

Shared Leadership

Underpinning of the MLCF

A key product from the Enhancing Engagement in Medical Leadership project has been the development of a Medical Leadership Competency Framework (MLCF). This document defines the skills and competences needed by doctors to engage effectively in the planning, provision and improvement of health care services. It applies to all doctors and is intended to be acquired across the medical career at each appropriate level (Undergraduate, Postgraduate and Continuing Practice). It is therefore not aimed at specific, positional leaders but is seen as a set of competences that should be fully integrated into the medical role and not a separate function.

The philosophical leadership model that underpins this approach is that of shared leadership, a more modern conception of leadership that departs from traditional charismatic or hierarchical models. In working with the MLCF it is useful to understand the shared leadership approach and this paper is an attempt to provide a simple description and guide to the shared leadership model, and to answer some of the questions about shared leadership that have been asked during the development of the MLCF:

- What is shared leadership?
- How does shared leadership underpin the MLCF?
- How does shared leadership relate to positional leadership?
- Where is the evidence that shared leadership works and what can we learn from other settings?
- What evidence is there from health care and how do we apply shared leadership in a clinical setting?
- What do the critics of shared leadership say?

What is shared leadership?

Leadership in any context has historically been described in relation to the behaviour of an individual and their relationship to their followers. This has resulted in an emphasis in both training and academia on the behaviour, characteristics and actions of leaders. As a result of the high technology, fast moving context that characterises the 21st century, successful organisations will need to increasingly rely on highly independent, knowledgeable individuals working as part of multi-disciplinary teams. Shared leadership is defined as an activity that is shared or distributed among members of the team that will underpin this way of working. Shared leadership can be defined as a dynamic interactive influencing process among individuals in groups for which the objective is to lead one another to the achievement of group or organisational goals or both. A key distinction between shared and traditional models of leadership is that the influence process involves more than just downward influence of subordinates by a positional leader. Leadership is distributed amongst a set of individuals instead of being centralised in the hands of a single individual who acts in the role of leader (Pearce and Conger, 2002: 1-3).

Each team member's individual experience, knowledge and capacity is valued and is used by the team to distribute or share the job of leadership through the team in response to each context and challenge being faced.

The multi-disciplinary team has become the fastest growing organisational unit within today's organisation. It is no longer possible for one person or one discipline to have all of the knowledge and experience to solve the complexity of today's problems. For example, governments, in trying to find a solution to global warming, need to ensure that scientists, engineers, geographers, meteorologists, biologists, botanists, oceanographers, doctors, computer programmers, ecologists and manufacturers all bring their unique knowledge and experience to this complex problem. The breakthroughs are more likely to come from the interaction between all the differing disciplines rather than a single discipline working by itself.

This approach is equally relevant within a clinical setting. Clinicians are becoming more and more specialised as a direct result of breakthroughs in technology and science which enhance our medical knowledge. For example, for patients with cancer, teams from different specialties and with different areas of expertise, i.e. surgeons, oncologists, anaesthetists, palliative care specialists, specialist nurses, general nurses, alternative therapists, radiologists, Macmillan nurses, general practitioners, physiotherapists and others, all have a contribution to make to the planning and delivery of care. Within a shared leadership model, leadership passes from individual to individual along the patient's pathway of care. This provides continuity of care for the patient through a key or caseworker without compromising standards of care. Supporting this clinical team there are further networks including support services, laboratory services, manufacturers, administrators and managers.

No individual clinician is an expert in all aspects of the care needed for the patient and therefore cannot lead the others in the team through a command and control model. In shared leadership everyone shares the leadership role so that the person in charge at any particular time is the one with the key knowledge skills and abilities for that particular moment in the patient's journey (Pearce, Manz and Sims, 2009: 234).

We can illustrate this with an example from cancer services. The oncologist or radiologist might be the leader in different aspects of making the diagnosis; the surgeon, after discussions in the team led by the patient, will assume the leadership role in the operating theatre, passing it back to the specialist nurse in the recovery phase on the ward. On patient discharge the leadership role may pass to the GP or a Macmillan nurse depending on the patient's needs. Each member of the team's unique contribution is respected by the other team members and the leadership baton is passed on at agreed points through the team recognising whose knowledge, expertise, experience and capability is needed in the leadership role at any given moment, based on the needs of the patient.

How does shared leadership underpin the MLCF?

The MLCF is built on the concept of shared leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times and are focused on the achievement of the group rather than of an individual. Therefore shared leadership actively supports effective teamwork (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2009: 6).

In the complex world of healthcare the belief that a single person is the leader or manager is far from reality. Leadership is a competency-based behaviour that has to come from everyone involved in healthcare. Doctors work in multi-disciplinary teams focused on the needs and safety of the patient where leadership becomes the responsibility of the team. Whilst there is a formal leader of the team who is accountable for the performance of the team, the responsibility for identifying problems, solving them and implementing the appropriate action is shared by the team. The formal leader's role is to create the climate in which the team can flourish through team building, resolving conflicts and being clear about the vision. Evidence shows that shared leadership can increase risk-taking, innovation and commitment which should result in improved care for the patient and an organisation that is responsive, flexible and successful. The team members can demonstrate acts of leadership by challenging the team whilst the team establishes the norms and protocols in which the team works, managing differences by using all of the skills, knowledge and professional judgment of individual members for the benefit of the whole team (Smith, n.d.).

