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Commentary

Who doesn't want to be a leader? Leaders are such wonderful people

Comment on "Leadership and leadership development in healthcare settings - a simplistic solution to complex problems?"

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Abstract

Leadership, as McDonald (1) argues, is a phenomenon which many people involved in healthcare around the globe put great emphasis on today; some even see the improvement of leadership as a panacea for all the ills of their healthcare system. This brief commentary on her work seeks to supplement the points she makes by emphasising the *personal* attractions leadership enjoys, at least in the eyes of many of those who exercise power in healthcare. It also endeavours to highlight some of the ironies and absurdities which arise as a result of the conflicts about what terms we should use to describe the "leaders" (or, alternatively perhaps, those who seek to enjoy supremacy) within healthcare.

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I recently put the question "what is leadership?" into Google, and the site that headed the resulting list offered me the following, rather unsurprising definition: "An effective leader is a person who does the following:

1. Creates an inspiring vision of the future.
2. Motivates and inspires people to engage with that vision.
3. Manages delivery of the vision.
4. Coaches and builds a team, so that it is more effective at achieving the vision" (2).

This, and similar standard formulations about what leadership is supposed to be, are all too familiar. Today, not only are they part of the ritualised pronouncements of leadership trainers (3), versions of this mantra are also incorporated into most of the person specifications, job adverts and other documents which describe expectations about top-level staff. It may be a bit of a caricature; nevertheless something like the following statement is almost always part of what contemporary adverts for top jobs in healthcare contain:

WANTED: INSPIRING LEADER TO TAKE THE ORGANIZATION TO THE NEXT LEVEL.

In fact, there is very little else it is possible to say when describing how people in authority should present themselves on a personal level, except that they should have leadership qualities. What I mean is that members of a Health Board simply could *not* advertise a top job with the words:

WANTED: TOUGH AND UNCOMPROMISING AXE-PERSON.

Not even if that statement were exactly to describe the very kind of person they would like to get in order to implement their next round of (ahem) "challenging cost savings".

Doubtless, if someone can pull off the trick of inspiring others to do what is probably against their best interests—a big "if" of course—then such a leader would appear (perhaps even to herself, and certainly to the Board who appoints her) as inspirational and team-orientated, however tough and uncompromising her actions might be thought to be by those on the receiving end of them.

Of course, there are plenty of people working in healthcare who are not taken in by all this leadership guff. Some might see it as little more than a joke. A bit like, I suppose, the words I noticed recently on a packet of snacks, which were obviously made in a factory:

EACH CRISP LOVINGLY COOKED BY HAND.

This statement is so evidently ridiculous that, rather than being a breach of trade descriptions legislation, it is undoubtedly meant to be ironic or tongue-in-cheek. (Surely no one would take it seriously?) Similarly, in healthcare, putting words like "authentic" or "servant" before leader, as is the current fad in many settings, might be thought of merely as ways to make the ironies of leadership (even) clearer.

However, many in healthcare (and in numerous other places) don't seem to get the irony. One of the reasons for this, I'd argue, is that leadership can be such a self-serving idea. For example, the thought of being a leader is often an attractive, romantic, or even a seductive one (4,5). Who can avoid being flattered given the opportunity to think of yourself as having an ability to create inspiring visions of the future for those lesser mortals (mere followers) who remain so reliant on *your* vision? Indeed, seeing yourself as a leader can be interpreted as a kind of wish fulfilment – a dream in which you start to believe that you're becoming the kind of self whom you have

always longed to be. Being a leader, from this point of view, is a rather more attractive way to think of who you might be than being a manager (the term that used to be the main one deployed, at least for a time in UK healthcare, for the people in charge). Unfortunately, however, whether you're a leader or a manager, one of the things you need to do to be successful is to comply with policy directives (i.e. you are expected to make the same cuts whether you are known as a manager or a leader).

