What is leadership?

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Overview

Central to this chapter is the deconstruction of leadership itself, citing world famous leaders and global influences. Focusing then on the allied health care professionals, the historic, political and gender impact on these professions is highlighted. Particular attention is paid to nursing as the largest NHS group of employees, and its power bases are examined, focusing particularly on the period since 1988. In considering where nursing has come from, the shape of the profession, the nature of the work and the value placed on it, questions are raised as to how it might consider its place in the future.

Setting the scene: why is professional leadership needed in health care settings?

It could be argued that to promote powerful leadership in all the allied health disciplines within an already heavily managed system is unlikely to achieve anything but turf wars; indeed historically this has more often than not been the case. At the inception of health care programmes within the Western world, there was something to be said for a more hierarchical system, where each knew their place. Saks, in chapter 3, succinctly describes the perceived vulnerability of physicians in the early days of organized health care in Western society, and their very successful manoeuvres to
establish professional dominance in pursuance of self-interest. In health care today it is unlikely that such elitist tactics would appeal to, or be upheld by, any professional group for any length of time. Medical dominance no longer remains socially appropriate (if it ever was) but is in fact unworkable in today's society where professionals have their own codes of practice and must fit their contribution to care within the jigsaw of a complete care programme that seeks to meet the demands of a rising consumer movement. We are now accustomed to collaborative working, are in many cases as well educated as our professional neighbours, and are well aware of global economies and their impact on health care resources. However, increased diversity, individualization and consumerism have led to a far more complex view of health both by the public and by health professionals (Wilmot 2003).

Health care is an economically as well as socially driven phenomenon, there are vested interests throughout and attempts to claim 'ground' from a range of interested parties. Not only have small societies such as professional groups been sorely challenged by these complexities, but also the impact of changes within greater global communities is felt locally, a view supported by Bottery (1998). Major events such as the breaking up of Russia, the growing power of China and India, and the growth of groups such as the United Nations and the European Community affect us all, not least as they are underpinned by a preference by most governments of almost all philosophies, to run with the apparent superiority of free market logic. Margaret Thatcher, UK prime minister from 1979 until 1990, embraced this wholeheartedly, introducing an internal market (that is a quasi-market in health care in which the state provides the finances but in which competition exists between independent suppliers to provide the service) within the NHS, and establishing a central tenet that health was to be run as a business. Despite Thatcher's fall from grace, and the election of a supposedly socialist Labour government in 1997, the basic philosophy has not changed, and the effect of all this for many has been a slow but insidious erosion of those core values of caring that drew many professionals into health care in the first place. Bottery (1998) noted from his research in the UK that professionals who had seen themselves as principal contributors to a co-ordinated system for the greater public good now perceive themselves as being mere functionaries of a system that resembles a marketplace that rates economy, efficiency and effectiveness above all else. That resources cannot be unlimited, that accountability for those resources must be made, is unquestioned by most health care staff. Indeed, on the face of it the values of evidence-based effectiveness would not cause health professionals any anxiety. However, strong policy interests are apt to dominate the judgements made in the name of evidence – based health care. Given the quasi-market values of policymakers and senior management, health care workers are finding that their practice is moulded into that culture, presenting them with ethical and
legislative challenges (Bottery 1998). Ethical issues such as the promotion of policies that are narrow (for example Murray et al. 2008), lack of properly qualified staff for the provision of safe care (Buchan 2002, 2004) and the obligation to pursue inadequately funded or poorly thought out strategies (Bottery 1998).

It is the response of health professionals to the changes described above that will set the scene, indeed write the script, for future decades of health care services. Despite the fact that collaboration between health disciplines is now commonplace in Western society, and the balance of power has shifted slightly from medical dominance to a more shared philosophy, none of the health care professionals – including doctors – have real ownership of the care that they provide. Public health care is owned by the funding governments, and as such, those professionals participating in its function such as doctors, nurses and therapists must – to have an effective voice – be cohesive.

Robinson (1992) blamed competing groups within nursing for failing to set occupational objectives within the wider socio-economic context of health, and attributed nursing’s subordination to its own divisiveness, a point expanded on by Stanley in chapter 2. Certainly today’s health care professionals need to consider the nature of their role within society as a whole, not just within their organization. Only by reflecting on their professional function in its entirety can new ways of effective working become established. This move from a tightly marginalized group to a cohesive and collaborative workforce requires clarity of vision, a wide breadth of knowledge, and strong leadership. In countries where patriarchy dominates, lessons may be learned from current developments in Hong Kong in particular, and from some understanding of how Western societies have moved on to some degree. In health care this has taken longer than in many other groupings and explanations of why are well described by Saks in chapter 3.

Leadership characteristics: inherited or learned trait?

Leadership, even in democracies, is central to the functioning of most societies, and involves at least two people in pursuit of a common goal. The literature identifies leadership as one of the critical success factors for sustaining continuous improvement in any organization (Zairi 1994; Taffinder 1995). Health disciplines working under the umbrella of one organization need, for optimum functioning, to be very clear as to the aims of that organization and – most importantly – they must also have clarity about their professional role and contribution to the business of health care. This clarity can come only from good leadership, at both national and local levels.
Bennis (1998 p. 161) considers that the need for leaders currently goes unspoken, while being ‘pathetically’ manifest in our idolatry of show business stars. He also notes that leadership courses are consuming billions of dollars with little sign of any leaders. So what is leadership? Stogdill (1974) wrote that there are almost as many definitions of leadership as people who have tried to define it, and in the intervening decades this is still true. It is important to differentiate, at the outset of this chapter, between great people and leaders. Scientists, heroes, Nobel prize-winners and wonderful individuals may or may not become leaders in the general understanding of the word, and some very sinister or intellectually challenged people can join the ranks of leaders. Leaders can give hope and direction or turn the world upside down; how they have such power is what we must begin to examine.

