Leadership in medicine: linking soft skills o moral values

Liderazgo en medicina: uniendo competencias sociales a valores morales

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Abstract

Leadership in medicine is still an underexplored field in Italy; while this topic is of increasing global importance in healthcare, its impact in Italian academia is still limited to nursing and only few courses are available. Worldwide, leadership in healthcare is equate to possessing soft skills abilities; on the contrary, in Italy healthcare scholars still link leadership to technical abilities. In this paper, we will propose to address the problem of leadership in medicine more generally: the increasing complexity of management activities in healthcare poses new challenges to the medical profession, which actually requires not only possession of soft skills but also abilities in the implementation of organizational, societal and professional values which need a moral awareness based on transforming leadership.

Keywords: leadership in medicine, soft skills, leadership ethics, transforming and transactional leadership.

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1. Introduction: the emergence of leadership in medicine

Leadership studies is a discipline of increasing importance in many professional sectors and it is increasing academic importance today [1]. The study of leadership in medicine has only recently started to take its place as a common medical term [2]. As Dowton noticed, since a few years ago, «leadership has received little attention in […] peer-reviewed medical literature.» [3]. Things are changed: leadership literature in medicine has dramatically increased in recent years. Leadership interest in medicine was triggered by the change in the organizational climate –from old fashioned to new forms of governance [4:2]– which lead to an increasing role of doctors not only in general management [5], but also by the shift from the General Practice (often referred to "bedside medicine") towards a more centralized form of medical care provision such as the hospital medicine [2]. At the same time, «fresh health challenges loom. New infectious, environmental, and behavioral risks, at a time of rapid demographic and epidemiological transitions, threaten health security of all. Health systems worldwide are struggling to keep up, as they become more complex and costly, placing additional demands on health workers» [6].

Leadership, in those pioneering countries (such as UK and USA) which are facing change in the National Health System, seem to equate leadership to skills different than just practical medical abilities; in other, more traditional countries, such as Italy, leadership in medicine generally seems still to be equated to technical skills.[1] According to Warren and Carnall, «Good medical leadership is vital in delivering high-quality healthcare,[2] and yet medical career progression has traditionally seen leadership lack credence in comparison with technical and academic ability» [7].

In fact leadership in medicine is not about technical skills which are the specific abilities of any professionally trained doctor, but, according to the mainstream general idea of leadership, it involves

organizational aspects (such us followers-leader relation) and the so-called soft skills (such as persuasion, motivation, negotiation, networking, and so on)[3] across all the medical professions [8] [9]. Indeed, without these soft skills, technical aptitude and business savvy aren't worth much if leaders don't have the skills to execute them; in other words, soft skills are needed in support of existing professionalism in order to achieve leadership [10].

In his James MacKenzie Lecture 2010 Sir Lewis Ritchie argues leadership importance ranges from general practice to nursing up to hospital services. However, «The patient consultation remains at the hub of clinical practice, but is now being delivered in different ways, in new settings, and by a growing team of health professionals. The exceptional potential of general practice continues to unfold, including anticipatory care and health promotion, in addition to our traditional role of alleviating suffering, pain, and distress» [11]. According to Frenk et alii, «all health professionals in all countries should be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centered health systems as members of locally responsive and globally connected teams» [6]. In other words, leadership in medicine should include the idea of person-centered medicine in which the moral element is a fundamental ingredient, as suggested by Ramsey [12], and is as much important as soft skills, as we will argue at the end of this paper.

2. Definitions of leadership and soft skills

While literature on leadership in medicine focuses basically on soft skills, the very nature (i.e. the "definition problem") of leadership is still a controversial matter.[4] Political leadership expert John Nye [14: X] claims there are about 211 different leadership definitions (from the literature of the Twenties to the Nineties of the past century). On the other had, Rost, an academic critical of leadership

studies, concludes that, looking at the popular press, leadership is a "hot word" which «has come to mean all things to all people» [15: 7]. Peter Drucker, one of the pioneers of management studies, famously stated that «The only definition of a leader is someone who has followers. Some people are thinkers. Some are prophets. Both roles are important and badly needed. But without followers, there can be no leaders» [16]. While controversial, the proposed definition is formally correct: whatever we mean with leadership functions in a particular profession (or leadership environment), a leadership is triggered only when someone gets followers: without followers there is no leadership. We can call this definition "a minimal leadership definition" [17]; any application of leadership to a particular field emerges specific skills that characterizes a leader in that particular professionalism. As Warren Bennis one of the pioneers of leadership studies, explained «To an extent, leadership is like beauty. It is hard to define, but you know when you see it» [18]. Harvard Business School professor John Kotter [19] defines leadership by what leaders do: they cope with change, they set direction, they align people to participate in that new direction, and they motivate people. The same difficulty is found when someone tries to define clinical or leadership in medicine; according to Daly and alii, «Like "leadership", the concept of clinical leadership can be defined in a range of ways; and while a standard definition of clinical leadership providing absolute agreement on meaning is not crucial to progress and is likely to prove difficult, it is useful to consider the various ways clinical leadership is conceptualized and presented in the literature. While effective clinical leadership has been offered up as a way of ensuring optimal care and overcoming the problems of the clinical workplace, a standard definition of what defines effective clinical leadership remains elusive» [20].

