# Editorial



## Introduction

In December 2019, a new coronavirus appeared in Wuhan, China: Severe Acute Respiratory Syndrome Coronavirus 2, causing the illness COVID-19. Word spread of illness and death. Over the next few months, the coronavirus spread inexorably across the globe carried by humans in our modern world where travelling thousands of miles for a short stay or work meeting is normal (WHO, 2020). The first UK cases of COVID-19 were identified on 31 January 2020; numbers gradually increased, first, in pockets around travellers returning from other countries and then more widespread transmission through communities. Since then the UK and the world have been overwhelmed by the infection with profound and long-lasting impacts on communities and economies.

In common with other health systems, the UK National Health Service (NHS) has had to adapt rapidly to cope with COVID-19 with major changes to delivery of emergency health care and almost complete cessation of elective clinics and operations. Now that the first peak of coronavirus appears to be over, we face the even more complex process of reinstating services while remaining vigilant for an upsurge in COVID-19 infection (Edwards, 2020).

Much has been written about the importance of effective leadership of health-care organisations in achieving excellence in operational performance (reviewed West *et al.*, 2015). In this time of crisis, there is more than ever a need for exceptional health-care leadership and engagement. So what can we learn from observing leadership in the time of coronavirus?

## Command and control

In many health-care organisations, there was a formal move to a command and control structure with tiers of leadership: in my organisation, these were termed Gold, Silver and Bronze Commands, names which reinforce the severity of the situation. A new hierarchy of command was intended to establish clear lines of connection between the top and bottom of the organisation, allow rapid and reactive decision-making and ensure coordination of use of resources. However, too much control of decision-making at the top of the organisation runs the risk of decision inertia at lower levels. Furthermore, substitution of a command and control structure for pre-existing leadership structures also risks inadvertently leaving out key individuals and teams, in particular clinicians.

When we consider the concept of leadership styles (Chapman *et al.*, 2014), the commanding style, also termed coercive in Daniel Goleman's style paradigm (2000), is associated with the poorest outcomes compared to other leadership styles such as democratic, authoritative and affiliative (Table 1). Goleman stresses that all styles are valid and have their uses, but despite this in the time of coronavirus, there is a need to engage teams and work collaboratively. With a commanding style, there is a danger that team members feel disempowered and this results in resentment, disengagement and de-motivation. So, how do leaders in the leadership tiers of a command and control structure ensure that at a personal level they carry the team with them, essential for the best outcomes? One important concept here is that of the authority gradient. This can be thought of as the perceived difference in status between different members of an organisation. If the gradient is steep people at lower levels in the leadership hierarchy feel that they are unable to communicate with those at the top – this prevents them from contributing ideas and raising concerns to give top leaders situational awareness to support their decision-making.

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First developed as a concept in the aviation industry, unfavourable authority gradients between clinicians can cause harm to patients (Crosby and Crosskerry, 2004). In managing organisations, a steep authority gradient also prevents awareness of broader safety concerns (Bassett and Westmore, 2012), a factor that was highlighted in the Francis's (2013) Report on profound failures of care at the Mid Staffordshire General Hospital NHS Trust. The report states that there was "a culture of fear in which staff did not feel able to report concerns; a culture of secrecy in which the trust board shut itself off from what was happening in its hospital". There was a lack of effective communication between senior leaders and healthcare workers on the ground; senior leaders were dismissive when safety concerns were raised resulting in poor care and avoidable death. In the context of coronavirus where many patients are particularly vulnerable to infection, and to poor outcomes of infection, it is even more important to ensure that the authority gradient is optimised for patient safety.