Leadership theories have developed from Machiavelli (1532), whose observations of the powerful Borgias who ruled while he served in Florence are written for posterity in *Il Principe* (The Prince). In his writings he noted the importance of shared information between those with power and influence, and the need for courtesy between collaborating parties. Today he is mainly identified with the adjective ‘Machiavellian’ meaning cunning or devious, owing to his theory that the end justifies the means. Girvin (1998) cites Galton (1870) as a relatively more recent contributor to leadership theory, with his perception of the heroic; a leader of troops with inherited characteristics of leadership, qualities passed down through generations. To some degree this view holds today, with wealthy families creating dynasties, and public (so called, but expensive and private) schools such as Eton in England being viewed as the most suitable institutions for educating and instilling leadership qualities in youngsters.

Max Weber (1864–1920), founder of modern sociological thought and cited in more depth by Saks in Chapter 3, took the debate further by defining three key bases for leadership power, described by Smith and Peterson (1988, cited by Girvin 1998):

- The **rational base**, which assumed the prevailing social norm as correct and that those in authority had the right to command.
- The **traditional base**, where the belief in a traditional power and authority holds.
- The **charismatic base**, where an individual possessing particular characteristics is given power.

Interestingly, it was Weber (1947) who introduced the term ‘charisma’, which (literally translated from Greek) means gift of grace. Frank (1993) posits that in essence this means that the person has the ability to develop or inspire others in an ideological commitment to a particular point of view. There are those, for example Roberts (2004), who consider that comparisons may be
drawn between true inspiration and ‘mere’ charisma. Roberts cites comparisons between Hitler and Churchill, two world leaders who were in forceful opposition. He finds Hitler charismatic and Churchill truly inspirational. I would suggest that this is a value judgement based on the atrocities carried out in Hitler’s name rather than a clear-cut rationale. Inspirational or not, when the British public no longer felt a need for Churchill’s brand of leadership they dropped him – his earlier triumphs a thing of the past, suggesting that even inspiration may be a transient talent. Charisma is often evident by a person’s presence or attractiveness combined with a positive and engaging manner. Conveying by a confident voice and positive eye contact that whomever you are talking to matters can be learned, as can good posture and the development of a wardrobe that gives you confidence. Charismatic people have sparkle, indicating an energy that their audience finds motivating, and while some people seem to be charismatic naturally, it can be learned, developed and honed as long as it is done with sincerity. Otherwise it will fail horribly!

Fundamentally, as Bennis (1998: 3) states, the key attributes of successful leaders are quite clear. They are ‘people who are able to express themselves fully … they know what they want and how to communicate what they want to other people in order to gain their co-operation and support’. Subsequent numerous studies on leadership following Weber’s earlier work cited above have resulted in a highly sophisticated set of interconnected views on leadership. I have concertinaed them into four, as the differences between some are subtle to the point of confusion. None are clear-cut as one theory may overlap with another, but the categorization allows distinctions to be made between genetic, circumstantial and learned styles of leadership.

1 (Genetic) Great man theory – leadership is inherent, not made. Based on military leadership concepts; traditional power bases of dynasties, and inherited genes.
   Examples: Ruling families, nobility, feudal kingdoms, family businesses.

2 (Genetic or learned) Trait theory, charisma – assumes qualities of persuasion, which can be inherited or developed.
   Examples: Individuals who attract followers.

3 (Circumstantial) Contingency and situational theories – environmental factors determining style of leadership; this leadership may be transient.
   Examples: Someone who takes control and holds the group’s confidence, for example in a shipwreck.

4 (Circumstantial or learned) Behavioural and participation theories – defined by actions, not genes. These include:
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- (Learned) Transactional theory – based on a system of reward and punishment, e.g. Management systems (see Chapter 2).

- (Charismatic or learned) Transformational theory – based on motivating and inspiring others, e.g. the moving of followers beyond their self-interest for the good of the group, organization, or society.

While leadership is central to the survival of most groups and organizations, the style of leadership depends on external factors and must fit with the environment of the time – even charismatic leaders may have a limited leadership span.

For those readers wishing to access a substantive and quite recent review of leadership studies, I recommend the work of Osseo-Asare et al. (2005), which looks at best practice in leadership in higher education. In this work leadership was found to be one of the critical success factors for sustaining quality and performance improvement in United Kingdom higher education institutions. Results also indicated that leadership ought to be effectively integrated with policy and strategy, and deliberately exercised through process ownership and improvement. Of course environmental issues impact on an individual’s responses; many people may have the characteristics seen as essential for an effective leader but are never in a situation to call them into play. Further, the great man or trait theory may be restrained by environmental factors, so the notion of one wrap-around theory is as far removed today as it was in Machiavelli’s time. To add to this lack of absolute clarity is the fusion, or confusion, between management and leadership. This is a crucial issue for health care professionals that is considered in depth by Stanley in chapter 2. Suffice to say, in sympathy with Bennis’s view that today we are ‘over-managed and under-led’ (Bennis 1998: 161), and for the purposes of this chapter, I will focus on the emotional rather than the functional aspect of leadership.

Bennis (1997) considers that a leader is more than the sum of his or her parts, and makes more of their experiences. He lists leadership qualities as:

- Integrity
- Dedication
- Magnanimity
- Openness
- Creativity
- Optimism
- Risk taking
- Passion.

