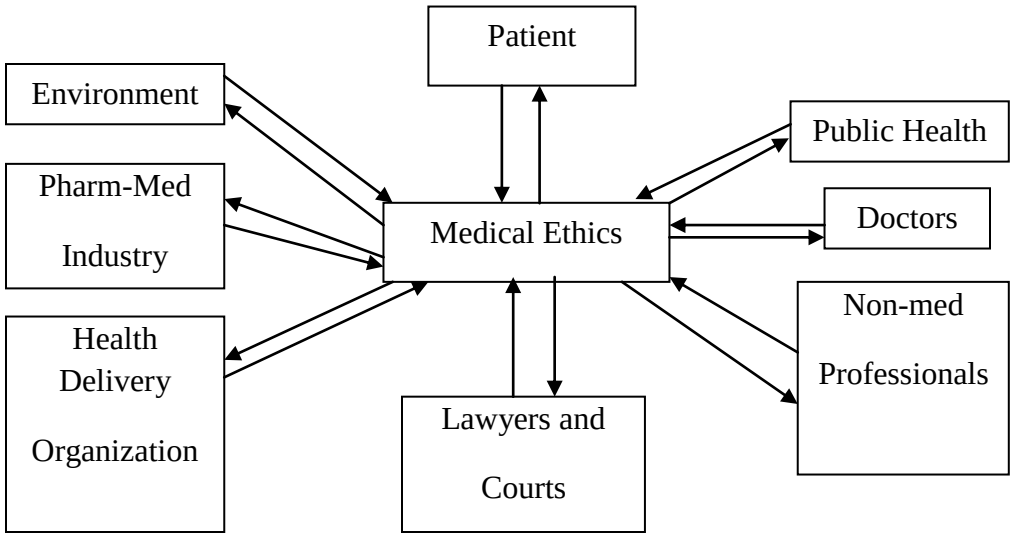
1986). Carter (2001. p.57) defines ethics as a "*framework stressing dignity and respecting for personhood*", suggesting that ethics means behaving in a certain fashion according to values, beliefs, traditions, religion, culture, law and notions of dignity.

For these reasons, the above authors suggested that the behaviour of leaders should increasingly try to take account of ethical factors including corporate stewardship, accountability, spiritual values, trust, humanity and good stewardship. Leadership and ethics go hand in hand; an ethical environment is conducive to effective leadership and effective leadership is conducive to good ethics. In other words, effective leadership is a consequence of ethical conduct and ethical conduct is a consequence of effective leadership. Therefore, ethics and leadership function as both cause and effect. Most theories have proposed that hospitals should ensure an ethical atmosphere (Peterson, 2004) enabling leaders to establish organizational values as well as impose rewards and sanctions. Krishnan (2003) has established that ethical behaviour on the part of leaders should work towards the growth of their followers and address their real needs.

Clinically, many authors, such as Hamric (2001), Takala (1999), Siebens (1998), Roberts and Reich (2002), Kelly (2002), Fox et al (1998), Thompson (1998), Holdway and Kogan (1997), Palfrey et al (2006), and McFadzean and McFadzean, have discussed topics related to ethics. These topics have included issues such as veracity, privacy, confidentiality, friendliness, the relationship between law and ethics, processes of decision-making, the rights to refuse treatment, end of care, consent forms, truth telling

and disclosing errors. Similarly, Emauel (2000) has discussed the structural ethics in medicine by defining health care values, as shown in figure 3.2, emphasising that ethics is surrounded by many important factors such as environment, patients, public health, doctors, lawyers and courts

Figure 3.2 Medical Ethics Environment



Source: Emanuel (2000)

In UK NHS hospitals there are distinctive parameters by which to measure the quality of health delivery, known as clinical governance; this constitutes "*a framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"* (Walsall NHS Trust, Clinical Governance

Review, October 2002). Millward (2005) has emphasised that clinical staff are empowered to accept responsibility and accountability at all levels of the hierarchy. In practice, this involves clinical audits, risk management, user involvement, and evidence-based practice. Also it involves continuous professional development, management of performance levels, encouraging reflective practice, team building and team reviews.