Management consultants, those who deliver staff training and certain types of business school academics are three groups who immediately come to mind when thinking about those external to healthcare who benefit directly from finding ways in which to flatter the people in charge of healthcare. Indeed, many such people are dependent on doing so in order to make a living. It is hardly surprising, then, that they are amongst the most enthusiastic external groups who endorse the benefits of leadership in healthcare. Indeed, as a business school academic myself, I have noticed how scholarly articles that used to be about health services "management" (or even older ones that used to use the term "administration") now use the term "leadership" as the standard, unexamined way of talking about power and authority; even though the underlying issues and debates seem basically the same whatever the favoured term (6).

I think one of the things going on here, is that issues of power and control in healthcare have come to be rebranded as "leadership"—for euphemistic reasons—at least in part. Leaders are (according to standard, common sense interpretations) inspiring, motivating and on your side; so using the term leadership seems to be acting as a kind of camouflage, disguising the less wholesome things done in the name of power – even when they get represented in the scholarly writing in healthcare. This is not a trend confined to healthcare – nor to business academics. Journalists, for example, seem increasingly to be using the term "leader" to refer to anyone who is senior in a work setting (the chief executive of a company is these days typically introduced as its "leader" on TV news items). The trouble is that as "leader" becomes increasingly the standard term for those with power, finding a convincing language of contestation gets harder and harder.

I think, therefore, that there is a particular responsibility on academics here. This is because those academics who use leadership for representing organizing activities in healthcare, as though the term is entirely unproblematic, unwittingly reinforce the processes of power to which I have drawn attention. As Currie and Brown have argued, in the context of healthcare, language "*in all its forms…are simultaneously the grounds, the objects, and the means by which struggles for power are engaged in*" (7). It is significant therefore that, for example, the web pages of the NHS Leadership Academy in the UK prominently cites a leading academic who supports leadership (3).

Unfortunately though, this kind of academic support for leadership implicitly takes the managerial side in conflicts, by lending independent authority and status to a belief that the organizational practices that are now called leadership "really are" leadership (and therefore should be regarded as beneficial) in their intrinsic essence. As a result, such work also simultaneously diminishes the availability of alternative representations of organizational life for deployment by other interests; and in so doing, it reduces the means through which such managerialist constructions can plausibly be contested.

So what can academics and other commentators do in the light of this debate, faced with the hegemony of the language of leadership in healthcare? On the one hand it is difficult to use the term leadership, without its automatic appropriation by managerial interests in the struggles and conflicts which happen in health. On the other hand, we increasingly *must* use the term to make ourselves intelligible. That's why in this short piece I've shown how leadership might be used in an ironic (maybe even a sarcastic) manner. I've also drawn attention to those views which reject the almost fetishist celebration of leadership so common in the official pronouncements about healthcare; celebrations which O'Reilly and Reed have recently called "leaderism" (8).

Unfortunately, I foresee little prospect of any immediate turn against leaderism in healthcare. I guess that the fate of this article will most likely be simply to get ignored by those who make a living out of running leadership development courses for healthcare professionals and by academics who make their reputations out of analysing healthcare leadership. After all, their livelihoods depend on being able to teach and write about leadership. Perhaps an even more important reason why leadership will continue to be celebrated, though, is because it is also ineluctably tied up with powerful people's self-serving images of who they are. It also seems, for the moment at least, to be potentially attractive to lots of other somewhat less powerful people in healthcare (especially clinicians) who want to be more powerful in the future.

In the longer run, though, who knows what will happen? I worked in the English National Health Service between 1981 and 1997. In 1981 I was (called) an administrator – at the time quite a prestigious thing to be known as (in those days no-one in healthcare was called a manager, let alone a leader). Today, though, people called administrators in healthcare enjoy virtually no prestige at all; and as Parker points out, even 'management itself…[is] beginning to go out of fashion (now being discursively articulated as something rather like administration) and leadership…[is] the new panacea' (9). My guess, therefore, is that within another generation, leadership will probably have been discredited and something else will have taken its place. In any event, it is hard to imagine healthcare becoming an even more oppressive environment in which to work – if that were to happen then perhaps it will be impossible to recruit and retain staff. "Governance" is one possibility that some people have mentioned to me; predictions on a postcard please….

Ethical issues
Not applicable.

Competing interests
Author declares that he has no competing interests.

Author's contribution
ML is the single author of the manuscript.

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