His portrait of a leader is a person with self-knowledge, a strongly defined sense of purpose, the capacity to generate and sustain trust and to have a bias
towards action. Bennis totally refutes the notion of born leaders, considering leadership to be learned through life and work experiences. This is consistent with the work of Osseo-Asare et al. (2005) where some respondents confirmed that they exercised leadership on the basis of what Mullins (1999) described as ‘sapiential authority’, that is by wisdom, personal knowledge, and reputation or expertise. Gardner (1989) studied a large number of North American organizations and leaders, and came to the conclusion that there were some qualities or attributes that enabled a leader in one situation to lead in another. These range from vitality and stamina to ‘people skills’, competence and courage. In my view Bennis hits the nail when he speaks of passion. It is passion that fuels an individual to realize their vision; passion that provides the energy, but this is not enough without a power base, and this was never more true than in the health services.

**Power**

Leadership without power is of little use in any environment; however, power is a concept that not everyone is comfortable with. It appears to go against our notions of democracy and equality. Nonetheless without a power base little can be accomplished outside the norm. An oft-quoted study that demonstrates this well is that carried out by Lewin et al. (1939). In their study of groups of youngsters it was noted that those following a democratic style of leadership got along together but did not accomplish difficult tasks so well, while those under a more authoritarian leadership style achieved more. Those with a laissez-faire approach were unsupportive to each other and accomplished little.

Central to leadership in health care is the notion of mastery. Mastery is an acquired set of competencies that provides a baseline of knowledge and expertise for a leader. With mastery comes a level of self-confidence in what the leader brings to the table. To be involved in health care, mastery of expert practice in a specialty or generalist area is often a stepping stone to becoming a leader, be it at a local level or at a wider forum such as a specialty network, or organization. The confidence that is derived from developing mastery can be empowering, and power is essential to leadership. Knowledge is intellectual power, credibility among peers. However, most of us will have met very knowledgeable individuals who fail to communicate or inspire others around them – they work well but have no shared vision; change is not on their agenda. Leaders are marked by their desire to meet challenges, to move forward, and to do this they use their knowledge and extend their private world to embrace those around them. While power bases come from varying sources, the most common types fall into one of three categories:

- Informational power
Authoritarian power

Charismatic power.

Informational power

Informational power is not only having knowledge but also using it creatively and politically. This involves an ability to connect and to relate to others and begins to address the issue of inspiring others. Nurses have more information about patients, their families and communities than any other professional group, yet nurses tend to be unaware and unable to own any significant level of power. No patient wants a powerless health professional.

Authoritarian power

Positions of authority carry an expectation of power, ‘legitimate power’, which is hierarchical in its principles. The history of allied health professionals to medicine is rooted in this tradition of leadership and power. Despite the fact that nursing in the UK has moved from the patriarchy of medicine, it has not yet stood alone as a professional entity but has borrowed the mantle of management and legitimized a fragile power base often away from clinical work, an issue picked up in Chapters 2 and 7 by Stanley in his work on cognitive leadership. While there are some moves to relocate a clinical power base for nurses, that power is, in the UK at least, more aligned to very specialized areas rather than across the board. Power bases for therapists, discussed fully in chapter 4, are more likely to develop from their clinical area of expertise.

Charismatic power

A third type of power is known as charismatic. Put simply, this is power derived from charm or personality. Charm may be ‘turned on’ but is none the less real, and can move and inspire huge crowds or just one other individual. The essence of charm is to enchant and to be believable. Charismatic people are usually great orators, motivating those around them and inspiring greater determination. While the power of fine speaking gives them a head start in the leadership stakes, oration on its own is not enough. The warmth that comes from caring about people and letting it show, by being positive and portraying a goal that is achievable and can be shared, and – most importantly – valuing the contribution made by those that are being led, lends real fire to the charismatic. Girvin (1998) notes that
personality power can too easily be abused, and the historical case studies described later in this chapter will demonstrate the truth of this!

None of these power bases are mutually exclusive, and a major task for any leader is to hold diverse parts of a system, conflicting issues among teams, and opposing arguments from equally worthy professional groups.

**Historical perspectives: selected case studies**

Leadership qualities are not specific to one environment. Leaders in health care will have the same attributes as leaders of huge conglomerates, successful businesses and charitable organizations, or educational institutions for example. To consider leadership qualities let us take well-known examples of leaders from across the world. Within the confines of one part of one book it is neither possible, nor necessarily helpful, to delve deeply into historical analysis, but a brief historical perspective may be very helpful in matching current theories of leadership to some well-known leaders. Thumbnail sketches may offend academic historians but for our purposes they can be very useful and illustrative. Moving in chronological order to consider the handful of well-documented leaders that I selected in the Introduction, we will consider a brief history of each.

**Queen Elizabeth I of England (1533–1603)**

Elizabeth was the daughter of King Henry VIII and his second wife, Anne Boleyn. He had desperately hoped for a son to succeed him as he already had a daughter by his first wife. Elizabeth’s early life was consequently troubled, not least by the execution of her mother and the declaration that her mother’s marriage to the king was null and void. Declared illegitimate and deprived of her place in the line of succession, the next eight years of her life saw a quick succession of stepmothers. Here was a woman of highest rank but whose security was, in her youth, very fragile, given that the beheading of inconvenient royals was not uncommon then and she was, for some time, perceived as very inconvenient. Her father sired one legitimate son, Edward VI, who was crowned king but died at the age of 15 years. Despite a troubled accession to the throne, her good education combined with her natural intelligence, eventually led her to becoming a sovereign of great significance, taking England, which had been racked by religious wars and poverty, to relative peace and considerable riches. Her reign is often referred to as ‘The Golden Age’ of English history. She was an immensely popular queen, and her popularity has waned little with the passing of time. Testimony to this
are the frequent cinematic portrayals of her life. She became a legend in her own lifetime, famed for her remarkable abilities and achievements.