How does shared leadership relate to positional leadership, self-leadership and super leadership?

Positional leadership

Positional leadership roles are those that individuals take on within the formal structure of their organisation. Individuals are appointed to those roles on the basis of their past experience and their future potential to be part of the formal accountability structure within an organisation. The roles themselves have a set of expectations around them regardless of the individuals who occupy them. Examples of positional leadership roles within healthcare are ward managers, matrons, clinical directors, medical directors, nursing directors, finance directors, directors, chief executives, non-executive directors and chairmen. We understand in principle the responsibilities of these roles and would have little difficulty placing them in a formal diagram of the organisational hierarchy.

Self-Leadership

Self-leadership is at the heart of shared leadership. Leaders need to be effective self-leaders understanding themselves and their impact on others, through self-regulation, self-management and self-control. To be self aware is to ask: "What impact am I having?" "Who is better at this than me?" "This is not working, what do I need to change"? Self-leaders need to learn to lead themselves before they can lead others in the team or organisation (Houghton, Neck and Manz 2002: 126 -132). Self-leadership and shared leadership are complimentary and self leaders will willingly and enthusiastically accept shared leadership roles and responsibilities as this may be the only way to get the job done in complex organisations.

The MLCF recognises that self-leadership is a building block for leadership and this is articulated within the domain Demonstrating Personal Qualities.

The MLCF also recognises within its domain of Working with Others that, whilst some doctors will take on positional leadership roles, all doctors will, as individuals, be leaders through working with others in multidisciplinary teams, making decisions about patient care, as well as being members of organisational teams making decisions about resources, people and strategy.

Super leadership

Super leadership is the art of creating and facilitating a culture of self-leadership and shared leadership in the organisation (123-135). Chief Executives and Directors increasingly need to create the context in which individuals flourish in a shared leadership model through self-leadership. Their roles are as coaches selecting the team members; developing skills and encouraging individual and team problem solving, thus pushing decision-making down to the frontline. Super leaders strive to replace conformity and dependence in organisations with initiative, creativity, independence and interdependence. These are the leaders of complex, fast moving, flexible organisations who strive to get the best from the people who work for them. They empower others to take decisions and facilitate and support individuals' initiative and creativity. People who are more used to command and control styles of leadership may initially view this style of leadership as lacking direction, indeed that this is a shirking of leadership responsibilities. Undoubtedly, it can take more time than giving orders. However, super leadership is about improving capacity and capability of leadership throughout the organisation.

Where is the evidence that shared leadership works and what lessons can we learn from other settings?

Organisations are changing in response to a fast moving and complex world. We can see this in our everyday lives; however the academic evidence base is only just catching up with these changes. The scientific base is growing to support the concept of shared leadership, however much of the evidence is through observation of successful organisations and failing organisations.

Shared leadership is a product of the culture of the organisation. Where an organisation is knowledge dominated and involves teams of individuals who collectively work towards a shared goal (such as the NHS) then shared

leadership will flourish. Where the cultural norm is for hierarchy with power and influence coming from the top then a more positional leader/follower norm will tend to exist.

The culture of shared leadership is not unique to UK publicly funded organisations and examples exist within other sectors and countries. For example in a recent study of 500 companies it was found that the leadership of CEOs was important but that the truly high performing companies were the ones who organised in teams and practiced effective shared leadership (Pearce, Manz and Sims Jnr, 2009: 234-237).

The Chief Executive of Cisco systems recounts facing severe financial difficulties in 2001. During this time, all decisions were made by the top 10 people in the Company, who drove decisions down. Cisco chose to change through the employment of a deliberative strategy of shared leadership. This has achieved impressive results and improved speed of innovation; for example, teams have reduced the time for the production of a business plan from six months to one week (234-237).

In another example, Southwest Airlines is the only continuous profit-making airline in the US. The former CE, Jim Parker, says, "Many people think that the source of our success is our cost structure that we pay our people less than our competitors but that simply is not true. The real source of our competitive advantage is our culture, which is based firmly on the principles of distributed or shared leadership" (234-237).

In the third sector, Alcoholics Anonymous is founded on the principles of shared leadership. There is no hierarchy or formal leaders; groups are self-governing and practice shared leadership within the framework called the Twelve Traditions of AA (not to be confused with Twelve Steps).

What evidence is there from health care and how do we apply shared leadership in a clinical setting?

Within the increasingly complex health system in the UK, there are many examples to highlight how shared leadership is developing, both within organisations and within modern clinical practice.

In Finland a research study looked at the occurrence of shared leadership in 703 middle managers in healthcare. They concluded that shared leadership was mainly practiced by female managers without a clinical background. They saw the move away from individual leadership to shared leadership resulting in increased innovation, motivation and readiness for development (Konu and Viitanen, 2008).

