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The Role of NHS Leaders in Times of Austerity

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Abstract

This paper evaluates the role of leadership in the NHS in times of austerity, times that are characterised by budgetary cuts and privatisation. As state employees, the role of today's NHS leaders is to enforce austerity measures by administering thought and praxis, socially reproducing, at microlevels, ideologies and politics that are circumscribed by the government that employs them. The paper inspects the moral worth of NHS leaders and the mechanisms they utilise upon the workforce to enable them to take forward austerity, that is, to fulfill their role.

Introduction

The current UK economic situation precipitates the need to enquire into the role of the public sector leader in times of austerity who oversees the ability to provide services for the population endangered by the economic burden. The paramount assertions, established to guide the discussion, surround concepts of moral leadership. Gini (Gini, 1997) asserted that: "all leadership, whether good or bad, is moral leadership at the descriptive if not the normative level." He also stressed that leadership is "ideologically driven or motivated" and hence, leaders hold an "agenda" as well as certain "values" and "beliefs." Public sector organisations are subordinated to, and realise the objectives of, state power. Consequently, this paper defines public sector leaders as state employees who are financially retributed for meeting those objectives. This means a contractual and financial relationship where the leader delivers politics that materialise, inevitably, through the manual and intellectual labour of others. The current financial retribution to leaders, for example, in the NHS, escalates up to a quarter of a million pounds. Such is the case for Maggie Boyle (Leeds NHS Trust) or Robert Naylor (UCLH London); for others, the minimum pay might be circa £130,000 which compares with Prime Minister David Cameron's salary. Money consolidates power. These figures not only represent an incentive for efficient performance, but they also demonstrate the

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inappropriate extent of a public service hierarchical structure and the remoteness of leaders' living standards in comparison with their subordinates.

Austerity as Maxim

The ideological force that drives a leader's performance is enacted by the government while the salary received plays a substantial motivating part. It is argued that the government, their agency, conceives Kant's categorical imperative (Kant et al., 1993) of "Act only on that maxim through which you can at the same time will that it should become a universal law" as a regulation for the social reproduction of their politics. By this, it is not intended to award the current state with a high moral status; on the contrary, the government, as guardian of the capitalist system, appeals to the categorical imperative in a Kantian fashion, understood as their urgency for permanent reproduction (Boisier 2005). However, their ideas and ideals are discursively articulated to the populous in terms of maxims. Consistently, leaders recreate government politics within their territoriality conforming, at the same time, to Kant's hypothetical imperative that is conditioned by personal motives, named (within others) by their salaries.

As capitalism collapses into an imposed age of austerity marked by fiscal budgetary cuts, the disappearance of public services, and job losses, the current Conservative-Liberal government's "Big Society" initiative aims to decentralise power and finances. By this, the state disengages from the responsibility of public services provision and administration "under the illusion of local empowerment" (Grint & Holt, 2011). Austerity measures, *per se*, embody a larger global project of perpetrating capitalist relationships of production within the government's logic; these measures are aimed to rescue the market economy. These procedures cascade through all aspects of social life and are particularly noticed within public services. Leaders, as the higher authorities of institutions and paid workers of the state are, indisputably, responsible for implementing and enforcing austerity within their respective jurisdictions.

Farewell to Morals

In the contemporary context of cuts and reform of public services, Pollit (Pollitt, 2010) asserted that leaders must consider the ethical issues of pretending that "cuts will not hurt anyone" and the legitimacy in terms of convincing the population of the rationality and social justice of such measures. As he points out, the latter would present a 'legitimacy crisis' requiring a more elaborated rational and strategy. Pollit proposal is part of the broader implications of medical leadership; Chervenak's (Chervenak & McCullough, 2001) work on the moral foundations of physicians' leaders would provide the basis for discussing the moral nature of current NHS leaders that enables them to undertake their role in these times of austerity.

NHS leaders are trained and shaped to serve organisational purposes. The NHS Leadership Academy is the body responsible for professionalising and developing "outstanding leadership in health." The Leadership Qualities Framework (LQF), a main document that defines certain domains and behaviours, has been designed by the Hay Group, a global management consulting company with long-standing services to multinational clients. Dismembering the framework invokes a four- staged progression system that ranges from individual team practice to that contained within a national level

position (it also provides a variation for the Clinical and Medical arenas). The seven LGF domains include personal qualities; they comprise business appropriate themes such as working with others, improving and managing services, creating vision, setting direction, and delivering the strategy. Each domain is further subdivided into descriptors entailing behaviours, skills, knowledge, and attitudes that must be attained (Leadership Qualities Framework 2012). The LQF is simply a tailored made framework based on innumerable business models that leaves behind the complications of moral values that are pertinent to social professions. Furthermore, the stipulated differences between managerial, clinical, and medical areas are simply an inadequate and false paradigm when referencing a public service.