- Her leadership skills are best described as somewhat Machiavellian, as she played prospective suitors along while never conceding to their wishes, but all the while strengthening her position. Her leadership stemmed from the rational and traditional, with a style that was typical of the day, autocratic and transactional (punishment/reward). Her power base derived from being the greatest power in the land, with all the coercion that meant in those days! None the less, many profited by her rule, and there was little attempt to remove her from the throne once her inherent strengths became obvious.

**Gandhi (1869–1948)**

Gandhi was born in India into a family of high caste (status), and his father held a leadership position in the area, so the notion of being born into a leadership role has a bearing here. Despite being a shy and mediocre student both at school and at college, he went to England to study to be a barrister, where he was very homesick. Immediately after passing his examinations he enrolled at the High Court in London and promptly sailed home the next day. Two years later, having had little success in establishing a law firm in Bombay, he joined an Indian firm with interests in South Africa and went to their Durban office as a legal adviser. Shocked by the widespread denial of civil liberties and political rights to Indian immigrants there, he threw himself into the struggle for their elementary rights, remaining there for 20 years and suffering imprisonment many times. In 1914 the government of the Union of South Africa made important concessions to Gandhi’s demands, including recognition of Indian marriages and abolition of the poll tax for them.

His work in South Africa complete, he returned to India where he became the most prominent leader in a complex struggle with Britain and fellow Indians for Indian home rule. Becoming the international symbol of a free India, he lived a spiritual and ascetic life of prayer, fasting and meditation. Periods of imprisonment for civil non-compliance met by fasting and peaceful non-co-operation served to strengthen his standing with his countrymen, who revered him as a saint and began to call him Mahatma (great-souled), a title reserved for the greatest sages. Gandhi’s advocacy of non-violence is implicit in the Hindu religion, and it was through his adherence to this that Britain eventually realized that violence here was futile and gave India its freedom, although his triumph was tempered by disappointment at the partition of India. Gandhi’s assassination was regarded as an international catastrophe, and his place in humanity was measured not in
terms of the twentieth century, but in terms of history. A period of mourning was set aside in the United Nations General Assembly, and condolences to India were expressed by all countries.

- Here we have a classic example of a visionary who responded to environmental and contingency issues, moved by a powerful sense of what is right. To say that Gandhi did not use coercion would not be strictly true – threatening to starve yourself to death if change is not achieved must be regarded as coercive, and the use of self rather than arms or violence indicates an acute awareness of one's worth. That surely was his power base, the knowledge of his influence on others around him. Biographies portray a man of great wit, a seeker of truth and a philosopher whose life might have been quietly spent meditating rather than challenging the most powerful politicians of the time.

Adolf Hitler (1889–1945)

Hitler has had more biographies written about him than any other world leader and while he must be held accountable for millions of lost and tortured lives, I suspect that this is not the only reason for such exposure. He just does not present a profile, initially, of a world leader, and there, I suspect, lies the fascination for biography writers.

He grew up with a poor record at school and left, before completing his tuition, with a vague ambition to become an artist. His father died when Hitler was 13 and between the ages of 16 and 19 he neither worked nor studied, but developed an interest in politics and history. At 19, after the death of his mother, he moved to Vienna in the hope of earning a living. However, within a year he was living in homeless shelters and eating at charity soup-kitchens; at this time the German economy was in dire straits and Hitler developed a hatred for non-Germans. At the outbreak of the First World War in 1914, he volunteered for service but despite being decorated rose only to corporal level. While working for a local army organization his ability to deliver fiery and eloquent speeches was noted and he was given responsibility for publicity and propaganda. Here he honed his oratory skills, and after the war he joined the National Socialist German Workers Party, known as the Nazis, later becoming its leader and increasing its membership quickly with his powerful speeches. Following a failed attempt to storm the government, Hitler was arrested and sentenced to prison where he laid out his vision for Germany in Mein Kampf (My Struggle). Released after nine months, he began to rebuild the Nazi Party and in 1933 he was appointed Chancellor of Germany. From this position Hitler moved quickly toward attaining a dictatorship. Under his government there was no place for freedom; the government controlled every part of people's lives. Hitler used
extensive propaganda to brainwash the nation into believing his theory about creating the perfect Aryan race. The atrocities and millions killed that were carried out to achieve this ‘perfection’ are fully documented elsewhere and still torment us today.

- Here was a man of insignificant stature, from an equally insignificant background, with little education. How could such a person lead a disparate population and almost win Europe? He is portrayed as immensely charismatic, not given to detail but preferring to leave that to others, and with an ability to orate and stir the masses. Circumstances in Germany at that time were dire; if they had not been, how differently might history have been written? Would his vision combined with his oratory skills have moved so many so far from decency? His introduction to power was his oratory, his later more ‘coercive’ tactics enabled him to hold on to it. The lesson here could be ‘beware of charisma’!

Nelson Mandela (1918–

Mandela was born in South Africa, the child of a chieftain. Despite his mother being one of the less important wives, Mandela received a good education, as well as a taste for rebellion, participating in student protests against apartheid. After qualifying in law he joined the African National Congress (ANC). When the ANC was banned in 1960, Mandela engaged in active military resistance against the ruling National Party’s apartheid policies, resulting in him being brought to stand trial for plotting to overthrow the government by violence. He refused legal representation in court and his statement from the dock received considerable international publicity. Nevertheless he was sentenced to life imprisonment.