So how do we ensure that the authority gradient is as shallow as possible to ensure that the command and control approach achieves its aim of effective leadership in a crisis? One of the key requirements is accessibility – building in a method for people in the organisation to contribute ideas and raise concerns, indeed actively seeking and welcoming these ideas and concerns, demonstrating that they are heard and considered and attributing innovative ideas to teams and team members to encourage others to contribute – developing a culture of inclusivity despite the need for a clear decision-making senior leadership group. Another model, the Leadership Flexibility Space, considers the interaction between these two requirements: consultation of team members and decision-making (Singh and Jampel, 2010). The "space" is a box plot in which is plotted the leader's (or leadership team's) consultative and independent decision-making propensity: the model incorporates five distinct leadership styles based on the balance between these attributes (Figure 1). The Active Manager is a leader who displays the most effective balance of consultative and independent decision-making activity. Leaders, who consult but cannot decide (Consensus Manager) organise endless meetings but do not move things forward; those who consult but then make decisions without considering the output of the consultation (Consultative Autocrat) or who have low consultative propensity and high decision-making propensity (Complete Autocrat) are also less effective. There is a danger that leaders in a command and control structure act as Complete Autocrats unless they make themselves accessible to staff at lower levels in the organisation.

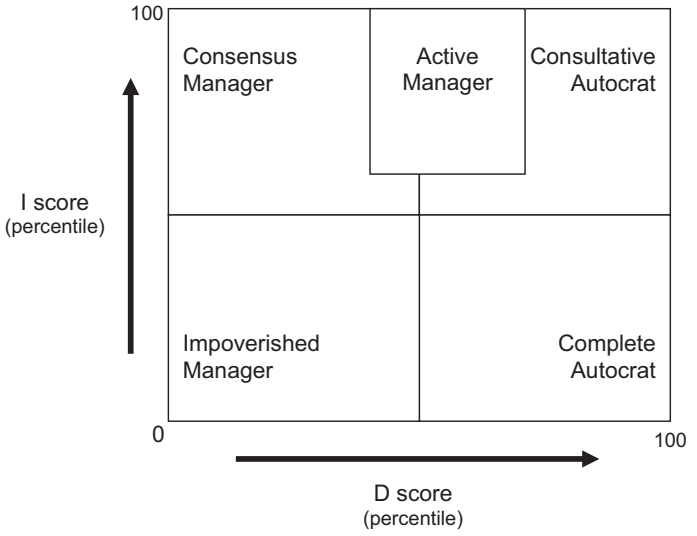
## Bring in the experts

We have been considering tiers of leadership within organisations and how they work optimally to achieve the best outcomes. However we also need to consider leadership team composition. Within health-care organisations there is a need more than ever for clinicians

**Table 1.**
Leadership styles

| Leadership style | The leader's modus operandi |
|---|---|
| Coercive | Demands immediate compliance |
| Authoritative | Mobilises people towards a vision |
| Affiliative | Creates harmony and builds emotional bonds |
| Democratic | Forges consensus through participation |
| Pacesetting | Sets high standards for performance |
| Coaching | Develops people for the future |

**Source:** Adapted from Goleman (2000)




**Source:** Singh and Jampel (2010)

**Figure 1.**
Leadership flexibility space

and professional managers to work together so that the best decisions are made. Over many years prior to COVID-19, there has been a disconnect between clinicians and managers, a divide so ingrained that clinicians in formal management roles are spoken of as having "gone over to the dark side" (Loh *et al.*, 2016). The importance of bridging the gap between clinicians and managers has been recognised (Ham, 2003; Swanwick and McKimm, 2011), and there has been a sustained effort to do so, for example through the development of a "triumvirate" leadership structure (e.g. lead doctor, lead nurse and professional manager) at many levels through healthcare organisations. Clinical input into decision making is even more important in the midst of a public health emergency. Furthermore there is a need for consultation with experts in many fields, in particular public health, epidemiology, infectious diseases, behavioural sciences and major incident planning, as clinicians in existing leadership roles may not have expertise in these areas. If this is not done, there is a danger that an inverse relationship develops between power and expertise, where the top decision-makers do not have the knowledge and experience to make the best decisions, with poorer outcomes and loss of credibility. This brings the challenge of introducing new members into established teams and consideration should be given to how to do this effectively and make the best use of each member of the team.

