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## PUBLIC HEALTH | RESEARCH ARTICLE

# Health professionals' perceptions of clinical leadership. A pilot study

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**Abstract:** *Aim:* To identify how clinical leadership was perceived by Health Professionals (HPs) (excluding nurses and doctors) and to understand how effective clinical leadership relates to initiating and establishing a culture of change and progression in the health services. *Methodology:* This pilot study used a mixed methods approach, although quantitative methodological principles dominated. An on-line (SurveyMonkey) questionnaire was distributed via email links to HPs throughout the Western Australian Department of Health. Qualitative data was analysed by Statistical Product and Service Solutions (Version 21). *Results:* A total of 307 complete surveys were returned. Participants represented 6.1% of the total WA HP workforce and a wide range of HP disciplines. The majority of respondents were female (86.5%), the median age was 38.9 years and the majority of respondents worked in acute hospital environments (59.9%) and in a metropolitan location (73.7%). Most participants (79.2%) saw themselves or were reportedly seen by others (76.2%) as clinical leaders. The main attributes associated with clinical leadership were; effective communicator, clinical competence, approachability, role model and supportive. The main attribute identified least with clinical leadership was “controlling”. Only 22.2% saw clinical leaders as managers, while the majority saw a clinical focus as important (85.3%). Clinical leaders were perceived as having an impact on how clinical care is delivered, staff support and leading change and service improvement.

### ABOUT THE AUTHOR



David Stanley

David Stanley (NursD, MSc HS, BA Ng, Dip HE (Nursing), RN, RM, Grad. Cert. HPE, Gerontic Cert) began his nursing career in the days when nurses wore huge belt buckles and funny hats. He is currently a Professor in Nursing at the University of New England NSW, Australia. He has researched and explored issues related to clinical leadership with a range of health professionals since 2001. He has also undertaken a number of other research studies exploring nursing and the media, men in nursing and clinical nursing issues. He has taught research methods and clinical leadership to UG and PG nursing and allied health students at a number of universities in Australia and Asia and supervised a number of Higher Degree Research students to successful completion.

### PUBLIC INTEREST STATEMENT

Understanding clinical Leadership from the perspective of a wide range of health professionals (excluding nurses and medical practitioners) has rarely been attempted. Yet health professionals who work as physiotherapists, occupational therapists, speech therapists and a host of others who offer vital health services provide significant leadership in clinical practice. This study offers an insight into their understanding of what clinical leadership is, who the clinical leaders are, and how they see their role as clinical leaders. Most health professionals saw themselves as clinical leaders who communicated effectively, set direction, were clinically competent, have integrity, are approachable, are supportive and act as role models for others. They were seldom in positions of control and while they faced many barriers to effective clinical leadership they were also perceived as having an impact on how clinical care is delivered, leading change and service improvement influencing organizational policy.

Many respondents (81.4%) suggested barriers hindered their effectiveness as clinical leaders. *Conclusions:* Improvements in clinical care and changes in practice can be initiated by clinical leaders.

**Subjects:** Allied Health; Public Health Policy and Practice

**Keywords:** clinical leadership; health professionals, leadership; qualitative research; mixed methods, pilot study

## 1. Background

Literature related to clinical leadership and its relationship to Health Professionals (HPs) is scant and there is almost no specific research related to HP clinical leadership. Therefore, huge gaps exist in what is known about the concept of clinical leadership and its application with HP (beyond nursing and medicine). Adding to what can be known in this area is vital if HPs are to play an enhanced part in quality healthcare delivery.

In addition, when leadership is studied or written about, it is often based on management or leadership principles developed from the management domain (Edmonstone, 2009; Stanley, 2006a, 2011, 2016), leading to further misunderstanding about the relationship of leadership to clinical/professional functions. Clarifying these concepts from the perspective of HPs will support better education and greater efficiencies in the delivery of health care.

It is suggested that the education and development of future HPs should be based on a clear understanding of their relationship to leadership (Jones & Bennett, 2012), however, without investigating this, it is likely that on-going HP education will simply propagate this potential misunderstandings and fill knowledge gaps with inappropriate “management” based concepts (Stanley, 2017) that may fail to support the growth of future clinical leaders.

The Western Australian Department of Health (WA DOH) provides and coordinates HP services across all of Western Australia and considering the issue of clinical leadership and its impact on the quality and effectiveness of HP practice became central to this study.

### 1.2. Aim

The aim of the study was to identify how the concept and application of clinical leadership for service improvement and the adoption of quality initiatives was perceived by HPs.

The study objectives were to:

- Profile HP clinical leaders in the WA DOH.
- Identify the attributes and characteristics of clinical leaders.
- Identify clinical leadership skill sets/practices/elements that influence service.

Improvement and the adoption of quality initiatives for change.