During his years in prison, where he studied assiduously, his reputation grew steadily, and he was widely accepted as the most significant black leader in South Africa. He became a potent symbol of resistance as the anti-apartheid movement gathered strength, and consistently refused to compromise his political position to obtain his freedom. Despite being removed from society he had become a huge thorn in the flesh of the ruling white class. While imprisoned his philosophy changed from a militant approach, to one that valued peaceful processes, and from prison he initiated a peaceful transition to a more democratic country. When he was released in 1990, after 27 years in prison, he plunged himself wholeheartedly into his life’s work, striving to attain the goals, through peaceful means, that he and others had set out almost four decades earlier. His leadership skills were now to become crucial to achieve his vision. He had to win the support of his followers and allay the fears of the ruling white population.
In 1991, at the first national conference of the ANC held inside South Africa after the organization had been banned in 1960, Mandela was elected its president. He and F.W. de Klerk, the then South African white president, worked together to end apartheid and to bring about a peaceful transition to non-racial democracy in South Africa. In 1993 they shared the Nobel Prize for Peace for their efforts. The patience, wisdom and visionary quality that he brought to his struggle, and above all the moral integrity with which he set about to unify a divided people, resulted in the country’s first democratic elections and his selection as president. He was inaugurated as the first democratically elected State President of South Africa in May 1994 and served until June 1999. Mandela has received numerous prestigious awards, and at the time of writing is a revered world leader. While he has retired from official work he is greatly sought after to endorse the work of others – a gold-plated sign of validity!

- Mandela considered that he was an ordinary man who became a leader because of extraordinary circumstances. Nonetheless we must recall that he came from a leading family in his area thus was possibly not uncomfortable with a leadership role. This is similar to the circumstances of both Gandhi and Thatcher. In common with them he had a firm and unshakeable vision, and the intellect to facilitate it. Knowledge brought him power and combined with his passion he was able to ‘sell’ his vision. That he has the common touch and is charismatic comes over clearly on all media coverage of him, and while he is a South African, born and bred, the entire world embraces him as theirs.

**Margaret Thatcher (1925– )**

Margaret Thatcher is considered by many to be the most significant Englishwoman since Elizabeth I, and was the first woman to head the government of one of the major world economies. Born in Grantham where her father ran a grocer’s shop and served as a senior member of the city, Thatcher was academically bright and went to Oxford University to study chemistry and law. Interested in politics she was elected, aged 34, to Parliament, where she rose to ministerial level as Secretary of State for Education – a position often given to a woman, and usually as far as a female could expect to get in a UK government. In a challenge for the Conservative Party leadership she became, unexpectedly, its first female leader. During her premiership unemployment rose steeply but her conviction that a tight economy would bring future benefits was very persuasive, and she remained in power. This was greatly helped by the enormous patriotic enthusiasm that followed her successful repulsion of the invasion by Argentina of the British-owned
Falkland Islands. This euphoria was enhanced by a uselessly divided opposition; Thatcher secured three consecutive general elections, a rare achievement. A champion of free markets and capitalism she introduced a system of an internal market into the NHS (see page 9), which was to place management in the highest position in the national health care system – still evident to date. Perhaps more to her credit was her concern on environmental issues voiced in the late 1980s when she made a major speech accepting the problems of global warming, ozone depletion and acid rain. Thatcher stated that she owed nothing to feminism; it could also be said that she did nothing for it. As the wife of a wealthy and supportive man she was able to work and run a family of two children with comparative ease. She was a tireless worker famously requiring little more than four hours sleep a night, and totally committed to her work. Aware of the massive impact of the media, particularly television, her voice, once somewhat tedious, was trained to more modulated tones, and her hair and clothes were ‘made over’ to promote an acceptable image – with considerable success.

Margaret Thatcher, like Elizabeth I, was apt to surround herself with young men, and women were not encouraged into her cabinet. Indeed the one woman who did achieve notable cabinet status (Edwina Currie) was dropped as soon as her profile became competitive. Apparently many men found the so-called ‘Iron Lady’ attractive, but increasingly her autocratic approach lost her a great deal of support. Her characteristics were profoundly warrior-like, and while apparently in private she was capable of changing her mind with bewildering speed, once set on a course she would not change her opinion nor listen to others with differing views. This strength of character that had taken her from the back benches to the fore was, in the end, to be her destruction. Widespread opposition to poll tax (community charge) culminated in a huge demonstration in 1990 in London that turned into the largest outbreak of public disorder that the UK capital had seen in a century. This, combined with her government’s proposed policy on entry into Europe, which was ill-timed economically, and her perceived arrogance made her vulnerable. Her Chancellor resigned, igniting a leadership challenge which resulted in an unsustainable narrow win. Thatcher resigned, leaving her admirers and critics to scrabble among themselves to find a new leader.

- Margaret Thatcher, like Gandhi and Mandela, was born into a family that held some position in its locality, and they also shared a personal conviction that theirs was the way forward – they had a vision. The word charisma is rarely used for Thatcher, the force rather than the charm of her personality was noted. Her power base was authoritative – the given right of a party leader and later, a premier – but she lacked what is known as ‘the common touch’, maintaining an autocratic approach which undoubtedly contributed to her downfall.
Bill Clinton (1946–)

The 42nd president of the United States of America, Clinton was born three months after his father died in a road accident, and took the name of his alcoholic and abusive car salesman stepfather when he was 14. Clinton proved to be an able student and a good musician. Graduating from university he won a Rhodes Scholarship to Oxford University and received a law degree from Yale University in 1973. He entered politics in Arkansas and became president in 1993, serving until 2001. During his administration Clinton defied his critics by surviving an array of personal scandals that the media highlighted across the world, and by sidestepping many major issues such as global warming. Despite this he turned the greatest fiscal deficit in American history into a surplus, achieving the lowest unemployment rate in modern times, the highest home ownership in the country’s history, and lowest crime rates in many places, with reduced welfare rolls. His influence was not restricted to home and he effectively used American force to stop the murderous ‘ethnic cleansing’ wars in Bosnia and Kosovo. His popularity was such that he was the first Democratic president since Franklin D. Roosevelt to win a second term. As part of a plan to celebrate the millennium in 2000, Clinton called for a great national initiative to end racial discrimination, and has been described as the first ‘black’ president in the United States. After the failure in his second year of a huge programme of health care reform, Clinton shifted emphasis and sought legislation to upgrade education, to protect jobs of parents who must care for sick children, to restrict handgun sales, and to strengthen environmental rules.