The "definition problems" match also with how to demarcating leadership from management. This is a vexata quaestio in leadership studies discussed since its infancy, yet there is no an agreed view on what managers or leaders should do and what they need to do.

According to G. Salaman, «there never can be, since such definitions arise not from organizational or technical requirements (which are themselves the product of manager's theory of organization), but from the shifting ways in which over time these functions are variously conceptualized» [21]. On the contrary, in his seminal paper, A. Zaleznik clearly distinguishes leaders from managers according to their tasks and their roles in organizations: the latter deals with day by day routinary tasks linked to their organizational rank, «ensuring that an organization's day to day business gets done» [22]. On the other hands leaders, «adopt personal, active attitudes towards goals. They look for the potential opportunities and rewards that lie around the corner, inspiring subordinates and firing up the creative process with their own energy» [22]. John P. Kotter, also adds other two elements that help us to distinguishing between leaders and managers: «Management is about copying with complexity» [19] its scope is to brings a degree of order and consistency to organizational key dimensions. «Leadership, by contrast, is about coping with change» [19], such as change in the very structure of organizations which needs to fit with new social and economical conditions and with technological change. These different functions, according to Kotter, shape the characteristic activities of management and leadership. Lewis Ritchie defines leadership more broadly as «the ability to influence and motivate people» and describes leaders as people who «cope with change, they set vision and direction, and stimulate team members to follow that vision» [11]. According to Rughani et alii «Ritchie makes a connection between (medical) professionalism and leadership and we should think of these as being intertwined, with leadership being both part of core professional behavior and a driver for its continual reform» [23].

To sum up, management seems linked to routinary competences linked to a person's role within an organization aiming at keeping oiled the organizational machinery, while leadership is more about vision, change[5] and the human factor in an organization. However,

the changing nature of the challenges faced by 21st-century societies drives new approaches to governance and leadership; Kickbusch and Gleicher claim «health is only one challenge and is not always given priority. Most of these challenges, however, have significant health effects, which have not been considered sufficiently so far. The challenges include systemic shocks, such as natural disasters and disease outbreaks, as well as longer-term processes, such as urbanization, epidemiological and demographic transitions, food insecurity, climate change and widening economic disparities» [4: VII-VIII].

Very importantly, recent leadership literature has focused on soft skills or powers (opposed to hard power which is linked to authority, hierarchical position in organizations and coercion); these powers or skills stem out from two different, albeit convergent facts: the shift from the military-industrial paradigm in macroeconomics and the increasing importance and complexity of information and the way in which that should be understood, elaborated and delivered [14: 45]. According to Kickbusch and Gleicher, living in a complex, information-based society «means that power and authority are no longer concentrated in government. Informed citizens, conscientious businesses, independent agencies and expert bodies increasingly have a role to play. Nevertheless, governments and health ministry's continue to be important in managing governance for health, setting norms, providing evidence and making the healthier choice the easier choice» [4: VIII]. The centrality of a leader's job shifted from skills linked to formal authority to soft skills that enable a leader to use information to persuade and attract followers.

In managerial and in political leadership, soft skills are not as central as in the medical field. While a certain amount of hard skills (skills that are connected to a formal position in a hierarchy) is required in the medical profession, they are less important than management. Interaction with colleagues and patients ask, as in universities, for a more flat hierarchy because complexity, knowledge

possession[6] and its sharing with peers require a different, more democratic approach than in management [14: 31] or even it requires a disperse leadership [4: VII]. According to Nye, indeed, political and management leadership benefits from the interplay between hard and soft powers which Nye calls *smart power* (14: X) which is a combination of skills derived by personal position (essentially coercion and rewards) and those personal skills we have seen above.

Therefore, there is a general agreement that soft skills are very important for leadership in medicine, especially in an organization such as the hospital in which doctors have to deal daily with clinical emergence, patient care and social relations with peers. Rughani et alii, indeed, claim that «General practice is characterized by uncertainty and complexity and operates through relationships with a wide range of people with whom partnership is a key principle» [23].