## 2. Literature review

The literature search began by consulting a wide range of literature, previous research papers and government documents. Searches were made of the terms; “Clinical Leadership,” “HP Leadership” and “Leadership in the Health Service”.

The literature review was informed by a consideration of literature about leadership and clinical leadership, as well as associated topics including literature related to change, organisational structure and culture, HP boundaries and their relationship to leadership roles within health care.

The literature considered for this study was accessed via library databases that included; MEDLINE, ProQuest, CINAHL, EMBASE, Allied and Complementary Medicine (AMED), Your Journals @ Ovid, Journals @ Ovid Full Text and Google Scholar. The date parameters in most cases represented the limits of the search facilities within the respective databases, although in some cases search limits were drawn from the year 2000 to the present. As well as university libraries and their computer database, a number of websites were accessed for additional or supporting information. No specific countries were excluded from the literature search, although much of the literature originated from Australia, the United Kingdom, the United States of America and New Zealand.

### **2.1. Leadership and clinical leadership**

There is a wealth of literature that deals with the role, nature and purpose of nursing and medical leadership, the leaders' characteristics and the value of developing and nurturing nurse and medical leaders. As well, there is a multitude of literature about the developmental needs of those who aspire to nursing or medical leadership positions. Pintar, Capuano, and Rosser (2007) and Jeon (2011) offer interesting examples of this from a nursing perspective, and Fulop and Day (2010) offer a thesis on the challenges clinical "managers" face as they learn leadership skills. However, there is much less of this type of literature and very little of an empirical nature, related to HP leadership.

Much of the literature reviewed uses the terms "leadership" and "management" interchangeably with little attempt to define either term (Cook, 2001c; Edmonstone, 2009; Firth, 2002; Lett, 2002; Swanwick & McKimm, 2011) and as a result, much of it fails to clarify who the leaders are, other than deference to their hierarchical or professional position. As such, the pool of information related to clinical leadership from an HP perspective is very shallow and in direct need of research to generate insights or information and knowledge about the application and perception of clinical leadership.

A number of publications were identified that outlined clinical leadership definitions. From a pharmacology perspective (Berwick, 1994; Schneider, 1999) conclude that a clinical leader is an expert in their field and that expertise and knowledge should be used to drive and lead reform. These views are supported by Stanton, Lemer, and Mountford (2010) and Swanwick and McKimm (2011) who write from a medical perspective and add empowerment and confidence to the definition so that clinical staff can improve the quality of health care. Malcolm, Wright, Barnett, and Hendry (2003) writing about doctors in New Zealand, sees clinical leaders as partners with other HPs, acting to promote the best care for the patient. He indicates that although they may be accountable to managers, they have not "crossed over to the other side" (p. 654) and that they remain focused on their clinical role.

From a nursing perspective, a number of empirically based studies were identified. These included, Christian and Norman (1998), Cook (2001a, 2001c), Stanley (2006b, 2006c), Stanley, Latimer, and Atkinson (2014) and Jeon et al. (2014); while Firth (2002) explored the balance between the clinical and managerial roles of ward leaders. These studies indicate that there has been a significant growth in research exploring clinical leadership from a nursing perspective.

