Who Are We? The Role of Team, Professional and Managerial Relationships in Collective Leadership Practices in District Hospitals, Cape Town, South Africa

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Background: Effective healthcare leadership is necessary in engaging with other stakeholders in moving towards universal health coverage (UHC) in Low-and-Middle-Countries (LMICs). To achieve UHC, hospitals are important in the provision of quality people-centred healthcare. Hospitals are complex social systems, where leadership is a collective phenomenon, practiced by different healthcare cadres. In such environments professional, work and social identities at group, relational and organisational levels are likely to influence how leadership is practiced. A rich evidence base, and relevant theorisation, is needed to understand the nature and consequences of leadership practices in LMICs. Yet, hospital leadership has rarely been studied in South Africa. This paper presents findings from a qualitative study on healthcare organisational context, leadership practices and effective leadership in district hospitals in Cape Town.

Methods: We used qualitative approaches to data collection in two case study district hospitals. We had a total of 42 in-depth interviews and two focus group discussions. We also attended management meetings, made observations in different areas, and reviewed internal memos and letters of relevance to the leadership practices within the hospitals. Our respondents included clinicians, nurses, allied health workers, frontline workers and administrators at various levels of management. Our analysis was both inductive and deductive to explore and explain emerging issues about collective leadership practices in hospitals.

Results: Our study revealed that respondents emphasised their roles as clinicians and nurses first and as leaders, second; and that work team, professional and managerial identity and relationships are critical to leadership practices, and their likely influence on staff motivation. Respondents linked collective leadership practices and relationships to the common goal of providing healthcare services. Senior clinicians were aware of their professional identity and had loyalty to, and collegial relationships with junior clinicians. Professional identity and pride among clinicians allowed them to exercise their leadership practices in a collective manner and they considered themselves more motivated as compared to their nursing colleagues. Nurses in management positions also viewed the transfer of leadership and professional skills to colleagues as an important way of sharing professional experiences. However, junior nurses viewed the professional hierarchies in nursing as giving them fewer opportunities to participate in collective leadership and saw this as undermining their motivation. In addition, the structuring of management into junior, middle, and senior levels depicted management identities within the hospital that created barriers to relationship building and collective leadership practices.

Conclusion: Clinicians and nurses hold dual professional identities in hospitals and this influences their leadership practices. Collective leadership practices have influences over healthcare worker motivation. To build leadership practices that are inclusive, policymakers and practitioners should aim at deliberate efforts to consider team, professional and managerial differences when designing and implementing leadership development programmes within the hospital as both a physical and enacted context where leadership practices are situated.