To summarise, ethics is a parameter by which to measure behaviour and make a judgement on how successfully clinical practice is being applied. Ethics is strongly linked with quality and morals. There are no real benefits from medical developments if not combined with ethical considerations. The law is not always enough to resolve conflicts and problems within health service management, it is much better for clinical behaviour to be ethically conducted. A lot of important concepts are also necessary to construct effective CL, such as trust, confidence friendship, openness, privacy and truth. It is only by ensuring that these matters are dealt with that hospitals can hope to establish responsible clinical leaders and highly experienced followers**.**

3.9 The Combination between Transformational Leadership and CL

It seems in general that transformational style is the most appropriate style in the medical field and hospitals. It is highly important to improve the clinicians' intellectual abilities in order to be capable of making sound decisions in the restless atmosphere of hospitals, full of emergencies and critical situations. Increasingly, the author Xirasagar (2008) states that command and control concepts are no longer good to controlling the behaviours

clinicians. Furthermore, codes of ethics, in which transformational style believes, make the clinical team understand and absorb the clinicians' individual needs; this creates a calm and appropriate atmosphere for making decisions, apart from randomization. In this vein, Rasdi (2009) adds that transformational style should take into account the individuals' needs and qualifications rather than legislative power and managerial positions. In other words, experience and knowledge is more significant than these classical issues.

Clinically, Kalra (2009) says that British hospitals (NHS) believes in the fact that hospitals' managements have become a challenge; to qualify clinical leaders in way that makes them capable of resuming big responsibilities . This agrees with Vera (2009) who stresses upon the fact that transformational style is a type of multiplicity in skills among clinicians in regard to technical and managerial responsibilities. She confirm that this type of skills make clinicians think in brainstorming technique, and consider their hospitals goals part of their priorities even if it were contradicting with their personal circumstances . In other words, the clinical agenda, written by the clinical team, formed from all clinical specializations, eliminate all individual differences due to the strong idea that all their experiences are highly important.

Transformational style is concerned with all the concepts of this study that discusses the clinical leader personality with their levels of experience and qualification in addition to how much scientific, legislative and technical power they have. Moreover, this type of leadership believes in cultural multiplicity in respect to religion, language, traditions and

customs, increases the patients' satisfaction. The clinical team is aware of the fact that culture is not less important than the clinical role of this team who are equipped with experience, sciences, and skills of management and leadership. They also know well that their thoughts and experiences are at their leaders' centre of interest. It is noticeable that transformational leadership attempts to spread leadership ethics that stresses upon the mutual respect. These aspects will have an important and effective role in creating the comprehensive culture of quality that does not look at management and technical services as a quantity. So quality improves the technological by enhancing the responsibility of adopting international concepts and certified measurements in medical service industry.

According to the mentioned literature of clinical leadership it can be concluded as seen in table 3.1(page 66-70) that clinical professions is being discussed within social, mental, cultural and administrative issues in order to demonstrate creative approaches to work through complex leadership .Health care professions such as physicians, dentists, chiropractors, optometrists, pharmacists, podiatrists, veterinaries, registered nurses, dieticians, health technologists, dental hygienists, health record technologists, radiological technicians and therapy assistants , it would be so difficult for them to do without institutional forms, associations and ethical codes. Also, the factors such as knowledge, human resource, process and academic institutions, as well as professional associations, began to be included in university modules as health service management.

The authors in this chapter emphasised that clinical leadership indicates that clinicians should share their knowledge and experiences in order to contribute positively towards

the successful development of the hospital. In other words organizational effectiveness of hospitals should be combined with clinical effectiveness .Also the concept of leadership rather than management has explained how hospital administrators often create cross-functional teams, including clinical and non-clinical staff drawn from different functional areas to deliver a high standard of health care. Basically, power is an important factor which means responsibility and accountability should match the balance between educational background and authorities. In health sector doctors have the strongest power in hospitals while others, from nurses to AHPS, have very little power, while others from nurses and AHPS are sharing their technical expertise, experience and knowledge with subordinates. Doctors practice management such as assessment and planning processes, this enables them to generate options and take action more efficiently. So medical schools through curriculum enabling them to increase management and strategic practises but they mostly resistant to organizational change and having some conflicts with clinical and non-clinical staff .On the other hand .Nurses reflect patients' needs to the top-level management, this would facilitate the concept of leadership due to the correlation between the level of their education and experience .They always try to apply the concept of transformational by demonstrating a respect and values as well as motivating other people to act. They also believe in supporting and motivating staff to achieve mutually negotiated goals.