Following the end of his presidency Clinton has remained very involved in global initiatives through his Foundation. This was formed to strengthen the capacity of people throughout the world to meet the challenges of global interdependence, working principally through partnerships with like-minded individuals, organizations, corporations and governments, often serving as a sounding board for new policies and programmes. Clinton is the typical charismatic leader, creating empathy with his audiences and projecting a deep concern for their welfare.

- My exposure to both Margaret Thatcher and to Bill Clinton has been solely through the media, television in particular. That Clinton is widely acknowledged as attractive is only part of the reason that I can recall his personality so well: he has huge charisma, and this comes through when people talk of meeting with him and when you hear him speak it is difficult to doubt his sincerity. Unlike Hitler, he has used his charisma very differently – though not without indiscretion – and is, at the time of writing nearly a decade after his presidency, still an enormously popular international figure.
Power bases in health care today

The creation of the National Health Service in the United Kingdom in 1948, offering free health care at the point of delivery financed by general taxation, was a remarkable achievement that has been the envy of many countries and has served as a model system. The dominant biomedical model of health care that underpinned its introduction has predominated for most of the twentieth century. Much of the rationale for this is discussed fully in Chapter 3, with fascinating insights of similarities on both sides of the Atlantic, and with doctors holding the reins of power. However, the ever-increasing cost of the NHS has always made it an obvious political football, and one which prime minister Margaret Thatcher kicked firmly into play, bringing together earlier moves to introduce management structures via the Griffiths Report (Department of Health and Social Security (DHSS 1983) that significantly restrained the authority of doctors. This was not without a knock-on effect, causing Robinson to note that ‘nursing after Griffiths has lost any illusion of the power it might have once possessed’ (Robinson 1992: 3). In fact the power base of nursing before the Griffiths management structures were implemented was very much a patriarchal one gifted from medical colleagues, rather than a true power base. While little has changed in the balances of power within health care disciplines since the creation of the NHS, a combination of many factors including increased diversity of health care options, increased emphasis on health education and promotion, the more open promotion of alternative therapies and a more aware, and litigious society and accompanying raised ‘user’ power has effected more opportunity for change than any single government.

In the 1990s nurse education in the UK moved from hospital-based schools of nursing into institutes of higher education, with the awarding of qualifications that were academically meaningful. At the same time junior doctors’ hours were being reduced to less arduous levels, and these two changes are unlikely to be unrelated! Nurses were to take on more work. Those nurses who had been quietly specializing in a given clinical area began to flourish openly, becoming consultants or advanced practitioners. This should have been advantageous to the profession as a whole, and in some cases it is, but as Stanley reports in chapter 7, often these new posts have a high management content and are often seen as divisive. At the same time that the new UK structures of acute health services were being introduced there was a legal obligation to include a nurse at board level, thus appearing to improve the status of nurses and other related health care professionals. Nursing, a discipline that has its history rooted in male-dominated hierarchical systems (initially the church and later medicine), rose to the management challenge with what could be seen, with hindsight, as thoughtless enthusiasm. For despite this apparent entrée into health care politics, many
management courses later, and the International Council of Nurses (ICN 2001) moves to improve nurses’ political and leadership expertise, nurses in all countries of the world continue to experience difficulties accessing and influencing local, national and international political agendas (Hennessy 2000; West and Scott 2000; Maslin-Prothero and Masterson 2002; Antrobus 2003). The reasons for this are discussed more fully in chapter 5 and constructive ways forward offered.

There are important lessons here for those countries that are moving towards the UK model, such as India and China. In India, colleges of nursing, offering diploma and degree courses, are expanding in number, while China has been strongly influenced by long-running developments in Hong Kong, where there have been major developments in nursing practice and education since the mid 1990s. In 1995 nursing education in Hong Kong moved into higher education and a four-year honours degree programme became the major route for pre-registration nursing education. Postgraduate education has also developed rapidly following the introduction of the first taught Master of Nursing programme at the Chinese University of Hong Kong in 1995. Master of Nursing programmes are now offered in an increasing number of specialities, with a significant number of nurses going on to complete doctoral studies. Although some universities are offering a choice of taught doctoral programmes based on the USA model, the majority of doctoral programmes are research based drawing on the UK model. It is perhaps of note that all academic staff working with nursing programmes in Hong Kong universities are required to hold a doctoral degree for posts of assistant professor and above, prior to taking up their appointment – a practice that has not been implemented widely in the UK. A similar expansion of education programmes has taken place in mainland China, with figures suggesting a total of 179 undergraduate programmes in 2005. Although some universities now offer taught Master of Nursing programmes, nurses in mainland China wishing to complete PhD programmes are currently receiving their education mainly in the United States or Hong Kong. The growth of postgraduate programmes has led to a major increase in research activity particularly in Hong Kong and currently all academic staff in Hong Kong are expected to be research active.