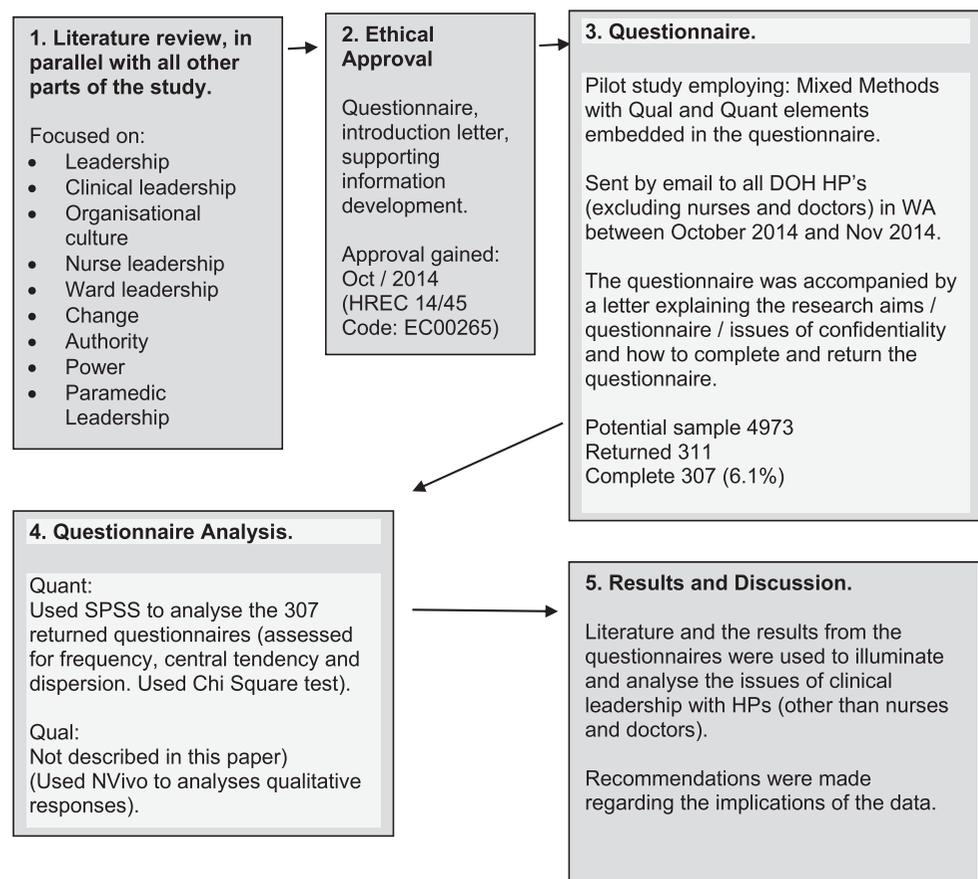
Stanley's exploration of clinical leadership with nurses, paramedics and ambulance volunteers (Stanley, 2006b, 2006c, 2008, 2011, 2014, 2016; Stanley, Cuthbertson, & Latimer, 2012; Stanley, Cuthbertson, Metcalfe, & Gallagher, 2013; Stanley et al., 2014) offered similar insights and found that clinical leaders were present in significant numbers and exist across all levels of staff, however they were rarely seen in senior management roles. These studies also showed that contemporary leadership theories failed to explain why clinical leaders were followed. These studies led to and supported the development of a new leadership theory; "Congruent Leadership" (Stanley, 2008, 2011, 2016) that suggests that clinical leaders were followed because they acted upon their values and beliefs about care. However, from the perspective of HPs, limited literature was located. Bishop's (2009) book called, "Leadership for Nursing and Allied Health Care Professionals" offers a chapter that addresses leadership issues for HPs with Lovegrove and Goh suggesting that leadership is vital for maximizing the potential of HPs. These authors add that leadership is the "key" to making and

taking opportunities that will influence policy at all levels and that HP's are best placed as inter-professional health care providers to be versatile and lead in response to change. However, there is no empirical data offered that supports the perspective of the authors. Another book by Jones and Bennett (2012) called "Leadership in Health and Social Care: An Introduction for Emerging Leaders" also offers an outline of why leadership is vital for HPs, but again fails to offer an empirical base for the content, and no mention is made of clinical leadership within the text. Both books offer a discussion about the vital role HP leadership has and why it should be fostered and better understood. Although, neither book offers any empirical or research based data to suggest what clinical leadership looks like for HPs or how it can be fostered within the HP sphere.

In the UK, the NHS Leadership Academy published the "Clinical Leadership Competency Framework" (2011) to help clinical leaders become more actively involved in planning, delivery and transformation of health and social care services. As such, it represents a substantial attempt to support leadership at all levels and to describe the competencies clinical leaders need to apply as they work toward improving services for clients and patients. The "framework" has five domains; (1) demonstrating personal qualities, (2) working with others, (3) managing services, (4) improving services and (5) setting direction, and is intended to be applicable for clinicians at all stages of their professional journey with HPs included in the HPs targeted for leadership development.

The net result of the literature search was that there is limited research related to clinical leadership from an HP perspective. This suggests a need to further explore clinical leadership as it relates to the experience and perceptions of HPs.

**Figure 1. Research process summary.**



### 3. Study design

#### 3.1. Methodology

The research process is set out in Figure 1. The theoretical framework used for this pilot study was mixed methods with a quantitative focus dominating. The results presented here relate completely to the quantitative data. While qualitative data was gathered, it is not addressed in this paper. The study undertaken was done as a pilot study for a later, larger study and to test the survey distribution method.

#### 3.2. Method

The primary method used to obtain data in this study is an online (SurveyMonkey) questionnaire.

#### 3.3. Population/sample

The questionnaire was provided to HPs (other than nurses and doctors) working full-time, part-time, or casually in Western Australia for the WA DOH in the Southern and Northern Metropolitan Health Services, the WA Country Health Service, and the Child and Adolescent Health Services in Western Australia. An email was sent to all Health Directors, Heads of Service, Heads of Department, Professional Leads, and Health Science Professionals representing HPs ( $n = 4,973$ ) in October 2014. They were asked to pass the email questionnaire on to all health staff (other than nurses and doctors), thus inviting them to participate in the study. A follow up email with the questionnaire attached was sent again to the range of possible participants in November 2014.