Quality in health care sector means quality of communication, training, preparing managers and individuals. Furthermore it means quality of procedures, techniques and personnel as well as customer requirements. In other words, TQM requires a partnership

of doctors, managers and other AHPS to be effective. Furthermore, clinical ethics which can be described as a system of religious, linguistic, legal and more general beliefs in addition to professional behaviour among employees. Some further concepts such as honesty, trustworthiness, friendship and confidentiality are also included to match ethical codes of professional associations. The authors also emphasised that values, beliefs, traditions, religion, culture, law and dignity are important factors to shape clinical governance and audits.

Table 3.1 The indications of Clinical Leadership Literature

Factors	Categories and indications
Clinical professions	Social, mental, cultural, educational and administrative issues
	Complex leadership and management
	Multi- professional teams, self-respect, mutual appreciation
	Communicate effectively with clients, colleagues and families
	Minimize the stressfulness and conflict between doctors and nurses
	Codes of practice and ethics
	Managing all aspects of the health care profession
	Power of doctors and their professional associations

	Develop knowledge and competence in complex clinical situations
	Doctors, nurses and AHPS in promoting team work and social interaction among them
	The transformational leader to be charismatic,
Clinical leadership	Organizational and clinical effectiveness
	Interaction between the leader and his followers within transformational leadership theories
	Cross-functional teams, including clinical and non-clinical staff
	Clinical governance and high standard of health care.
Clinicians and Power	Responsibility and accountability to policy
	Chief medical staff and head nurse to become leaders
	Characteristics of the individual rather than educational degree to have a stronger influence
	The power of members from health authorities.
	Doctors have powerful pressure group as national associations
	Doctors have the strongest power in hospitals while others, from nurses to AHPS, have very little power
	Power derives from the willingness of subordinates to accept the leaders' right to lead".

Clinicians and Power	Expert power from experience and knowledge
	Position power such as: legitimate , reward, coercive and informational power
	Personal power includes rational persuasion, referent power and experience
Doctors as leaders	Practicing management such as assessment and planning enables them to do efficiently.
	Medical schools and curriculum to teach them administration, management and leadership
	Doctors are a combination of medical experience, communication and health advocate
	Mostly resistant to organizational change as they do not consider themselves to be ordinary employees
	Current conflicts with clinical and non-clinical staff
Nurses as leaders	They strongly reflect patients' needs to the top-level management.
	They are in a position to improve the quality of care through managing team, patient- centered care and becoming more politically aware
	There is a correlation between the level of education,

Nurses as leaders	number of years practice, place of employment and personality type
	Nursing workforce doesn't mean only a task completion but developing transformational and relational leadership
	Demonstrating respect and value for their essential role in leadership
Clinical leadership and Quality	Quality of management is embodied within the quality of procedures, techniques and personnel
	Quality of management means the actual leadership by adopting principles
	Clinical quality means customer requirements
	Clinical quality means also a partnership among doctors, managers and other AHPS to be effective
	Quality reflects the achievement of organization objectives
Clinical leadership and Ethics	Ethics means system of religious, linguistic, legal and more general beliefs
	It is the highest level of satisfaction and professional behavior among employees
	Something related to honesty, trustworthiness, friendship

	and confidentiality.
	Ethics would not be complete without paying attention to total care management
	Concepts of family, religion, friends, culture and ethical codes of health professionals
	Certain fashion according to values, beliefs, traditions, religion, culture, law and notions of dignity.
	Responsibility and accountability
	Clinical audits and risk management,

3.10 Interactions of Clinical Leadership Factors

Clinicians have traditionally only been qualified to lead clinical settings due to their practice and experience.

