Contingency theories of leadership: how might we use them in clinical practice?

This article explores how contingency theories of leadership (pragmatic theories that note 'no one size fits all') can be used by multidisciplinary health-care teams to improve communication and patient care.

Large organizations and systems, such as the UK NHS which has multiple hospitals and community organizations across the country, each with multiple departments run by multiple individuals, require flexible leadership approaches. A 'one size fits all' approach to leadership and management is unlikely to be effective, particularly in a rapidly changing, volatile environment. Thus the ability to deploy different leadership and management approaches at different times in response to different situations is an important skill for clinical leaders to possess.

The original concept underpinning contingency theories was fairly simple and pragmatic in that leaders were advised to take different approaches or adopt different styles of leadership contingent on the situation or context. While this may seem obvious, many leaders and managers struggle to maintain this flexibility and adaptability when the clinical environment is tough and busy. This article considers how an understanding of contingency theories can help leaders bring perspective and control to situations, as well as some of the limitations of this approach.

What are contingency theories?

Contingency is defined as a 'future event or circumstance which is possible but cannot be predicted with certainty' (Oxford Dictionaries, 2015). Contingency theories (also known as context theories and situational leadership) therefore propose that there is no single best method for leadership, rather the situation will dictate the style and methodologies that need to be used, drawing on a toolkit of styles relevant to the context and followers at the time (McKimm and Phillips, 2009). This article considers contingency theories in relation to leadership at three levels:

1. That of the individual leader
2. Leadership of groups and teams
3. That of organizations or systems.

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Contingency theories and the individual leader

At an individual level, leaders need not only to be willing to be flexible and adaptable, but also to consider future possibilities and prepare for them. Leaders who use contingency theories take account of unique situations and individual circumstances and consider which particular aspects of a situation might require more thought, different management and additional input.

Fiedler (1964) was one of the first theorists to describe contingency theories. He suggests that the most effective leadership styles take account of the situation or task across three dimensions:

1. The task structure – leaders make sure the task is clear and well defined
2. Leaders understand and can use their positional power or degree of authority
3. They understand the importance of leader–follower relationships and have the respect of their followers.

Hersey and Blanchard's 'situational leadership' model (1977) takes this further by explaining why different approaches are needed in supervision or management depending on people's competence (ability, knowledge and skills) and commitment (confidence and motivation) (*Table 1*).

In situational leadership, effective leaders need to be versatile and consider several factors before choosing an appropriate leadership style: the nature of the task, how well group members work together and work with the leader, and the level of experience, commitment and readiness of the followers. Everyone has a preferred style of leadership, but understanding that people and groups need different approaches helps the leader be more effective.

A number of interpretations and variations on contingency theory exist because the underpinning concept of contingency theories is that there is no one single leadership style or characteristics of followers. In effect each situation is unique and therefore the style and approach to a situation must also be tailored and adaptive. This requires a flexible approach in which leaders should actively seek feedback on their performance and approach and whether this could be improved. A good leader will

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Table 1. Hersey and Blanchard's situational leadership model

Follower's development level	Leader's style or approach	What leaders might do
D1 – Low competence, high commitment	Directing High directive, low supportive	Provide specific instructions and closely supervise performance
D2 – Some competence, high commitment	Coaching High directive, high supportive	Explain decisions and provide opportunities for clarification
D3 – Moderate/high competence, low commitment	Supporting Low directive, high supportive	Share ideas and facilitate joint decision-making
D4 – High competence, high commitment	Delegating Low directive, low supportive	Turn over responsibility for decisions and their implementation

always have a 'plan B' in his/her mind should a change of direction or a different approach be required. Doctors use contingency theories in their day-to-day practice without labelling them as such. Clinical practice and training (e.g. when moving from job to job) by its nature needs a flexible, reflective approach, so actively translating these day-to-day professional behaviours into the leadership arena will help the leader deal more effectively with a variety of people and situations.

Team working and contingency theory

The leader can use contingency approaches when working with teams as well as with individuals, balancing the needs of the task with the competence and confidence of individuals and the way the team functions. Contingency theories also help our understanding of team working in terms of the relationship between different teams, and between teams and the organizational or external environment.

One way of applying contingency theory to team working is through the way people are socialized into their profession, cultures or organization. This helps us understand similarity and difference and how to work with people from very different backgrounds or professional disciplines. Feldman (1981) considers three distinct aspects of organizational socialization:

1. Development of skills and capabilities
2. Acquisition of appropriate role behaviours
3. Adjustment to the group's norms and values.