#### 3.4. Survey instrument

The questionnaire used was a modified version of a survey tool used in a number of previous, similar studies to explore clinical leadership amongst nurses and paramedics in both the UK and Australia (Stanley, 2016a, 2006b, 2006c; Stanley et al., 2012, 2014). As such construct validity was assured. Cronbach's alpha was also used to measure the homogeneity in the survey and a Cronbach's alpha of 0.87 was associated with these questions. As a version of the survey instrument had been used successfully in previous studies with other HPs, it was not tested with this specific sample group. Based on Gilbert's (2001) work of questionnaire design the survey included 22 questions, with 12 of these focusing on measures of clinical leadership, formalisation of leadership skills and the relationship of leadership to management, with 10 questions focused on demographic data. The questionnaire was delivered via the SurveyMonkey platform. The advantages of this delivery method included that data collection was quick and easy to administer, there were fewer cost implications, and it provided the researchers one point of data collection. Additionally, the results could easily be drawn into SPSS21 for analysis.

Several questions included a 5-point Likert Scale, and further descriptive data (not described in this paper) was collected in 4 open-ended questions. The introduction to the on-line questionnaire included a covering letter.

#### 3.5. Analysis

Questionnaire data was analysed using Statistical Product and Service Solutions (SPSS) computer software. The questionnaire analysis used a descriptive analysis which focused on frequency, measures of central tendency and the use of a chi square test. Clinical leadership was measured using a cross-sectional design from which a descriptive analysis was developed.

#### 3.6. Ethical considerations

Ethical approval was sought and gained through the Government of Western Australia Department of Health South Metropolitan Health Service Human Research Ethics Committee (HREC 14/45 Code: EC00265). Each questionnaire was provided with an accompanying letter of explanation detailing the research aims, issues of confidentiality, ethical approval and the participant's right to withdraw with impunity. Participant anonymity was assured and no participant information was linked to

individual responses. Any responses that may have been linked to individuals or specific departments was removed from the data.

### **3.7. Limitations**

The use of an online questionnaire potentially reduced the number of respondents who had access to the study. Additionally, the cascade pattern of distribution associated with the questionnaire platform resulted in some potential participants being prevented from accessing the questionnaire. These processes lead to a poor response rate, however this may be due to the organisational changes that were introduced at the time the questionnaire was promoted via email. Additionally, providing SurveyMonkey by email may not have been the best vehicle to supply the link as respondents may never have experienced this format of questionnaire delivery before. While direct access to all potential subjects would have been ideal, as researchers working from outside the health service, access to direct emails was restricted. Piloting the study indicated the issues with access, although the design of the survey was shown to be sound.

## **4. Results**

### **4.1. Who took part?**

Of the 4,973 potential HPs (other than nurses and doctors) who were employed in the WA DOH at the time of the study, only 311 questionnaires were returned, and only 307 of these offered data of an assessable nature, a return rate of 6.1%. Of these, 13.5% were male and 86.5% were female; the median age of respondents was 38.9 years. With the majority of respondents being younger than 40 years of age (55.3%). The primary area of work practice or workplace was in a hospital (59.9%) while, 40.1% worked in a community location. Most of the respondents worked in a metropolitan area (73.7%) while the remainder (26.3%), worked in a rural or remote work location. The mean time that respondents had been HPs was 14.6 years, with 63% having been in their respective professional roles less than 15 years.

Most respondents held junior HP roles with 68.1% being at level P1 or P2. The remainder (39.1%) were at P3 to P9 (P Level is a Western Australian HP professional level (P level), as such, a P1 is junior and P9 a very senior HP level). This was followed by exploring the level of line management responsibility respondents had, with 46.1% of the respondents indicating that they did not manage any staff/employees. Just over 30% managed between 1 and 5 staff (31.6%) and only 4.3% managed large numbers of staff/employees. Significantly, the majority of respondents had not undertaken any formal leadership (56.6%) or management (68.1%) training.

The range of HPs that responded to the survey was wide, although five key professional groups responded in greater numbers. These were; Physiotherapy (19.7%), Occupational Therapy (17.8%), Social Work (18.4%), Speech Pathology (16.4%) and Dietetics (11.2%) (Table 1).

### **4.2. Clinical leader attributes**

Respondents were prompted to consider the qualities and characteristics associated with clinical leadership. As such, they were offered a list of 54 qualities and characteristics (taken from prior literature reviews of leadership) and asked to select the attributes, qualities or characteristics that they *strongly* associated with clinical leadership, then *least* associated with clinical leadership. Tables 2 and 3 shows the respondents "top ten" selections of these qualities in ranked order. Respondents were also asked to suggest other qualities or characteristics (not on the list of 54 attributes) that they also associated with clinical leadership. Less than half (41.8%) offered additional suggestions with words that linked to issues of integrity, leadership skills, approaches to effective communication, a passion for clinical practice, approaches to "bigger picture thinking" and developing leadership knowledge.