All professionals establish their identity through professional associations' support and the exchange of experience and information from the surrounding environment. For example, universities are responsible for clinicians gaining suitable management sciences to enable them to manage health care and become aware of how to take rational and professional decisions. As summarised in figure 3.3, the power of law and clinical associations' support are often not sufficient for them to effectively lead health sector.

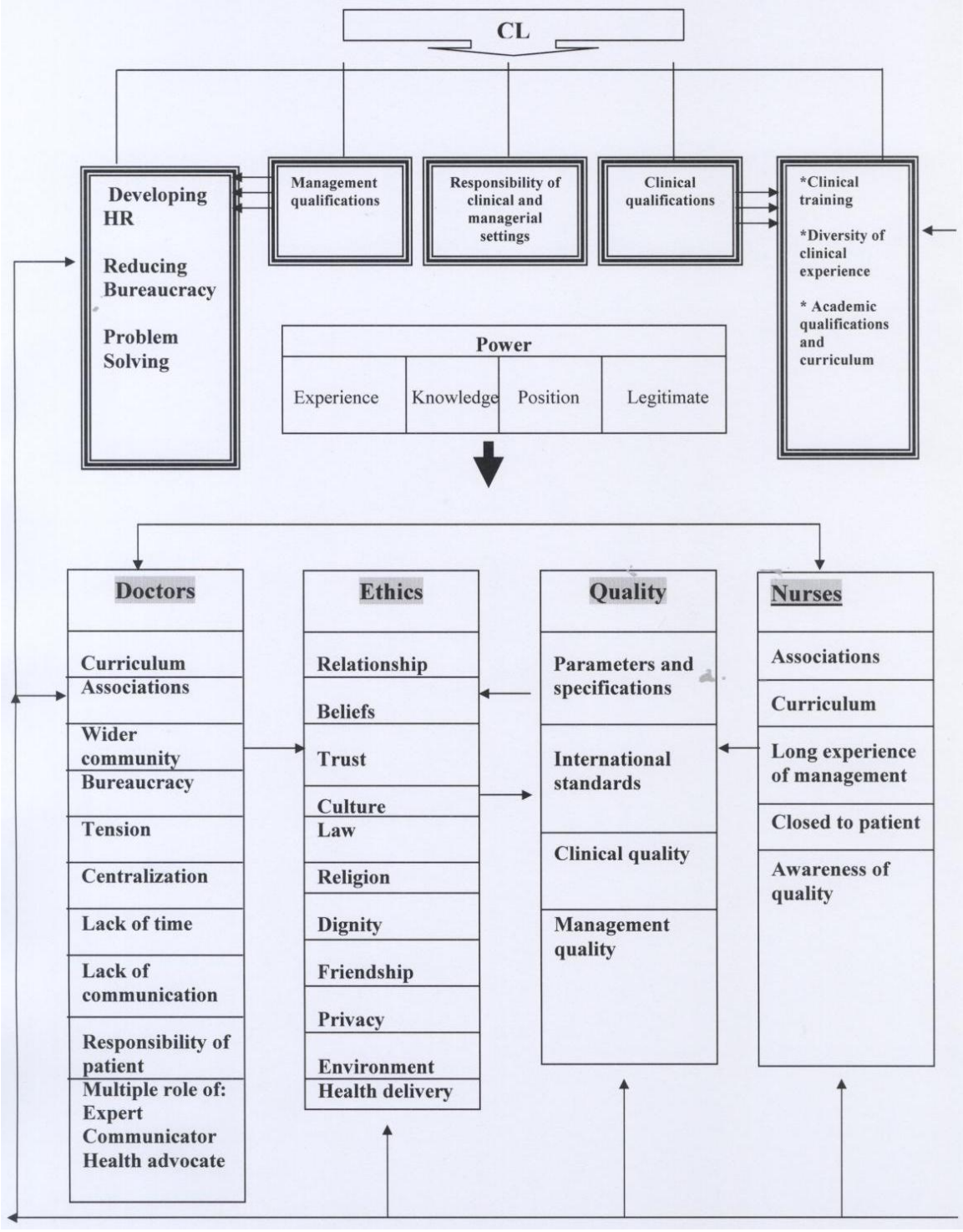
It seems that doctors have the strongest power in hospitals, often as a direct result of their academic qualifications, and clinical situation. The tendency of doctors to make individual, autonomous decisions, as well as tension created as a result of bureaucracy and centralisation, may contribute to the lack of communication between doctors and other hospital workers (clinical or otherwise). Unfortunately, hospitals often have no option other than to ignore these problems because, usually, doctors are the decision makers and policy planners in their institutions. At the same time, it is the responsibility of the health service to ensure that doctors are able to manage hospitals properly by providing them with management courses. But they cannot work alone; for example, effective teamwork concepts need to be adopted in conjunction with nurses and other AHPS, such as pharmacists and clinical technicians who are qualified in both clinical and managerial approaches.