What are these soft skills? According to Warren and Carnall, doctors should «be able to take a macroscopic view on healthcare provision and resource allocation and to understand the political, economic, social and technological drivers for change that will influence this view throughout their careers. Doctors, who until now have been taught little of the NHS, will need to learn about the funding, organization, governance and management that are integral to its workings. They need to be supported by well-developed systems, clear lines of reporting and responsibility, and an organizational culture that provides good information and encourages its use as a vehicle for performance improvement. Finally, all doctors, whether they remain predominantly as medical practitioners, move to lead organizations or take on more strategic roles, need to learn more about "followership" […] that recognizes the importance of participation and allowing others to lead» [7]. Still Warren and Carnall suggest these skills however need to be supported by «a broader range of non-technical skills to allow (future medical leaders) to lead others, not just within medicine but across all professional boundaries» [7]. Basically, soft skills require doctors to «create and communic(ate) their vision, setting clear direction, service redesign

and healthcare improvement, effective negotiation, awareness of both self and others, working collaboratively and networking. They will need to be able to balance many different competing interests and priorities and manage themselves effectively; to enhance peer credibility; many will seek to continue to deliver high-quality clinical care alongside these prominent leadership positions. They must hold, voice and enact strong personal moral values and beliefs that impact positively on those around them and place the patient at the centre of decision-making, not the priorities of the provider» [7].

While a general consensus emerges about the ends of soft skills in leadership medicine, there is no consensus on which particular skills a medical leader should possess: some scholars emphasize on the ability at creating a vision [1; 9], some on enabling trust [11], others on empowering [8], and others –especially those dealing with nursing– on emotions [20] or emotional intelligence [24]; the importance of particular soft skills range not only on the kind of medical profession, but also, as happens in leadership, more generally, on the organizational and cultural context.

3. Leadership in medicine and moral values: the normative theory

We have claimed that, alongside with development of soft skills, those involved in leadership in medicine should develop a further sensibility for values. Values «can be defined as broad preferences for appropriate courses of action or outcomes; they therefore reflect a person's sense of right and wrong and what ought to be. Values influence attitudes and behavior and thereby shape policymaking and entire societies by setting the rules and standards (the principles) that determine acceptable (that is, ethical) actions in the area of family and community or in terms of governance of society and interactions between communities and societies with different values and principles» [4: 47-48]. Ritchie argues, indeed, that «Patients rightly

have increased expectations of involvement, accountability, and transparency but also have responsibilities as well as rights» [11]. It is not odd at all that Ritchie goes back to Plato's Republic when describing the ideal leader. Ritchie claims: «the Greek philosopher Plato, who first defined the ideal leader as someone who commits to, and is trained for, a life of service and devotion to their fellow citizens» [11]; Plato's ideal leader «has immediate resonance for us as GPs the link between commitment, continuous learning (or self renewal), and the needs of our patients. Irrespective of scientific, societal, or political change, our leadership credentials should be founded on the enduring rock of our moral values and obligations to patients and society. These values and obligations amount to our "professionalism" as GPs» [11].

This call for moral values in leadership in medicine not only implies themes already discussed in bioethics and medical ethics as it happens already in nursing, [24], but also includes the recent discussions on the role of ethics in leadership (Leadership Ethics). Leadership ethics indeed claims that ethics is central to the study of leadership which started the so called normative theories of Leadership. Normative theories of leadership were famously proposed by –among others– political scientist James MacGregor Burns [25], and taken as a starting point the ethical/moral dimension of leadership; scholars engaged in this school of ought believe that ethics is a crucial element of leadership or even, the essential element of leadership [26: 15], for no leadership can be effective without being ethical at the same time; and because choice –and therefore moral hazard– is coincident with leadership.

According to James MacGregor Burns, two basic kinds of leadership can be distinguished: *transforming* and *transactional* leadership.

Burns characterizes *transactional leadership* in terms of the notion of exchange: «Such leadership occurs when one person takes the initiative in making contact with others for the purpose of an exchange of valued things. The exchange could be economic or political or psychological in nature: a swap of goods or one good

for money; a trading of votes between candidate and citizen or between legislators; hospitality to another person in exchange of willingness to listen to one's troubles. Each party to the bargain is conscious of the power resources and attitudes of the other. Each person recognizes the other as a person. Their purposes are related, at least to the extent that the purposes stand within the bargaining process and can be advanced by maintaining that process». [25: 19-20]

The relationship, Burns argues, will last only as long as the bargain will be kept but does not really bind leaders and followers together in a mutual and continuing pursuit of a higher purpose. Once the aim of the bargain is fulfilled the leadership relation will end; that will result in an ethics of choice and individualism that characterizes the market and (arguably) contemporary politics [27].