Medical teams need to demonstrate highly developed professional skills and capabilities. Whereas a lack of knowledge and procedural competencies may not typically be the reason for poor patient care, learners and those moving into new roles or organizations may well have to learn or develop new skills and capabilities. Delivery of care is therefore contingent on the team (and the individuals who comprise it) having the abilities to carry out required tasks. A good clinical leader will recognize when there are gaps and give time and space for learning to occur or will ask for additional help and not try to struggle on.

Role behaviours can be another source of difficulty, for example when individuals are unsure about their role in the team (role confusion) or where there is conflict between people's roles. The leader's role is to clarify team goals, define each individual's role in achieving the goal and support people to work well together. Stereotyping of certain groups or teams may also contribute to conflict. If a team thinks that one group will behave in a particular way (possibly being antagonistic or negative towards them) they might then expect them to do or not do certain things. This can result in a devaluing of future potential input, evoking unhelpful responses and perpetuating the stereotype (Maguire and Pitceathly, 2004). The leader's role is to challenge such stereotyping and encourage team members to be tolerant and welcoming of diversity and difference: this is 'inclusive leadership'.

The third aspect leaders need to consider is how team members adjust and contribute to team norms and values. What one group or individual perceives to be reasonable and necessary, another may not, and so requests or actions may need to be justified and effectively communicated so that all those involved can see the value and need for the task, rather than obstructing it. Effective communication within and between teams is imperative. A good leader will clarify and discuss ways of working and values, and foster productive dialogue or 'creative conflict' with a view to obtaining different views to inform and enhance a proposed course of action.

Most health-care teams work interdependently (e.g. on patient discharge or with complex, frail elderly patients) but are often located in separate departments or units. When these teams are well aligned with one another and with the system or environment (i.e. there is a good 'fit'), they can perform well, both within their own spheres of influence as well as on activities carried out between teams and across professional or system boundaries.

Some interdependent multidisciplinary teams work very effectively to coordinate the input from one professional group to another, ensuring clear working practices and smooth patient pathways. However, this is not always the case and poor communication and failure of collaboration can result in detriment to the patient. While teams may fully intend to collaborate with one another to provide optimal patient care, the reality is much messier and often multiple teams or 'tribes' seem to work independently of each other. If there is a poor alignment or fit, then the benefits from interdependent working can be lost, particularly in terms

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KEY POINTS

- Contingency theories argue that no single method or leadership theory can be relied on for all situations.
- Leaders need to be able to draw on multiple leadership tools.
- Contingency theories are useful to consider how different groups and individuals might respond to different leadership styles and what approach to take.
- A leader needs to be aware of emerging and changing clinical situations, and be prepared to adapt to changes quickly and flexibly.
- Effective communication within and between teams is essential for a leader using contingency theory, ensuring the correct approach is taken, tailored to different interdisciplinary groups.
- There is no gold standard or 'one size fits all' on how to lead.

of enabling individuals and groups to improve the patient experience and health outcomes (Hollenbeck et al, 2002). The role of the leader is to work across tribal boundaries, to provide a 'sense-making' or translational role for their own team members and those in other teams and be prepared to adapt their style or approach depending on the different task, situation or teams involved.

Being able to bridge the 'gaps' between different health professions and other disciplines and ensuring these different tribes are all focussed on the most important goals, rather than fighting between themselves, is an essential leadership skill. Contingency theory argues the need to be flexible and adaptive, recognizing the needs and capabilities of different groups, and that responding in a particular manner to one group may not be met with the same results as if one responded the same way to another group.

Contingency theory, organizations and systems

At the organizational level, these theories help us think about the most relevant organizational design and structure in relation to the environment. Morgan (2001) reminds us that the aim is to achieve a 'good fit' between the organization and the external environment. Organizations are open, complex and dynamic systems which require careful management to maintain equilibrium between the internal needs of the organization and stakeholders and the changing external environment and pressures. However, the need to adapt appropriately while retaining internal stability is challenging.