Nursing practice has also developed rapidly since the late 1990s in Hong Kong with developments that have involved the implementation of clinical nurse specialist posts, advanced practice roles such as nurse-led clinics and most recently piloting of nurse consultants. Interestingly, the location of Hong Kong means that nursing developments have been influenced by US, UK and Australian models of care. For example a nurse practitioner programme based on the US model has been implemented, although difficulty has been experienced in obtaining the 500 required clinical hours and appropriate mentors for clinical practice (difficulties that are not uncommon
in the UK). The nurse consultant model is being developed from the UK model bringing an eclectic approach to nurse development and leadership. Generally, however, developments have focused on advanced practice roles, linked to the Master's programmes and nurses usually require a Master's degree to take on the role of an advanced practice nurse. An Academy of Nursing is currently being developed to accredit specialization in nursing and to facilitate the development of expertise in advanced practice. In mainland China the increasing contact between nurses and academic staff in Hong Kong has contributed to the early developments of advanced practice roles in mainland China. These moves to improve care and develop expertise must be praised, but those leaders involved with these new developments may care to heed the work of Stevens (1997: 10), who noted that ‘the art is in recognising the need for specialisation but not allowing it to become segregation or professional insularity, potentially leading it to oblivion.’

One issue that still has to be considered in China on the development of advanced practice is that of nurse prescribing. Currently nurses do not have the right to prescribe, which is constraining the development of some nurse-led roles. Current anecdotal evidence suggests there is reluctance among medical practitioners and pharmacists for nurses to take on such roles (Twinn 2008, personal communication). While in the UK nurse prescribing and the role of the nurse practitioner has moved on, albeit slowly, it is in management structures that any real professional power exists. Interestingly, our medical colleagues rarely drop their medical expertise entirely in exchange for a management post, whereas nurses do. There is a strongly held view that the continued move to integrate nursing into a general management framework has resulted in further marginalization of nursing leadership and has served the nursing profession badly, a view highlighted by Greer (2004). While devolution has brought interesting changes in this area and while there is evidence of professional coherence in Scotland, Northern Ireland and Wales, Greer's observations are less positive about England. He observes that the most visible experiments in health policy have been carried out in England, but comments on the restlessness and often heedlessness of these exercises. The resultant lack of cohesion and somewhat opportunistic approach to health care has had a profound effect on nurse leadership in England, and there is a view that the nursing profession in the UK generally has never been more vulnerable than it is at present.

The reasons for this are not difficult to identify. In recent years no one has consolidated the attention of the nursing profession in the UK, and maintained that attention. The reasons for this are threefold, and all have a major impact in the ideal of a ‘profession’ and any leadership strategy to take that ideal forward. A leader, to function well for a large population, must be visible. The role of the Chief Nursing Officer (CNO) has been central to that and in the past in England, as in the other UK countries, was supported in
that role by a cadre of senior nurses drawn from most specialities. Their role was to advise the CNO and ministers on all aspects of nursing and midwifery, strongly promoting the role of these professions and their impact on quality care. The CNO role has more recently moved from one of accepted head of the profession to a barely visible figurehead supported in the main by secondees (temporary staff loaned to government by their employing organizations) who are unlikely to have vital organizational knowledge or to have had time to develop a powerbase to make much impact on professional issues. As well as the diminution of the CNO role, we have seen, in the UK, the demise of regional offices and the loss of the highly pivotal regional nurse director posts which had provided an important focus for development and succession planning across the regions and nationally. The more recently formed Special Health Authorities provide services to the whole of England. They are independent organizations with their own boards that include directors of nursing, but still fall under ministerial direction. Time will tell as to whether these nurses will achieve cohesive leadership. The opportunity exists for collegiate working and peer support through the Nurse Directors Association (NDA). This is an independent organization, with membership open to all nurse directors and senior nurses working in NHS organizations, and equivalent posts in the armed forces, independent sector, voluntary and charitable organizations in the UK. Given that historically, nurse leaders have risen in the main through the ranks of regions, this organization may go some way to meet the need for peer support, but its members are placed in a somewhat competitive position being employed by different health care trusts rather than by the government. This, combined with the gradual integration of senior nurses at trust level into the management framework, has eroded the opportunity for professional peer review, collegiate support and – most importantly – a degree of professional consensus at national level. This adds up to a profession in the UK that is successfully being marginalized from the leadership agenda at almost every level, despite making some very laudable advances in nurse-led initiatives at the clinical level.

Does this matter? Frustration at the nursing profession’s apparent desire to be all things to all people and the concomitant manipulations by management to tread the paths of others may not be justified (Bishop 2002, 2004). If individuals can carve out for themselves careers which satisfy them, if quality control is handed to various agencies, and if nursing as a profession disappears into the integrated woodwork while generic health care workers pick up the hands-on aspects of health care, perhaps nursing as it has been identified over the past century is no longer needed. In which case one does wonder why a great deal of government and personal funding goes into degree courses for nursing. It is important to note here the massive impact that nursing has made on higher education, not only bringing in huge
capital to universities for teaching commitments, but also creating an academic career structure which is only sometimes matched by essential resources in which the incumbents may flourish.

It seems that the nursing profession is at a very important point in its development and one which requires careful consideration if it is not just to survive but also to grow (Bishop and Freshwater 2004b: 196). Health care of today and into the future has the same complexity whether it is in developed or developing countries. The UK NHS has long been considered something of an ideal, and because of its size, leadership within its structures has become a critical issue. It is the largest European employer (NHS 2007) and the third largest world industry after the Red Army of China and the Indian Railway (NHS 2005). Never has clear leadership been more important if the NHS is to meet the demands of society, and never has nursing been in such a powerful position to improve the experience of patients. Maben and Griffiths (2008) rightly state that leadership and ownership are fundamental to the delivery of high quality care, and note that leadership has been one of the neglected elements of the UK reforms of recent years, echoing earlier words of Keyzer (1992), who considered that the nursing profession will have to adjust its strategies to suit the prevailing social climate. It could be argued that nursing has been too malleable and over-adjusted! Keyzer also argued that nurses will have to identify new leaders, adding that the choice is simple: the survival and growth of nursing, or its demise.