**Table 1. Areas of health professional practice (excluding nurses and doctors)**

Respondents were asked to “Please indicate your area of health practice with a tick, on the list below”  
 The responses offered are below

Answer options	Response percent (%)	Response count
Audiology	1.6	5
Biomedical engineering	0.0	0
Clinical perfusion	0.3	1
Clinical psychology	2.6	8
<i>Dietetics</i>	11.2	34
Exercise physiology	0.0	0
Medical imaging technology	0.7	2
Medical librarian	0.0	0
Medical physics	0.0	0
Medical science	0.0	0
Neurophysiology technologist	0.3	1
Nuclear Medicine technology	0.0	0
<i>Occupational therapy</i>	17.8	54
Orthoptics	0.0	0
Orthotics and prosthetics	0.0	0
Pharmacy	4.9	15
<i>Physiotherapy</i>	19.7	60
Podiatry	3.0	9
Psychology	2.0	6
Radiation therapy	1.0	3
Respiratory science	0.0	0
Sleep technology	0.0	0
<i>Social work</i>	18.4	56
Sonography	0.0	0
<i>Speech pathology</i>	16.4	50
<i>Answered question</i>		304
<i>Skipped question</i>		3

**Table 2. Qualities and characteristics MOST associated with clinical leadership**

Rank no.	Quality or characteristics	%
1	Is an effective communicator	88.3
2	Sets direction (planning)	84.7
3	Is clinically competent	83.7
4	Has integrity and is honest	83.1
	Is approachable	83.1
5	Is a role model for others in practice	79.8
6	Copes well with change	76.9
7	Is supportive	75.2
8	Is a mentor	73.3
9	Is a motivator	72.6
10	Is a decision-maker	70.7

**Table 3. Qualities and characteristics LEAST associated with clinical leadership**

No.	Quality/characteristic LEAST associate with clinical leadership	%
1	Is controlling	83.7
2	Works alone	81.4
3	Is conservative	46.3
4	Must have relevant postgraduate training	38.4
5	Is artistic/imaginative	33.9
6	Deals with routine	33.6
7	Is a regulator	29.3
8	Deals with reward and punishment	28.7
9	Is an administrator	28.0
10	Has management experience	22.8

**Table 4. Barriers to effective health professional clinical leadership**

Item	%
A lack of time and or high clinical demand	29.6
Having to deal with bureaucracy	17.2
Lack of an opportunity to be a clinical leader	13.6
Limited funding/resources	11.2
A lack of mentoring	9.6
Part time work	8.8
Problems with the whole health system	8.4
Limited post Graduate opportunities or training opportunities	8.0
Lack of confidence	7.6
AHPs not respected (to be clinical leaders)	4.0
Resistance to change	4.0
Isolation	4.0
Burnout	3.2
Bullying	2.8
Lack of support from managers	2.8
Innovation not supported	2.8
Managing a work life balance	2.4
No time to study	2.4
Micro management	2.4
Some people have a negative attitude to clinical leadership/Unclear career path/In a new role/Clinical Leadership role is not valued/A blame culture/Blurred role boundaries/Not having a permanent position/Lack of admin support/Waiting lists/Conflict at work/No time to stop and reflect/A lack of autonomy/A slow and unresponsive health service/Fear/Travel/Imminent retirement/In a constant crisis/Parenting commitments/Hard to maintain visibility/Only a manager can be a leader/A lack of accountability/Cannot reward staff/Poor pay/Poor clinical leadership skills/Not part of the "purple circle"	2.0 or less

#### 4.3. Who are the clinical leaders?

Respondents were asked if they saw themselves as clinical leaders. Most respondents answered "yes" (79.2%) and added that this was because they had clinical leadership experience, senior experience, the right attributes and management skills. In addition, when asked if they thought their colleagues saw them as clinical leaders the majority again answered "yes" (76.2%). This was because they were seen to have clinical leadership skills or attributes, management skills and attributes, or because they had been told so.

**Table 5. Skills identified as being important across all health practice areas**

Skill	%
Excellent communicator	53.6
Clinical experience	27.9
Management skills	13.1
Fair/trust/integrity	12.1
Time management	11.1
People skills	9.8
Understands other disciplines	9.2
Clinical skills	8.5
Team working	8.2
Flexible	8.2
Change management	7.2
Organisational skills	7.2

#### 4.4. Barriers?

Respondents were asked to suggest barriers or matters that diminished their ability to be effective clinical leaders with a majority (81.4%) indicating that barriers hindered their capacity as clinical leaders. When asked to describe the barriers a number of responses were offered, with a lack of time and high clinical demand dominating (Table 4).

#### 4.5. Leadership skills needed

Respondents were asked to outline the skills they saw as central to the application of clinical leadership. A plethora of views were offered from 98.7% of respondents, with the skill of being an excellent communicator far out weighing others offered (53.6%). Table 5 offers a list of the “top 12” leadership skills indicated by respondents.

