Debate & Analysis

Clinically led or clinically fronted?

An alternative view of leadership

Fearful that the general public will never support the closure of local hospitals and other service redesigns, there are calls from political decision makers for such reconfiguration decisions to be 'clinically led'.¹ But if decisions are to be truly clinically led we need to consider what that means and, importantly, not to confuse it with decisions being clinically fronted. To do so we need to dispel some common misconceptions of leadership and build a picture that clinicians can recognise as realistic, valid, and helpful.

Contrary to the impression given by those advocating leadership as the solution to all ills, we believe it is not about creating a compelling vision of the future. Neither is it about winning hearts and minds to a particular change, nor about solving problems, nor about knowing better or seeing further ahead, and it's not about knowing answers.

So what is it about? We suggest a completely different way of looking at it, which we will first define and then go on to unpack:

- leadership is helping others to see the present differently — clearly, broadly, multidimensionally — and, by encouraging their sense of agency and building on their desire to achieve something worthwhile, to enable them to make changes they design for themselves that cumulatively build a better future; and
- leadership involves supporting, challenging, and enabling people to be the kind of people they want to be.

WHAT DO WE MEAN?

All of us behave in ways that are altruistic, constructive, thoughtful, and valuable some of the time, and in ways that are self-centred, complacent, and destructive at others. So leaders need to support us when we are doing the former and challenge us when we lapse into the latter. In doing this they enable us to become more effective, more like the people we want to be.

Clinical leadership, then, is about supporting, challenging, and enabling clinicians. Supporting us wholeheartedly when we are being creative, dedicated, passionate, thoughtful, inclusive, and curious. Challenging us determinedly

---

"But if decisions are to be truly clinically led we need to consider what that means and, importantly, not to confuse it with decisions being clinically fronted."

---

and effectively when we are being self-righteous, complacent, judgemental, profligate, and careless. And in doing so, enabling us to be the kinds of clinicians we want to be; leading the creatively designed, patient-centred services that are needed.

Such services are enacted through conversations; genuinely engaging conversations, in which both participants share their own enthusiasms and concerns and those of the people they represent. They talk about the things that matter.

- What is it that matters to you and to your patients and your community of patients?
- What matters to me and to the organisation I have responsibilities to?
- How can we bring those together in the way we move forward?

Clinicians are most likely to be committed to the clinical task, focusing on the work in front of us, and often drained by the emotional labour of the care work in which we are involved. So it is not surprising if the world we see is not as large as the one that leaders are trying to operate in, nor that the problems and pressures are perceived differently. If we are to contribute to a future in which things are better rather than worse we do need to see beyond our current horizons. But we are all too often sold a faulty picture: an imagined and tidy future in which all will be well if only we will agree to do what we are told. What we need instead is to see for ourselves the complexities of the present situation, the underlying forces and factors that contribute to it, and the impact on it of our own behaviours and those of others: in fact the whole 'mess'.

PUZZLES, PROBLEMS, AND MESSES

It was Russell Ackoff, a systems scientist of the 1970s and 1980s, who coined the distinction between puzzles, problems, and messes,² suggesting that puzzles have a right answer, problems merely have better or worse ways of approaching them, and messes are dynamic systems of interacting problems. When we are trying to understand anything other than tiny, tidy issues we are almost always dealing with (and in) a mess. So it is not surprising that we find it difficult to describe or comprehend. What is more surprising is that so many people feel able to describe a future that is not also a mess. Inevitably the future will be as complex and chaotic as the present; it will be a different mess and with different outcomes (which, when they differ from those imagined in the mythical tidy future are described as 'unforeseen consequences'), but it will inevitably and necessarily be as complex and untidy and unpredictable as the present. Trying to achieve a future that is neatly delivering all of what we want and none of what we don't would require magic.

So clinical leaders must help clinicians to see for themselves a bigger picture, a more complex picture, to glimpse the character of the mess. Then we can gauge for ourselves the scale and urgency of any problems. We will need to be supported and challenged as we do so, to take seriously the impact on others as well as on ourselves, and to be enabled to make choices about how to move forward without feeling overwhelmed.

Unfortunately, all too often leaders compound the problems they face by failing to see the complexities of the situation. We

---

"Clinical leadership ... is about supporting, challenging, and enabling clinicians ..."

"If we took seriously the need that all of us have ... for connection with others, and the pain that is caused when we are cut off from others ... how might we design systems differently?"

suggest that some insights into complexity theory³ and a grasp of the multiple factors that contribute to today's complex environment should form an essential part of leadership (see Appendix 1 for a useful discussion aid about such factors).