Another organisation that actively supports shared leadership is The Health Foundation. In the *Health Service Journal* in 2007 the CEO Stephen Thornton said:

'Shared leadership works on the principle that teams work together more effectively to deliver high quality patient care if all members assert their individual leadership qualities. This does not mean no-one takes ultimate control but, if the team leader has a day off or moves, that the team continues to work effectively. The days of naive reliance on a single hero who can supposedly solve everyone's problems are over.

The clinicians and managers involved in our safer patients initiative have been learning how to influence colleagues and to make patient safety everyone's responsibility. Changing people's behaviour when they have been in the same job for years is one of the hardest things to do. Safer patient initiative teams now think less in terms of 'why won't he do that for me?' and more in terms of 'how can I get him to do that for me?'

Furthermore, the teams are encouraged to find their own solutions to problems and the team leaders are prompted to say 'how can I help you?' not 'how can I do that for you?'

I recently heard a nice example of this comes from NHS Tayside. A young medical student on rotation was encouraged to develop a better form for recording anti-coagulation rates. She stepped up to the challenge

and tested the new form with her senior colleagues. They helped her to revise it and the result was a better form which she will now take with her to use in other parts of the hospital. She afterwards said that the experience had been unexpectedly empowering.

Making the culture shift to shared leadership cannot happen overnight. However, our teams have been working very hard over the past two years to make small but important changes. We are seeing tangible benefits for patients which confirm that leadership development is for all members of the team, not just for the senior management' (Thornton 2007).

In some ways health care has led the way incorporating more and more individuals into multi-disciplinary teams for the care of patients. Children with special needs have complex care packages that rely on the knowledge and skills of a very varied team that crosses the boundaries between healthcare, social care and education. For a child with cerebral palsy this may include specialist teachers, a special educational needs co-coordinator (SENCO), physiotherapists, occupational therapists, an audiologist, an optometrist, a community paediatrician, a hospital-based general paediatrician, a paediatric surgeon, a neurologist, community and hospital nursing teams, respite carers, social workers and others. Different events will influence and change the key issues for the child and their family so the main focus of care will need move accordingly. A shared leadership approach is the model that best supports this.

The MLCF provides a helpful means to integrate shared leadership in practice. For example, if the team providing care for children with complex needs was asked to review its current service by the positional leader, in this instance the clinical director, they might start by setting out the direction of the service; they would then look at ways they could improve the service through their experience of managing the service. They would examine how they worked as a team and the personal qualities of all the team members. No individual could hold the knowledge and experience to incorporate all the dimensions so they would use shared leadership to incorporate all the team members' views and use the interrelationship to innovate new solutions.

What do the critics of shared leadership say?

There are critics of shared leadership who argue that highly creative driven people are better at working as individuals rather than as members of teams (Locke 2002: 271-284). However in health care we know that individual clinicians cannot provide the best service for their patients alone. The science, skills and knowledge are too complex, and patients are too diverse to believe that beyond the most simple of tasks clinicians should not work in teams. Although Locke contends that leadership is more than the delegation of tasks, he argues that shared leadership is not in itself a solution to this problem but rather a tool that an able leader will use, among others, to accomplish the tasks that leadership requires. His views may fit a culture when strict hierarchy is needed and almost certainly describes an individual in a positional leadership role. Shared leadership works where every individual has knowledge, skills or experience that are not common to all and are used to the benefit of the end goal or result. In order for shared leadership to work those involved need to recognise when they need to follow. An effective leader as described by Locke would know when to step forward and when to follow.

Teams are not always high performing and shared leadership is not without its problems. There will be conflict. There will be disagreements about direction, who has the most influence and the implementation of decisions. These conflicts need to be positively harnessed, as they will allow creative thinking to develop and progress to be made. The trick is that the conflict needs to be managed by the whole team in an open way involving direct discussion. This will ensure that the issues are clarified saving time; everyone is forced to think about their position and evidence it. Conflict is potentially a guard against group-think and will clarify where people stand and will lead to more energy, interest and creative solutions (Bradford and Cohen, 1998: 275).

The literature often draws upon examples from industry and manufacturing but most clinical teams by their very nature manage these issues through the clear focus on the patient and whilst there may be differences of opinion on clinical pathways, consensus decisions have to be reached and differences resolved.

Conclusions

Shared leadership is a description of leadership within teams. It is a social process between people and is the process through which people working together can solve problems in an increasingly complex world, where individuals have specific experience, knowledge and competencies but are dependent on complementary experience, knowledge and skills in others. Shared leadership is about the quality of the interaction rather than people's formal positions, and is evaluated by how well people work together to enhance the process. Shared leadership is where everyone is involved in acts of leadership, where communication and making sense of conflict ensure that the process is democratic, honest and ethical and where the common goal in health care is improved services to patients based on evidence and professional judgment.

The challenge for healthcare systems in the implementation of shared leadership is that whilst clinical decision-making is delegated to the clinical team, other decisions about strategy, resources and policy are not. The success of shared leadership within healthcare organisations will in part depend upon the acceptance of this paradigm by the non-clinical leadership of the organisations. The MLCF attempts to align both sets of activities in a shared leadership model.

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