### 5. Discussion

#### 5.1. Demographic profiles

The response rate to this study was not extensive, however as a pilot study the process showed flaws that can be address in a later, larger study. However, the data still represents a significant body of empirical insight into HP views about clinical leadership. The average respondent had spent 14.6 years as an HP. The vast majority of respondents came from seven HP groups listed above with the majority of respondents at clinical level P1 or P2 (68.1%) and with only about 8% of respondents being at Level P4 or beyond. As such, most respondents were “managed” rather than had a prominent managerial role. This was confirmed as 46.1% managed “no one”, while another 20.1% managing only 1 or 2 staff. Very few respondents were responsible for large groups of staff (11 or more staff = 12.9%). The respondents had a female/male ratio of about 8.5/1 and a median respondent age of 38.9 years. The majority of respondents worked in acute hospital environments (59.9%) and in a metropolitan location (73.7%).

The study participants offer a reasonable profile of the HPs in the WA DOH. However, it is noted that the response rate from rural respondents represented a higher than average percentage, as 26.3% of study respondents indicated they were from rural or remote location, while only about 14% of WA HP’s currently work in rural and remote locations.

#### 5.2. Management/leadership training

While understanding management or having formal leadership training or education are not considered prerequisites for success as a leader (or manager) it was interesting to note that few respondents had any formal leadership training (43.4%) and fewer still had any formal management training

or education (31.9%). This is not unusual and in a similar study with nurses (Stanley, 2006b, 2006c, 2008) only half the respondents indicated that they had had any leadership and half again that they had had any management training. Likewise, in a study with paramedic professionals (Stanley et al., 2012) only 40.6% had leadership or management (26%) training or education.

These results indicate that clinical leadership effectiveness is not dependent upon formal management or leadership training, although experience from all over the world (Edmonstone, 2009; Ferguson et al., 2007; Freshwater, Graham, & Esterhuzen, 2009; Jones & Bennett, 2012; NHS Leadership Academy, 2011; Pintar et al., 2007) has shown that specific, clinically focused leadership instruction can impact positively on the performance of clinical leaders and the application of clinical leadership. It is worth noting that while 53.9% of the study participants claimed to manage one or more staff/employees, few had undertaken management or leadership training.

### **5.3. Clinical leadership defined**

Much of the data sits comfortably alongside previously developed definitions of clinical leadership. Harper (1995) offered one of the earliest definitions of clinical leadership suggesting that a clinical leader possesses clinical expertise in a specialist practice area and uses interpersonal skills to enable nurses and other healthcare providers to deliver quality patient care. This definition is supported by Peach (1995), Dean-Baar (1998), McCormack and Hopkins (1995), Rocchicciolo and Tilbury (1998), Berwick (1994) and Schneider (1999), Wyatt (1995), Stanton et al. (2010), Swanwick and McKimm (2011) and O'Sullivan and McKimm (2015) who all highlight attributes of specialist practice, clinical expertise, effective communication skills and a relationship to quality patient care. Attributes evident in this study data. McCormack and Hopkins (1995), Cook (2001b) and Lett (2002) support Harper's (1995) view, suggesting that clinical leadership can be described as the work of clinicians who practice at an expert level and who have or hold a leadership position. Rocchicciolo and Tilbury (1998) also cite excellence in clinical practice as an element of their perspective, but add that it also involves an environment where staff are empowered and where there is a vision for the future. Lett (2002) suggested that a clinical leader is an expert who leads their followers to better health and health care by providing a vision to their followers and empowers them.

Data from this and other studies (Stanley, 2006b, 2006c, 2008, 2011, 2014, 2017) about clinical leadership seldom link leadership and vision. This is constant with the findings in this study where vision was seldom encountered in the data describing clinical leader attributes. Instead clinical leaders were more likely to be followed for matching their values and beliefs with their actions in clinical practice. Stanton et al. (2010) offer the view that anyone who is in a clinical role and who exercises leadership is a clinical leader, before suggesting that a clinical leader's role is to, "empower clinicians to have the confidence and capability to continually improve health care on both the small and the large scale."

Combining the views identified across the literature it is evident that clinical leaders practice effective communication (Cook, 2001b; Cook & Holt, 2000; Harper, 1995; O'Sullivan & McKimm, 2015; Stanley, 2011, 2014, 2017), are clinically experienced or experts in their practice areas (Berwick, 1994; Harper, 1995; Lett, 2002; O'Sullivan & McKimm, 2015; Rocchicciolo & Tilbury, 1998; Schneider, 1999; Stanley, 2011, 2014; Swanwick & McKimm, 2011), are empowered, respect others and work within teams (Cook & Holt, 2000; Lett, 2002; Rocchicciolo & Tilbury, 1998; Stanley, 2011, 2014; Stanton et al., 2010) and drive change make care better or focus on quality care (Berwick, 1994; Clark, 2008; Cook, 2001b; Harper, 1995; Lett, 2002; O'Sullivan & McKimm, 2015; Schneider, 1999; Stanley, 2011, 2014; Stanton et al., 2010; Swanwick & McKimm, 2011). Results from this study firmly support and correlate these aspects of the definition of clinical leadership.