A useful tool that helps leaders analyse the complex external environment is the PESTLE (PEST, PESTEL or PESTELI) model. The model reminds leaders to keep the political, economic, social, technological, legal and environmental change drivers in mind and provides a means of analysing how such drivers might impact on the organization's activities, particularly when major changes are planned (Yüksel, 2012). Such analysis can also help leaders to consider the nature, activities and power of interdependent groups within health systems that are striving for continuing improvement alongside technological advances and shifts in the burden and patterns of disease. Leaders taking a contingency approach may well use more sophisticated scenario planning and modelling tools to simulate the impact of such diverse factors as climate change, changes in the economy, political shifts, and changing consumer demands and supply availability (Van de Ven et al, 2013). Modelling future patient and community needs and demands using economic, demographic and epidemiological data (e.g. in relation to an ageing and multi-racial population) can help to identify trends which in turn can inform the design and implementation of health and other services.

Limitations of contingency theory

One of the main limitations of contingency theories is that they are very general and it is sometimes hard to see their practical benefit. Therein lies the paradox, leaders looking for 'the answers' won't find them in contingency theories alone, but need to be aware of and be able to apply a variety of tools, approaches and theories. This is what contingency theories tell us. Some models have a 'guide' or 'step-by-step' approach to change such as Kotter's eight-step approach to change (Kotter, 1995) or Bass and Avolio's approach to transformational leadership (Bass and Avolio, 1993). These can be helpful, but leaders need to understand when they might be most useful and relevant. To overcome these limitations, leaders need to be able to identify the strengths and weaknesses of the organization, the external pressures and challenges, and acquire and select the right management skills and tools to guide the organization through change. The 'right tools' are those which give consistent results, are relevant and accessible and have a proven track record of delivering desirable outcomes within a particular field and application (Rigby, 2001; Hoffmann et al, 2004).

Contingency theories consider how an organization behaves, the structural design, performance outcomes and how planning and management strategies work (Van de Ven and Drazin, 1984). The theories have been criticized for lacking clarity in their theoretical statements and embedding assumptions within the theory and its application (Schoonhoven, 1981). That aside, one of the main limitations is that the theories tend to downplay the complexity of relationships between technology, structure and organizational effectiveness, and that while individual and group behaviours may have some predictable elements, they also have agency and autonomy (Almond, 1960). This is where theories such as complexity and systems theories are more helpful in guiding leaders as to the approach to take (McKimm and Till, 2015). For example, individuals with autonomy, in an environment where they are allowed to adapt and adjust practices, will sustain a situation and environmental pressure for a longer period of time and show greater resilience (Nelson et al, 2007).

Conclusions

Contingency theories provide a useful reminder that a static or inflexible leadership style will not be effective in

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today's clinical environment which is exposed to an array of internal and external pressures and demands. Leaders need to be aware of and keep pace with changes and developments in wider public services and the external environment. They also need to recognize that services and patterns of care will continually require review and reconfiguration. Being able to model and predict scenarios can be useful, but they often fail to take account of all the variables and so leaders need to have some contingency plans in place. Finally, from a personal perspective, keeping in mind that authentic leadership (being yourself with your own values) is important and that there is no one 'right way' to lead can be very reassuring. **BJHM**

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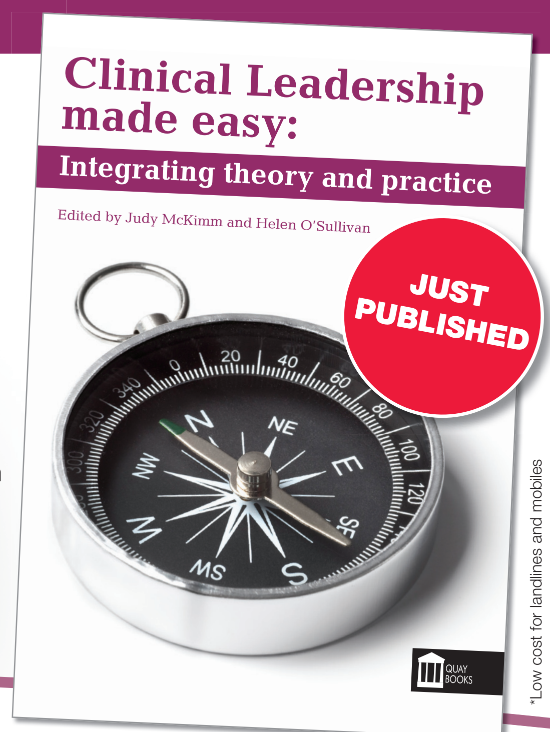

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