On the contrary, *transforming leadership* takes on another path: it is normative. It is normative in two senses. Firstly, it describes how moral values and value-based choices may be influenced by the actions of leaders and ways in which followers perceive them. Secondly, it does not intend to simply describe how leaders in fact behave but, rather, prescribes how they ought to behave.[7] Burns defines transforming leadership as follows: «The transforming leader recognizes and exploits an existing need or demand of a potential follower. But, beyond that, the transforming leader looks for potential motives in followers. The result of transforming leadership is a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents». [25: 4]. Thence, according to Burns transforming leaders aim at moving beyond people's wants and wishes, thereby engaging their real needs and moral values. Burns argues that transforming leadership is the capacity to transcend the claims of multiplicity of everyday wants, needs and expectations by raising both leaders and followers to «higher levels of motivation and morality» [25: 20]. Therefore leaders and followers mainly start from a recognition of shared moral values that they leverage for collective actions. Pioneer leadership ethics scholar, J. Ciulla argues that «Burns's theory

of transforming leadership […] rests on a set of moral assumptions about the relationship between leaders and followers. Burns's theory is clearly a prescriptive one about the nature of morally good leaders» [26]. Very importantly, according to Ciulla, Burns's «transforming leaders have very strong values.[8] They do not water down their values and moral ideals by consensus but rather they elevate people by using conflicts to engage followers and help them reassess their own values and needs» [26]. In other words, Burns's transforming leaders are transforming because they find a resonance between their own and others' moral beliefs, such that those others experience themselves as followers. The motive force for leader and followers starts from shared moral values, morality and beliefs that create trust not only between GP and patients but also among peers.

4. Conclusions

The ethical component in leadership across the medical professions is fundamental; in nursing, for example an Italian empirical study demonstrated that «Ethical leadership acts on nurses' organizational behavior [...] The nurses' organizational behavior is crucial to the outcome of the health care service. Therefore, the ethical leadership indirectly affects the quality of the care and the cure offered to the patients» [24]. More importantly, the general literature on leadership in medicine seems to converge on the centrality of soft skills, but they very likely need to walk hand in hand with the moral elements based on transforming leadership. Even though, some soft skills (such as creating trust, negotiation and awareness), require some ethical sensibility. While in management the stakeholder view puts profit forward, for leadership in medicine special moral sensibility (which is also part of the medical tradition since the Hippocratic oath) plays a fundamental role: «Medicine is not a business, and the differences between it and a commercial enterprise are

profound, although perhaps less well-defined in the current entrepreneurial climate when compared to earlier times» [1]. As Ritchie has indeed highlighted, «Medical professionalism has been described as: 'A set of values, behaviors, and relationships that underpin the trust the public has in doctors'. For GPs, we must include our own core professional values [...] which form the basis of a moral covenant between GPs, patients, and society and, in turn, provide the foundation for effective leadership in general practice. While maintenance of professional values was once seen as the responsibility of individual doctors alone, I would argue that successful professionalism also vitally depends on the moral culture of the organizations in which we work» [11].

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[2] The NHS Leadership Academy in its webpage claims: «Why does leadership in the NHS need to change? Quite simply, because there's so much evidence connecting better leadership to better patient care. Francis, Berwick, Keogh point to it and so does leading academic, Michael West. They all make the link between good leadership and making a positive difference to patient care, care outcomes and the experience of care»; see https://www.leadershipacademy.nhs.uk/ retrieved 1.10.2017.

[3] This is actually what is being done in the Leadership in Medicine Altems Master provided by the Catholic University of the Sacred Heart since 2016.

[4] Levine and Boaks, for example, claim that the issue of the definition of leadership just what leadership is both central to the question of its relationship to ethics and it is problematic. It cannot be solved by either course of action taken by most authors namely either dismissing the question or answering it preemptively. But, nor can it be ignored. It must be answered in order to tell us what we need to know about the relationship between ethics and leadership and also to ground that answer [13].

[5] It is interesting to notice how change is advocated for the healthcare sector; according to Frenk et alii, «Health professionals have made huge contributions to health and socioeconomic development over the past century, but we cannot carry

out 21st century health reforms with outdated or inadequate competencies. The extraordinary pace of global change is stretching the knowledge, skills, and values of all health professions.

[6] Despite the tendency of the various professions to act in isolation from or even in competition with each other, i.e. the so called "tribalism of the professions": J. Frenk et alii, *Health professionals for a new century: transforming education to strengthen health Systems in an interdependent world* [6].

[7] Before Burns, leadership scholars were indeed ambiguous (or did not notice this point) regarding whether they were proposing a descriptive or a normative theory of leadership; this ambiguity led to a number of internal contradictions in much the same way as ambiguities between questions of ethics and law in normative reasoning lead to ethical and legal fallacies: J.B. Ciulla, *Leadership Ethics: Mapping the Territory and Id. Conversations and correspondence with Burns on the ethics of transforming leadership* [26; 28].

[8] Burns distinguishes between two main classes of values: modal and end values. Modal values include responsibility, fairness, honesty, and promise keeping. These rest on the values found in the means of an act. End values, on the opposite, include liberty, justice and equality. These enable leaders to turn their followers into leaders: J.B. Ciulla, *Leadership Ethics*… [26].

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