Respondents in this study made similar suggestions, with vision still not a dominant feature of the study results. There may be more to understanding clinical leadership than the definitions, adjectives and views offered above, with results from previous studies (Stanley, 2006b, 2006c, 2011, 2014) suggesting that something more significant may be evident and that clinical leaders are

followed because they display “Congruent Leadership” (Stanley, 2006b, 2006c, 2008, 2011, 2014, 2016) where a clinician, who is an expert in their field and who because they are approachable, effective communicators and empowered, are able to act as a role model, motivating others by matching their values and beliefs about professional practice and care with their actions, while they support and guide the work of others (Stanley, 2014, 2016).

The study results are very much in parallel with the earlier definitions and other study findings. Confirming that clinical leaders are not necessarily managers, or in higher positions within an organisation. That it is the professional’s commitment to acting in accord with their values and beliefs, their approachable nature and their commitment to quality and client focused actions that make them stand apart as leaders in their field.

#### **5.4. How to recognise a clinical leader**

The results offer a clear picture of what HPs are looking for in a clinical leader. They seem to be speaking of a person who is an effective communicator, is able to plan and set direction, is clinically competent, has integrity and is approachable. They require clinical leaders to be role models for others in practice and be able to cope with change. They should be supportive, a mentor and motivator who is able to make decisions. Significantly they were clear that they absolutely should not be in a position of control. As such, these results are consistent with a range of other studies looking at clinical leadership attributes for other HP groups (Stanley, 2014, 2016).

In addition, clinical leaders should be visible and involved in team activities, have initiative, be innovative, have a positive impact on standards and use best practice. They should have excellent clinical skills and knowledge, inspire confidence and lead by example. They should also be guided by their values about excellent patient care.

Other terms or functions that may have been expected to be associated with leadership roles such as management responsibilities, creativity and being visionary were selected much less commonly or were seen as unrelated to clinical leadership functions. The absence of “visionary” from the top characteristics indicates that traditional leadership theories such as transformational leadership and situational leadership may not offer a base on which to understand approaches to clinical leadership.

When respondents were asked if they saw themselves as clinical leaders, most (79.2%) said “they did” because they saw themselves as having clinical leadership skills, senior experience, the attributes of clinical leaders, management skills and that they retained links with clinical practice. The results suggested that a deep pool of HPs saw themselves, or were seen by their colleagues as clinical leaders.

A few (20.8%) did not see themselves as clinical leaders because they did not have clinical leadership skills, were not able to access opportunities or time for clinical leadership, because they lacked clinical leadership experience, were too new to the job or frequently because of barriers from management to being clinical leaders.

When asked if respondents thought their colleagues saw them as clinical leaders the percentage was slightly lower at 76.2%. They suggested this was the case because they thought their colleagues saw that they had clinical leadership and management skills, leadership attributes and experience. As well, many suggested that their colleagues respected them and had made this clear to them. They also said it was because people asked for their opinion and advice, because they were approachable and knowledgeable, and because they supported their colleagues. A few (23.8%) suggested that they were not seen as clinical leaders by their colleagues because they were too new or inexperienced in clinical practice. These views again supported the notion that leadership and management functions were different and that management skills were not seen as essential or valued in a clinical leader as much as retaining a clinical focus.

This concept was explored further with respondents asked to indicate the importance of a clinical focus on their clinical leadership effectiveness. Of the 307 that responded, 85.3% agreed that a clinical focus was of value to be an effective clinical leader. The vast majority of respondents suggested that clinical leadership skills and attributes were vital because it allowed an expression in their leadership role of their clinical knowledge, communication skills within the team, that it allowed for leaders to stay in touch and informed or hold a current perspective of the work environment.

A minority of respondents added that while management skills were important they felt management should not be the overriding focus and it was not essential. Managers with “control” were seldom seen in this way and a focus on the skills and attributes identified in question 1 were seen as vital to how a clinical leader was recognised or functioned.

### **5.5. Clinical leadership skills**

A wide range of clinical leadership skills were identified. Answers were offered by 98.7% of respondents, although two skills were identified above all the others, excellence in communication (53.6%) and clinical competence (27.9%) (Table 4). Management skills were suggested by 13.1% of respondents and being fair, trust and integrity were suggested by 12.1% of respondents. Having vision or being visionary was only suggested by 2.6% of respondents. As such, many of the skills suggested equated to and supported the clinical leadership attributes identified above.

