Perceptions of Clinical Leadership in the St. John Ambulance Service in WA

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Abstract

Introduction:

This article outlines a study aimed at identifying how clinical leadership is perceived by paramedics and ambulance personnel and the effectiveness and consequences of the application of clinical leadership in out-of-hospital care delivery. The research was conducted in Western Australia with a questionnaire distributed via in-service training sessions to St. John Ambulance operational staff between February 2010 and November 2010.

Problem:

To identify how clinical leadership is perceived by paramedics in the course of their everyday work and the effectiveness and consequences of the application of clinical leadership in out-of-hospital care delivery.

Methods

A questionnaire was distributed via in-service training sessions to St. John Ambulance operational staff in WA between February 2010 and November 2010 (n = 250). The methodological principals of the study were based on phenomenology, with a mixed methods approach. Analysis of the quantitative data was via SPSS software and the qualitative data was analysed by spread sheet and word documents.

Results

Most respondents recognised that clinical leaders were involved in team work, the generation of new ideas, effective communication and involved others appropriately. While clinical experience was valued highly, research skills or qualifications were less well recognised as an aspect of a clinical leader. What mattered was that the values of the clinical leaders were matched by their actions and abilities. Many saw clinical leaders as teachers or guides. Most saw clinical leaders as able to influence care, but only half recognised their ability to influence organisational issues. Clinical leaders were seen to be visible role models, clinically experienced, approachable, knowledgeable, driven by their desire to provide high quality care and change practice. They were seen to be team members who make decisions often under pressure.

Conclusion:

It is hoped that with a better understanding clinical leadership and how it is perceived by paramedics and ambulance officers they will be able to play a more effective part in service improvement, the implementation of a quality agenda and impact positively on out-of-hospital care delivery. As well, a better understanding of clinical leadership may support a more responsive and effective ambulance service where the focus can remain on the clinical aspects of the paramedic's role.

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Introduction

This paper outlines the rationale, literature review, research methodology, results and discussion from a study aimed at identifying how clinical leadership is perceived by paramedics and ambulance personnel in the course of their everyday work and the effectiveness and consequences of the application of clinical leadership in out-of-hospital care delivery. The research was conducted in Western Australia with a questionnaire distributed via in-service training sessions to St. John Ambulance operational staff between February 2010 and November 2010.

Background

Many leadership theories have developed primarily from management paradigms. However, these theories may be ineffective in helping clinical leaders amongst paramedic practitioners to gain an insight into clinical leadership or to develop and implement clinical leadership skills. It is important to recognise that leadership theories based on the management paradigm may not be appropriate for all clinical applications. Clinical team leaders are experienced paramedics that are employed to shape and influence out-of-hospital health service care through effective clinical leadership. It was proposed that by exploring paramedics perceptions of clinical leadership, ambulance services would be well equipped to provide strong clinical leadership behaviours that are consistent with leadership qualities and create an enabling culture for managing complex change and quality health improvement.

The rationales for the study are that leadership related to paramedics is poorly documented and there is almost no specific research related to paramedics and clinical leadership. Therefore, gaps appear in what is known about the concept of clinical leadership and its application within the ambulance service. As well, when leadership is studied or written about, it is often based on management or leadership principles developed from the management domain, leading to further misconceptions about the relationship of leadership to clinical/professional functions.

In addition, education and the development of future paramedic leaders should be based on a clear understanding of the concept of clinical leadership. Without further investigation it is likely that all paramedic education will do is propagate the misconceptions and fill knowledge gaps with inappropriate 'management' based concepts that may fail to support the growth of clinical leaders for the future.

Context

St John Ambulance WA Incorporated provides ambulance services to all of Western Australia through either paid or volunteer staff. This study examined the perceptions of paid ambulance service staff who attended in-service education sessions between February 2010 and November 2010.

Aims and Objectives

Aims

The aim of the study was to:

> Identify how clinical leadership is perceived by paramedics in the course of their everyday work and the effectiveness and consequences of the application of clinical leadership in out-of-hospital care delivery.