Conclusion

We have considered the components of leadership. There are views supporting genetic, circumstantial and learned leadership origins. Leadership cannot function effectively in a large organization without a power base, and that will derive from an informational, authoritarian or charismatic base – none of these being mutually exclusive. Through the case studies we can identify the ways in which effective leadership has been wielded, for good or ill, and the qualities and skills to be learned or honed for potential leaders. We have also examined the structure, or lack of it, to support leadership in nursing and the allied professions in the UK. What is not highlighted in the above text is how to lead the largest professional workforce in the NHS, or any similar organization across the globe, nor how to determine shared values and beliefs globally. If there was an easy answer it would have been done! However, the following chapters address the complexities and offer some solutions. This chapter has identified the issues. Do we have a shared vision? I suspect not. Too many individual aims and too little professional cohesion. Nursing is slow to use the media, as if we are ashamed to come out from the shadows. Today the media can make or break individuals and
organizations. The good or bad of this is not an issue for this text, but the importance of visibility is, and that visibility should not be tied to the government of the day but to the nursing profession and its ideals.

We have considered the power bases of leadership in theory, and how government policies over the past decades have tended to impact on nursing as a finite profession with a strong clinical focus. Multi- or interdisciplinary working can sometimes translate as ‘de-professionalization’. Professional boundaries formally blurred in the UK with the introduction of reduced working hours for junior doctors, with nurses picking up some medical tasks (Department of Health (DoH) 1993). In the community, and in some specialized units, this blurring has long been informally practised, with a tacit understanding between the health care team, to the advantage of patients and staff. This in itself is no bad thing; however, the power base for a profession must lie in the evidence of its effectiveness. Despite the fact that most health care is delivered by teams, of which nurses are an essential part (Bloor and Maynard 1998, Maynard 1999 notes that most of the evidence base is dominated by doctors. This is a real chicken and egg situation – how do you get the egg without the chicken? Unless health care professionals are very clear as to their role and contribution to health care services, they will have difficulties in developing a power base of any significance. All professions that provide health care need to underpin that care with research and all employing organizations need to demonstrate that they are supporting staff in their professional development, and that they are good investors in people (Bishop and Freshwater 2004a).

It is in local areas that good leadership can be nurtured and honed, but would-be leaders must have good connections with the bigger picture and this means stepping out of the ‘comfy zone’ and mixing with peers from across the region, the country, and the wider profession across the world. Technology makes this possible. It also means being visible, articulate and with that wonderful energy of a passion and a vision to be shared. Leadership is not necessarily about destroying the status quo, although it may be. It can also be about strengthening it, and it is not reasonable to expect one person to meet all the leadership needs of a profession, or of a functioning group. Leaders are needed at every level in a large organization, and examples are highlighted in chapters 4 and 5 of leadership initiatives that individuals have taken forward very successfully. Some of the leaders were heading a team, others had lead roles in a particular area and developed the services further, others led in a highly individual way, but they all stand out as leaders within their sphere. Perhaps what they all have in common is the courage to ‘be a tall poppy’ and stand above the rest. This does not necessarily make for comfortable living, as others may resent the attention given to these people. For those professionals who want to impact on a larger scale there are also unjust local preferences that may have to be managed when it comes to
promotion. For example in the UK there was a period in the 1970s and 1980s when the fact that 90 per cent of the top nursing posts were held by men was widely cited. Today, despite the increase in black and minority ethnic health care staff in the NHS and the private sector, the percentage of executive posts held by them is still low. This is not a dilemma restricted to the UK; when a professorial post in nursing was created in Hong Kong over a decade ago (at time of writing) it was made quite clear to all interested parties that the incumbent had to be of Chinese origin. Such issues are not to be ignored, and undoubtedly cause some heartache. However, they are not a reason to give up! Policies are constantly changing, the world is shrinking with speedy travel and almost instant communication techniques, making old prejudices more and more irrelevant. This book will prepare any health care professional to lead in his or her field, if they want to.

Key points

- Leadership is essential to the effective functioning of groups and societies.
- Effective leadership involves having a vision, and the passion and intellect to sell it to your peers.
- A leader must have followers; this entails having good communications skills.
- Leadership ability may be inherited but it can certainly be learned.
- Leadership, to be successful, must have a power base, e.g. knowledge, funding, authority.
- Leadership may be transient, arising from changing circumstances.

Reflective exercises

1. Are there similarities between the leaders in the case studies? Does one kind of leadership style predominate in the group?
2. If you can imagine all six alive at the same time, and in the same environment, who do you think would be the leader? (This may seem a silly question, but in considering a serious answer you will clarify many of the fundamental issues about leadership theory.)
3. Consider the organization in which you work, and identify the leadership style that predominates there.
4. Write on one side of a page the attributes that you would like in a leader. On the other side, list how many of those that you consider that you have.
5. What formal opportunities exist where you work to network with colleagues? What external networks do you connect with?
The role of a follower is important, no leader can function without them. Do you connect with your current leader? Consider what skills you demonstrate to them.

List on one side of a page what special attributes you think that you would bring to a leadership role. On the other side, list what you think would be your weakest aspects as a leader. Then consider how you can improve on that.

References
What is leadership?


Twinn, S. (2008) Professor of Nursing, Nethersole School of Nursing, The Chinese University of Hong Kong, personal communication.