### **5.6. Barriers: What is stopping more leadership?**

The majority of respondents (81.4%) indicated that there were barriers hindering their development as effective HP clinical leaders. The types of barriers hinted at included, a lack of time or a high clinical/client demand on their time. This was the strongest barrier identified and was seen as a significant frustration in work by O’Toole, Schoo, and Hernan (2010) who considered why HP staff left work in rural settings. The frustrations seemed to be based on the perception that clinical leadership is grounded in clinical practice and yet it is this very practice activity that is seen to negatively impact upon the implementation of other aspects of clinical leadership.

The second most common barrier was bureaucracy within the workplace. This issue was also identified by WA paramedics (Stanley et al., 2012), with this being the strongest factor identified by paramedics as hindering their progression of clinical leadership. Another barrier was the lack of opportunity to be a clinical leader. This was again confirmed by O’Toole et al. (2010). This barrier is linked to a lack of time or high clinical demand that stifle engagement in activities associated with clinical leadership. It is also linked to other barriers, such as a lack of mentoring (9.6%), part time work (8.8%) and remote area practice or isolation (4.0%). Other barriers included a lack of opportunities to work in a clinical leadership role and a lack of training opportunities (8.0%). Another issue identified by paramedics (Stanley et al., 2012) suggested that HPs in general feel that accessing training for clinical leadership development remains a problem. A number of other issues hindered engagement with clinical leadership including a lack of confidence (7.6%), burnt out (3.2%) or being bullied (2.8%).

For many respondents the barriers were significant and were clearly hindering effective clinical leadership. Addressing some issues, for example, training issues, should be an easy strategy, although it may not yield the greatest results if corresponding organisational culture issues, limitations on staff time or negative staff attitudes or resistance to change are not also addressed. Addressing staff attitudes and the perceived organisational barriers rest on dealing with organisational culture, and shifting these barriers by looking in detail at the organisation’s culture can be an altogether tougher, but ultimately necessary undertaking.

### **5.7. Perceptions, experiences and understanding of clinical leadership**

A main aim of the study was to explore the respondents understanding, perceptions and experiences of clinical leadership. A majority of respondents either agreed or strongly agreed that clinical leaders need to have the skills and resources necessary to perform tasks effectively (93.8%) or to

work well in a team (95.4%). That they need to be able to communicate well, present ideas logically and effectively (97.0%), be flexible and able to improve and respond to a variety of situations with appropriate skills and interventions (94.1%). Many other respondents indicated that clinical leaders need to have a high moral character, know what is right and wrong and act accordingly (90.2%), initiate interventions (87.9%) and recognise optimal performance and express appreciation in a timely manner (84.6%). Indeed, a significant number of respondents saw clinical leaders as needing to be visible in the clinical environment (79.4%) and be willing to take risks for something they believe in, whether for people or ideas (69.3%).

Only 22.2% indicated that for a clinical leader to be effective they needed to be in a management position. Respondents also suggested that clinical leaders needed to encourage initiative and be involved in innovation (96.7%), engage with and lead service improvement (95.7%), lead change (94.1%) and provide staff support (95.1%). Clinical leaders also needed to initiate innovation (93.4%) and influence the way clinical care is delivered (93.8%).

## 6. Conclusion

This study did not attract a large number of respondents, however, valuable data has been offered from a range of HPs that provides a reasonable profile of HPs, with a focus on the five larger HP disciplines (Dietetics, Occupational Therapy, Physiotherapy, Social Work and Speech Pathology) that adds to an understanding of their perception of clinical leadership.

Respondents saw themselves or their colleagues as clinical leaders and recognised them as such because they were effective communicators, clinically competent, approachable, set direction for others, had integrity, acted as role models for others in practice, coped with change and were supportive. HPs sought clinical leaders who had the skills and resources necessary to perform tasks effectively and who worked well in teams. Clinical leaders were valued if they presented ideas logically and effectively, were flexible, had appropriate clinical skills and if they displayed high moral character. They also needed to remain visible in practice, recognise optimal performance and express appreciation in a timely manner. HPs valued clinical leaders who encouraged initiative and innovation, who engaged with and led service improvement, change and influenced the way clinical care was delivered.

Clinical leaders appear not to be followed for their vision or creativity (although they may have these attributes) or their ability to control other staff. Clinical leaders were not recognised because of their position or seniority, but because their beliefs about practice and support for their colleagues were on show and were matched (congruent) with their actions. They built their approach to clinical leadership on a clinically focused foundation and clinical practice that was fundamental to their view of HP practice. As such, they were actively involved in care provision and it is proposed that clinical leaders display Congruent Leadership (Bishop, 2009; Stanley, 2006b, 2006c, 2008, 2011, 2014, 2016).

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### Competing Interests

The authors declare no competing interest.

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