It is useful to enquire into the moral values that leaders in the health profession should possess, Chervenak's work initiates this discussion by quoting Plato for whom a leader is one "who commits himself and is trained for a life of service and devotion to fellow citizens" (Plato 1997 in Chervenak and McCullough, 2001). He also asserts that the role of leaders is to shape an organisational culture that supports fiduciary professionalism. Moral leadership values are, therefore, the foundations of any management decisions in medical settings that enable doctors and health care workers to be the "moral fiduciary of the patient." He describes a set of virtues given by Gregory and Percival (McCullough 1998 in Chervenak & McCullough, 2001) that must guide medical leadership; three of these are of particular interest and are explained in a doctor-patient and leader-subordinate context:

1. Self-Sacrifice. The leader must risk his own job security to meet patients' needs and enable workers to maintain their fiduciary role to patients.
2. Compassion. With regard to patients and employees, leaders need to challenge cuts which culminate in emotional stress to employees' families derived from resulting financial hardship.
3. Integrity. The leader's decisions must be based on scientific evidence and he must balance economic judgements in relation to workers and resources (Chervenak and McCullough, 2001).

It is notable that the LQF does not enlist the personal qualities that Chervenak enumerates as required for leadership. Although "acting with integrity" is desired, it is classified as a behaviour that entails undefined personal ethics and values surrounded by communicational skills and the ever present respect for diversity. The absence of notions of morality within the scheme that prepares leaders for such important institutions as the NHS – an institution responsible for overseeing the well-being of the population – generates the need to question the very essence of this organisation..

A Leader's Compromised Morality?

If these values are not present, indoctrinated by training or taken into account for appointment, or in the daily performance of leaders, then, what other values are being articulated and envisioned for leaders? Chervenak continues his work by presenting the corresponding vices to the previously named virtues. He offers some examples accompanied by an illustration of what they might mean in practice. *Self-Sacrifice* is compromised when a leader denies expenditure on equipment and services while securing his/her own salary, or by failing to advocate fair earnings for subordinates even if higher than that of the leader. *Compassion* is dishonoured by being "indifferent to the

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suffering and distress of patients” or by implementing “salary freezes and reductions” of employees in order to meet financial targets. *Integrity* is compromised through actions ranging from the early release of patients to moral organisational statements that seldom pertain to the leader’s own behaviour.

Guiding this discussion of the notions of moral leadership is the assertion that today’s NHS leaders have overruled the core virtues of the medical profession by adopting the government agenda as their own. They do this by materialising these vices through cuts in services and staff, pay freezes or privatisation– all of which are reflected in deleterious social consequences. It is appropriate to suggest that altruistic moral values are not endemic to trained NHS leaders and that as paid workers, they fulfill their total responsibilities by implementing the government economic plan. Responding to the posed question, it is valid to state that, perhaps, it is not values that are sought in leaders but the very same abilities as those desired in executive positions in the profit-making private sector.

As previously mentioned, the plans of a *Big Society* involve redistributing power and finances within a named localisation, jurisdiction, or territory where “leaders” are to implement austerity. It is assumed that, up to a certain extent, the NHS workforce – and in particular those of lower rank and pay – have secured such employment on the underlying basis of engaging a particular set of personal and collective altruistic values. The leaders and the workforce are both participants in a system of social relations within the field (the organisation); the moral imbalance represents an often silent conflict of interests. Nevertheless, NHS local bodies are still able to execute reforms deemed amoral. But these could only be materialised when workers – the leader’s subordinates – engage with the project through every thinkable task. The collision of interest between leaders and middle managers, and so forth down the structure, does not disappear; instead, it is dissipated through a series of mechanisms used by leaders in order to achieve their objectives. By this, it is not only the leaders who move the institution away from moral frameworks, but the workers at large gradually contribute as well.

The Health Worker: Another Brick in the Wall

The first mechanism that leaders might use to engage the workforce with amoral labour is the process of dehumanisation of medical practice. Haque (Haque & Waytz, 2012) asserts that the modern characteristics of hospital’s organisations facilitate this process. He explains the causes, arguing that several are strictly related to the working environment.

1. **Mechanisation** objectivises the patient into parts to be treated; they become depersonalised and are viewed as unable of experiencing emotion.
2. **Empathy Reduction**, which is initially instilled in medical school, reduces stress, hence enhancing problem-solving abilities. Evidence has been provided by a study showing that empathy in doctors decreases proportionally to the time spent working in hospitals (Haque and Waytz, 2012).
3. **Moral Disengagement** (discussed in more detail *infra*) is required when inflicting unavoidable pain treating a patient; health care workers suppress feelings of self-guilt which drives workers to regard patients as incapable of feeling pain. It has

been suggested that the dehumanisation process provides permission to suspend moral values and, by doing so, validate immoral actions (Bandura, 2002 in Haque & Waytz, 2012).