Objectives

The objectives of the study were:

1. To identify who the clinical leaders were in the ambulance service.
2. To identify the attributes and characteristics of clinical leaders in out-of-hospital care.
3. To identify clinical leadership skill sets/practices/elements that influence effective out-of-hospital care.
4. To explore recommendations for understanding and improving the application of clinical leadership in the St. John's Ambulance Service in WA.

Literature Review

The literature search began with the consultation of a wide range of journals and books, previous research papers and Government documents. Searches were made of the terms: 'Clinical Leadership,' 'Paramedic Leadership,' 'Pre-Hospital Care Leadership,' and 'Ambulance Service Leadership'.

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, the service improvement agenda in the Western Australian Department of Health, organisational structure and culture, health professional boundaries and their relationship to leadership roles within health care, authority, emergency service systems and power.

The literature considered for this research was accessed via library databases and included, MEDLINE, ProQuest, CINAHL, EMBASE, Allied and Complementary Medicine (AMED), Your Journals @ Ovid and Journals @ Ovid Full Text. 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 in the early 1990's to limit the volume of information gathered. As well, a number of websites were accessed for additional or supporting information. Some of the literature discovered was arrived at in a serendipitous fashion during random journal searches or from contacts with professional colleagues. No specific country was excluded from the search, although much of the literature originates from Australia, the United Kingdom, the United States of America and New Zealand.

Leadership and Clinical Leadership

There is very little literature related to paramedic leadership and nothing at all could be found of an empirical nature related to paramedics and clinical leadership.

It is important to note that much of the literature reviewed uses the terms 'leadership' and 'management' interchangeably with little attempt to define either term[1,2,3,4] and as a result, much of it fails to clarify who the leaders are, other than deference to their hierarchical position. The pool of information related to clinical leadership from a paramedic clinical or out-of-hospital activity/care intervention perspective is therefore very shallow and in dire 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 and Schneider (1994) conclude that a clinical leader is an expert in their field and that expertise and knowledge should be used to lead reform.[5,6] These views are supported by Stanton, Lemer and Mountford (2010) who wrote from a medical perspective and add empowerment and confidence to the definition so that clinical staff can improve the quality of health care.[7] Malcolm et al. (2003) (writing about doctors in New Zealand) see clinical leaders as partners with other health professionals, acting to promote the best care for the patient indicating 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.[8]

From a nursing perspective, a few empirically based studies were identified. Of these three investigated clinical nurse leadership[9,10,11,12,13] while one explored the balance between the clinical and managerial roles of ward leaders.[14]

Christian and Norman (1998) investigated clinical leadership as part of a comprehensive evaluation of twenty-eight Nursing Development Units (NDU) in England, concluding that there was considerable conflict that existed between the clinical leaders' managerial responsibilities and their leadership potential.[9] Those clinical leaders low in the organisational hierarchy suggested that they did not have the authority to make their leadership vision a reality. While those with managerial responsibility and therefore some authority felt they couldn't extricate themselves from the day-to-day management to be able to think strategically and lead the NDU. Christian and Norman suggested that the clinical leader's role required re-evaluation.[9]

Cook (2001c) explored clinical leadership from the perspective of a critical examination of the nursing leadership themes from the United Kingdom (UK), United States of America (USA) and Australian nursing literature as well as a set of five interviews with clinical leaders in the UK and a study tour of the USA and Australia.[10] Cook (2001b) concluded that while leadership was seen as important and that it impacted directly on the standard of care, the application and type of clinical nurse leadership varied from country to country.[11]

The most recent and largest study[12,13,14] explored who the clinical leaders were within one large NHS Trust in the UK and explored the experience of being a clinical leader. This study found that clinical leaders were present in significant numbers and that they existed across all levels of staff, but they were rarely seen in senior clinical or management roles. The study also showed that contemporary leadership theories failed to explain why clinical leaders were followed. It led to the development of a new leadership theory "Congruent Leadership."[12,13,14]

In relation to paramedic practice and clinical leadership there is significantly less empirical data. There is much written describing the executive level leadership involvement in the ambulance service, but very little about leadership at a clinical level. From the UK, Woollard (2006) outlined the role of the Paramedic Practitioner and implied that clinical leadership is increasingly featured in this developing role.[15] While Stirling et al. (2007) and Cooper et al. (2004) in a similar vein to Woollard[16,17,18] describe the expanded roles that paramedics are being asked to take and suggest these roles require paramedics to develop greater leadership responsibilities. However, none of the articles define or explicitly mentions clinical leadership as a feature of the paramedics skill set.