However, even with the greatest engagement of subject matter experts, we still need to bear in mind that we are continually learning how to manage the impact of this entirely new virus, so there are likely to be conflicting views and no obvious correct answer. Decisions made with the most careful consideration and consultation may in time turn out to be wrong. Leaders at all levels need to have the humility to learn from others and the generosity to share.

## Affiliative approach

Earlier we considered briefly the concept of leadership styles in the context of command and control structures, and touched on other leadership styles including the affiliative style, where leaders are concerned for the well-being of their colleagues and of the team as a whole

(Table 1). I am returning to this concept as it is critically important in the time of coronavirus. There has been much in the media about the "bravery" of healthcare staff (and others), and indeed the NHS has never been held in such high regard by the public perhaps since its inception in 1948. It is of course true that health-care staff are particularly at risk of COVID-19 infection and many have died globally. There is a palpable level of personal fear amongst health-care workers, associated perhaps with an exaggerated perception of personal and family risk given that many are fit and healthy adults. Health-care workers have gone to great lengths to avoid infection themselves or in their families, for example moving out of the family home. Sickness absence has increased, not only through COVID-19 infection and self-isolation but also through anxiety and fear, and this has put further pressure on services that are already stretched through having to deliver health care differently to minimise hospital transmission. In this febrile atmosphere, it is important that those in leadership positions adopt an affiliative and empathic, rather than judgemental, approach, acknowledging peoples' fears and adapting work patterns to support them. It has been pleasing to see the development of staff support initiatives such as enhanced (socially distanced) rest areas and access to psychological and counselling services. Ward "positivity boards" help to maintain morale and the wonderful initiative of letters from health-care organisations to the children of health-care workers to thank them for supporting their parents' work has again lifted spirits and enhanced the perception of being valued and part of a team (Britton, 2020). The coronavirus pandemic has paradoxically resulted in a greater appreciation of the work of all NHS staff, not just front-line clinicians, and leaders at all levels should aim to institutionalise this more affiliative approach for the future.

## Embracing change

Finally, some comments about change management. Change is frequently planned as a series of defined stages such as the seven-step approach proposed by Edmonstone (1995). Successful change, however, requires consideration of other factors, for example, the need to create an impetus to change, to develop and communicate a vision, to engage key stakeholders and to celebrate progress along the way (Kotter, 2006). However in this time of coronavirus these structured and planned approaches to change are not possible. Organisations have had to be much more "nimble" and adaptable as the external environment changes on a daily or weekly basis – changing case definitions, advice about PPE, guidance on whom and when to test, development of the concept of shielding and impact on use of hospital beds and patient flow, creation of vast new hospitals in a matter of weeks. There has been a bewildering amount of change over a period of a few months with much inconsistency and variation in practice as we tackle this novel virus. Health-care organisations have had to not only adapt and change as a result but also maintain staff engagement and trust, which is hard to do without the time to ensure effective communication and understanding of why these sequential changes are important. Thus, the leadership team needs to work extra hard to keep health-care staff on board.

One positive impact of coronavirus has been the development of new ways of working to maintain health-care services while minimising attendances at hospitals and GP surgeries. There has been a step change in use of telemedicine, for example, telephone or online consultations with patients, enhanced communication between primary and secondary care to aid patient care and online management meetings. These have all been available for years and have been used to a limited extent, mainly where geographical or other barriers to "standard" health care are present. It is perhaps surprising that health-care organisations have not made better use of these developments previously considering that they are efficient in cost and time for both health-care staff and patients and have been embraced far more by the business world.

Enrico Coiera (2011) describes the concept of system inertia, that is, the "failure of an organisation to initiate or achieve a sustained change in behaviour despite clear evidence that change is essential", and argues that it is a consequence of increasing complexity of health care organisations. Complex organisations have multiple interconnections with other organisations and many competing interests; positive change in one area leads to negative impact in other parts of the system and the natural response to this is to do as little as possible, to avoid risk and to maintain the status quo. It is only when there is a real crisis and a dramatic impetus to change that these competing interests pale into insignificance and major changes can be achieved. Here the driver is safety – of staff and vulnerable patients – a goal that is universally important. However when coronavirus "ends" we must strive to continue to deliver care differently, to hold onto the positive developments, and resist the temptation to slide back into doing things as we did before.