Accordingly, the type of transformational leadership mentioned in chapter two may be the ideal way to implement a better relationship among clinicians because power can be distributed between all of them. It is evident that there is a strong interaction amongst clinical job descriptions for all clinical professions. Therefore, the aspects of consultation, intellectual sense and individual consideration are suitable environment to make decisions as mutual and sharing roles within open channels of communication. For example, there is no opportunity to exchange information within the health team considering only formal and written styles. In other words, the informal style may help to break down hierarchical barriers allowing individuals to get information in the easiest and shortest way, saving time and money as well as effort.

Matching health care quality is the mutual responsibility of all clinicians. Quality assurance programmes are not only the responsibility of quality officers, who are sometimes non- clinical staff. Also, transformational leadership means leaders who trust others directing them through mentoring, delegation and negotiation. Health care depends on these basics in order to construct a hierarchy that all clinicians feel satisfied to achieve the hospital's goals for the good of their patients.

In clinical transformational leadership, doctors are no longer the only decision makers in hospitals; nurses with even longer experience in hospitals cannot consider themselves the ones with the best clinical awareness of everything in hospitals, similarly, AHPS are not the only health technicians doing a job in separate and closed rooms without representation in top management. Transformational leadership means recognising everyone's experience; knowledge, position, training and academic qualifications, as well as taking into account ethical considerations, respecting cultures and norms, displaying loyalty for your hospital and maintaining open channels of communication. This open-ended form of power sharing is the real means by which to achieve effective and successful leadership.

Figure 3.3: Interactions of Clinical Leadership Factors



To summarise, it can be seen from figure 3.3 that CL could be achieved by implementing a fair distribution of power among all clinicians. For example, it should be recognised that doctors have neither enough management awareness nor enough time to practice CL, but their wide responsibility towards public and communities makes them able to take part in hospital and health care management. Also, nurses' experience and qualifications provide them with a comprehensive picture about the clinical industry, in particular, relating to issues surrounding quality, ethics and management skills, but these skills and abilities are frequently overlooked because of the favour that is shown to doctors. Other hospital workers, such as AHPS, have no clear role in health management and leadership because very little power is provided to them, and not enough management skills are taught to them as part of their curriculum, nor do they receive enough support from professional associations. Clinical quality and ethical management cannot be achieved properly unless there is much more awareness of the culture, religion, beliefs and social lives of team members.

3.11 Summary

Hospitals and medical care providers all over the world are seeking to provide clinical and administrative training for medical personnel. Accordingly, there arises a need for clinicians to be given the necessary support in order to gain managerial expertise, without the overburden of bureaucracy. This empowerment will enable clinicians to fulfil their skills alongside the kind of development, offered by universities, other academic institutions and professional associations.

Doctors are considered more qualified clinicians in the medical services to manage hospitals due to their clinical experiences more than others. On the other hand, nurses are considered the biggest structure in hospitals that are clinically and practically qualified. The same is almost true according to AHPS of assistance medical profession in order to maintain the quality and ethics of teamwork as considered guidelines and parameters. The medical industry is primarily interested in international quality, both in clinical and administrative settings .Also, it is necessary to have ethical considerations where the medical profession is concerned.