The second mechanism exists in the leader, a normally charismatic one, who induces subordinates to commit “crimes of obedience” (Beu & Buckley, 2004) by utilising his/her political skills. Crimes of obedience are those actions classed as illegal or immoral by society that are committed by obeying authority (Kelman & Hamilton, 1989 in Beu & Buckley, 2004) even if one does not agree with the action itself. At both the personal and collective level, the predicament rests in the obligation to abide or to reject. Tactically, there are a diversity of techniques and processes that leaders institutionalise:

1. **Moral Disengagement**, in the context of labour, consists of several psychological techniques. For example, when workers are unaware of the social consequences, then moral dilemmas fail to arise. However, when such consciousness is present, the leader validates actions by reclassifying them as “acceptable practices.” The organisational “vision” and loyalty to the institution might be used to overrule individual moral values (Kelman and Hamilton, 1989 in Beu & Buckley, 2004), further providing justification for amoral actions.
2. **Framing Conduct** is another tactic whereby leaders are able to define the “reality” of workers (Smircich & Morgan, 1982 in Beu & Buckley, 2004). This is accomplished through the use of language and the re-naming of activities that disclaim workers of moral responsibility in order for the amoral to present itself as benevolent (Bandura, 1991a, 1991b in Beu & Buckley, 2004). Through division of labour, the “organisational structure” morally disengages workers (Bandura, 1991a, 1991b in Beu & Buckley, 2004), as perfunctory work patterns alleviate resistance to unethical practices (Kelman & Hamilton, 1989 in Beu & Buckley, 2004).

These mechanisms and techniques, involved in the manipulation of workers, are, perhaps, a more frank description of what commercial leadership theory pretends to preach and sells as a viable conduct. As much as a public sector leader should be something very close to what Plato proposed, the reality is quite different: public services in the UK are directed by men and women with an unashamed scarcity of moral values.

Reproducing the Politics of Austerity

The social and financial power attributed to public health leaders enables them to exercise symbolic violence (Bourdieu and Passeron, 1990) upon their subordinates; this further enables the “production of beliefs,” which, in turn, produces “agents” that assimilate discourse and obedience (Bourdieu, 1985). Through this process, leaders administer thought and concepts that converge into praxis by the daily labour of others. This strategy allows for the disintegration of individually and collectively constructed moral frameworks pertinent to the just health care worker, entering a continuous phase of acculturation that responds to the economic need of the on-call government. Workers’ values are metamorphosised to a scale that permits emergent conceptions to be socially reproduced within and beyond organisational frontiers. Through processes of dehumanisation and the induction of employees to commit crimes of obedience, health care workers are disenfranchised and stripped of their professional worth. While it could be argued that workers seldom possess power to prevent such a process of

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dehumanisation, they ostensibly are still accountable for their ethical behaviour — or lack thereof.

The role of public sector leaders is to implement reforms and measures that are dictated by governments in power, and hence respond to a predetermined national project. Such current reforms seem to inhumanly contradict the very nature and purpose of the NHS. By inspecting the amorality of leaders it is argued that, through the systematic and sustainable application of mechanisms of power, they are able to consistently reproduce the politics of austerity at micro geographical levels. Decentralisation of power and finances facilitates this reproduction. According to Kant's categorical imperative, the social reproduction of governmental policies is consistent with conceiving each of them as part of an ideological package. In this manner, behaviours and measures are expected to be universalised. It could be suggested that leaders, as individual agents, are intersected between the commands of the categorical imperative and the hypothetical imperative with high salaries acting as the prime motivating catalyst.

Conclusions

This paper has moved away from conceptualised corporate definitions of leaders asserting the contractual transaction between government and paid employee. It has evaluated their roles by assessing their moral foundations and has discussed the means that leaders likely utilise to meet their objectives. This has helped to assume a more necessary and abstract perspective to explain how they articulate austerity measures within their own territorialities.

It has been argued that the role of public sector leaders is to administer thought and praxis that would socially reproduce ideologies and politics within their respective jurisdictions; these ideologies are circumscribed by the national project of contemporary austerity. Managing the national project at the micro level is rewarded highly and to such extent that it is incommensurable with respect to the majority of the workforce governed and alien to constructs of leadership as public servitude.

The NHS Leadership Qualities Framework serves the purpose of training efficient agents that would not comply, under any conditions, with the high commands emanating from the government. The framework allows the inspection of leadership behaviours to be judged, *per se*, in a business fashion. But most importantly, it is the evident vacuum of moral ideals that permits leaders to regard it as a meagre operational handbook.

A leader has duties because he or she has rights. Those social duties should involve a set of virtues that have been discussed through Chervenak's work on medical leadership; instead, it is the leadership's vices that emerge undisguised as a result of austerity prescriptions. On a higher level of reason, Price (Price, 2008) already discussed the relationship between Kant's categorical imperative and leaders, asserting that they, even under any change of circumstances, are not excused from the imperative's authority and should not use subordinates to meet their ends. The NHS continues to distance itself further from the role of moral fiduciary of patients. While leaders enforce austerity, they are also manufacturing moral austerity within the workforce. The moral condition of the healthcare workers is, or should be, deeply troubled because these leaders still carry the full weight of responsibility for committing crimes of obedience.

Remaining in this discussion is the question of how to breed a new generation of true cadres leaders who are able to recover the moral foundations of healthcare and return the sense of social justice to the NHS. This invokes the need to return austerity of leaders' salaries to the point that disables the poisonous hypothetical imperative, thereby forcing them to be purely servants of society.

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