## Conclusions

In conclusion, we all know that the coronavirus pandemic has had an enormous impact on the world at societal and personal level – it has truly changed everything. In this turbulent environment, effective health-care leadership is more important than ever yet more challenging. So what can we learn? I have outlined some important considerations: clear leadership structures but with a shallow authority gradient; aligning power and expertise to ensure optimal decision-making; being nimble in a shifting environment; investing in people to build engagement, motivation and resilience; recognition and retention of positive changes; and new ways of doing things. In due course, there will be much analysis of the decisions made and their outcomes, and it is critical that we continue to consider the health of our health-care leadership to enable us to deliver the most effective clinical care in the time of coronavirus.

**Ann L.N. Chapman**
*Directorate of Medicine, NHS Lanarkshire, Airdrie, UK*

## References

Bassett, S. and Westmore, K. (2012), "Systems and processes that ensure high quality care", *Nursing Management*, Vol. 19 No. 6, pp. 18-20.

Britton, P. (2020), "'Your love, hugs, laughter, smiles and jokes are really helping your parents': health bosses write touching letters to the children of 'complete legend' NHS workers", Manchester Evening News, available at: www.manchestereveningnews.co.uk/news/greater-manchester-news/health-bosses-letter-coronavirus-nhs-18083604 (accessed 8 June 2020).

Chapman, A.L.N., Johnson, D. and Kilner, K. (2014), "Leadership styles used by senior medical leaders: patterns, influences and implications for leadership development", *Leadership in Health Services*, Vol. 27 No. 4, pp. 283-298.

Coiera, E. (2011), "Why system inertia makes healthcare reform so difficult", *BMJ*, Vol. 342 No. 1, p. 3693.

Crosby, K.S. and Crosskerry, P. (2004), "Profiles in patient safety: authority gradients in medical error", *Acad Emerg Med*, Vol. 11 No. 12, pp. 1341-1345.

Edmonstone, J. (1995), "A new approach to project managing change", *British Journal of Healthcare Management*, Vol. 16 No. 5, pp. 225-230.

Edwards, N. (2020), "Here to stay? How the NHS will have to learn to live with coronavirus", Nuffield trust, available at: www.nuffieldtrust.org.uk/files/2020-06/nhs-returning-to-normal-nigeledwards-nuffield-trust.pdf (accessed 9 June 2020).

Francis, R. (2013), "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry", available at: www.midstaffspublicinquiry.com/report (accessed 8 June 2020).

Goleman, D. (2000), "Leadership that gets results", *Harvard Business Review*, Harvard Business School, Boston, MA.

Ham, C. (2003), "Improving the performance of health services: the role of clinical leadership", *The Lancet*, Vol. 361 No. 9373, pp. 1978-1980.

Kotter, J.P. (2006), "Leading change. Why transformation efforts fail", Chapter 10 in Gallos, J. (Ed.), *Organization Development. A Jossey-Bass Reader*, John Wiley and Sons, San Francisco.

Loh, E., Morris, J., Thomas, L., Bismark, M.M., Phelps, G. and Dickinson, H. (2016), "Shining the light on the dark side of medical leadership – a qualitative study in Australia", *Leadership in Health Services*, Vol. 29 No. 3, pp. 313-330.

Singh, A. and Jampel, G. (2010), "Leadership flexibility space", *Journal of Management in Engineering*, Vol. 26 No. 4, pp. 176-187.

Swanwick, T., McKimm, J. (2011), "What is clinical leadership ... and why is it important?", *The Clinical Teacher*, Vol. 8 No. 1, pp. 22-26.

West, M., Armit, K., Loewenthal, L., Eckert, R., West, T. and Lee, A. (2015), *Leadership and Leadership Development in Health Care: The Evidence Base*, The King's Fund, London.

World Health Organisation (2020), "Coronavirus", available at: www.who.int/health-topics/coronavirus#tab=tab_1 (accessed 8 June 2020).