RELATIONSHIPS MATTER

There is another essential aspect of clinical leadership: helping to build systems that recognise that we are human; and allowing and encouraging human-to-human relating. If we took seriously the need that all of us have (whether patients, clinicians, or leaders) for connection with others, and the pain that is caused when we are cut off from others with whom we have developed relationships, how might we design systems differently? Similarly, how would we recognise and honour our needs to matter, to learn and grow, to have a sense of meaning and purpose; and our needs to celebrate and to mourn when these needs are or are not met. If clinical leadership is to result in more humane systems and processes (and people) we need to develop clinical leaders who are literate and effective in these aspects.

And since our clinical roles all involve human-to-human relating we can see that this kind of leadership is everyone's business. All of us find ourselves in situations where we need to support, challenge, and enable others (whether they be clinical or non-clinical colleagues or patients), and at other times we need to be supported, challenged, and enabled by others ourselves.

THE DEMOCRATIC DEFICIT

Does our picture look different from the kind of leadership that is implied as required in today's 'clinically led' reconfigurations? We hope so. We suggest that many of these may perhaps more accurately be described as 'clinically fronted' because, typically, few local clinicians are involved in the design of the proposals, and fewer still have been involved in reaching a shared understanding of the problems they are addressing. Here 'clinically led' can be an antidemocratic fig leaf aiming to reassure

the public while denying them any genuine involvement.

We argue that this is not clinical leadership, but the imposition of the views of a technocratic elite far removed from an understanding of the worlds of patients or professionals.⁴ A technocratic elite that knows little about the role of the NHS in people's lives, indeed knows little about other people's lives. Its members are too busy to know lives that differ from their own: prosperous, rational, mid-life, family, busy, connected, confident, articulate. It is exactly this kind of imposition of the views of a powerful minority that professionals as part of their contract with society⁵ must challenge.

So we suggest that genuinely clinically led decisions will not be the tidy, rational, but democratically unpopular decisions that policymakers seek to persuade tame clinicians to front. Instead clinical leaders faced with complex problems (and this means all of us) will:

- genuinely involve all local clinicians;
- encourage them to bring their powerful intellects and their concern for patients and communities, expose them to the full complexity of the situation faced, and not to be fobbed off with platitudes about increasing demand and flatlining resources;
- insist on real ethnographic engagement with the deep-seated feelings and needs of the public
- encourage all ideas and actions that will have an impact, however big or small;
- support them when they are being constructive and honouring their social contract, and challenge them when they are not; and
- be prepared to 'muddle through elegantly' from one mess to a better mess, and resist the temptation to propose a way forward that is neat and tidy and undeliverable.

It won't appeal to those who share the belief that solutions are rational and logical, nor to those who want to believe that the

ADDRESS FOR CORRESPONDENCE

Sanjiv Ahluwalia

Watling Medical Centre, 108 Watling Avenue, Burnt Oak, HA8 0NR, UK.

E-mail: sanjiv.ahluwalia@nhs.net

answer is always more money. But, to those who understand that real life is and must be messy, it may come as both a relief and a welcome challenge.

Valerie Iles,

Honorary Professor, London School of Medicine and Tropical Medicine; Honorary Professor, Bucks New University; Director, Really Learning.

Sanjiv Ahluwalia,

GP, Burnt Oak, London.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

REFERENCES

1. Wollaston S. *Future of the NHS*. Hansard, 2011. <http://www.drSarah.org.uk/in-parliament/news-and-speeches/future-of-the-nhs/383> (accessed 25 Nov 2014).
2. Ackoff RL. The art and science of mess management. *Interfaces* 1981; **11**(1): 20–26.
3. Sweeney K, ed. *Complexity and healthcare: an introduction*. Abingdon: Radcliffe Publishing, 2002.
4. Martin GP, Learmonth M. A critical account of the rise and spread of 'leadership': the case of UK healthcare. *Soc Sci Med* 2012; **74**(3): 281–288.
5. Wynia MK. The short history and tenuous future of medical professionalism: the erosion of medicine's social contract. *Perspect Biol Med* 2008; **51**(4): 565–578.

©British Journal of General Practice

This is the full-length article (published online 29 Dec 2014) of an abridged version published in print. Cite this article as: **Br J Gen Pract** 2014; DOI: 10.3399/bjgp15X683281