The net result of the literature search was that while more is being written about clinical leadership in the health service, there is limited research related to clinical leadership from a paramedic perspective.

Figure 1: Research Process Summary

1. Literature review, in parallel with all other parts of the study.

Focused on:
78 Leadership
79 Clinical leadership
80 Organisational culture
81 Nurse leadership
82 Ward leadership
83 Change
84 Authority
85 Power
86 Paramedic Leadership

→

2. Curtin Ethical Approval

Questionnaire and introduction letter development.
Approval gained: 8/1/2010

→

3. Questionnaire.

All paramedics employed in the St. John Ambulance service (paid Staff) were offered a copy of the questionnaire if they attended in service training between Feb 2010 and Nov 2010.

The questionnaire was accompanied by a letter explaining the research aims / questionnaire / issues of confidentiality and how to complete and return the questionnaire

→

4. Questionnaire Analysis

Used SPSS and spread sheet to analyse the questionnaire data
Return Rate 41.6%

→

5. Results and Discussion.

Literature and the results from the questionnaires were used to illuminate and analyse the issues of clinical leadership in the ambulance service. Provided in this report and subsequent publications.

Recommendations are also made regarding the implications of the data in this report.

Study Design

Research Process

The research process is set out in Figure 1. The questionnaire used was specifically designed for this study although it is a modified version of a questionnaire used to explore clinical nurse leadership in the UK.[34] The main purpose of the questionnaire was to identify who the clinical leaders are in the ambulance service, to identify the attributes and characteristics of clinical leaders in out-of-hospital care and to identify clinical leadership skill sets/practices/elements that influence effective out-of-hospital care.

Methodology

The methodological principles of the research rest upon phenomenology with the application of a mixed methods approach. This theoretical framework best supports this study approach as phenomenology and a mixed methods approach was developed from a form of systematic enquiry that leads to the development of an understanding of the nature of peoples transactions with themselves, others and their perceptions.[35]

Method

The principle method employed to generate data in this study is a questionnaire.

Population/sample

The questionnaire was offered to 250 paid (non-volunteer) ambulance service staff who attended in-service education between February 2010 and November 2010. In all, 104 questionnaires were returned for analysis, a return rate of 41.6%.

Analysis

Questionnaire data was analysed initially with the aid of an SPSS computer package and a manual data configuration was used with the qualitative data.

Ethical Considerations

Ethical approval was secured at Curtin University (Western Australia) and each questionnaire was provided with an accompanying explanation letter outlining the research aims and addressing issues of confidentiality, confirmed ethical approval and the participant's right to withdraw with impunity. No participant information was linked to individual respondents and participant anonymity was assured.

Limitations

Volunteer ambulance staff where not accessed during this research. As well, accessing regional staff proved difficult although some regionally based staff did participate.

Results

Who took part?

Of the 250 ambulance service staff who attended in-service education between February 2010 and November 2010, 104 returned questionnaires, a return rate of 41.6%. Of those respondents, their average length of service with the St. John Ambulance Service was just under 7 years (6.9 years), with the longest service of any respondent being 30 years. In terms of formal leadership training, 40.6% indicated that they had some sort of formal leadership training (although it was not clear what this constituted) and 59.4% indicated that they had not. In terms of formal management training, 26% indicated that they had had some sort of management training while 74% indicated that they had not.

The gender make-up of the respondents was in keeping with the profile of the ambulance service with 64.1% indicating that they were male, and 35.9% indicating that they were female. Current ambulance service demographic data for WA indicates that of the approximately 500 ambulance paid staff employed in Western Australia at the time of the study, 319 are male, a comparable 63.8%.

While it was hoped that accessing regional ambulance service staff would be possible, only 7.4% of respondents indicated that they were based in regional areas. While 92.6% stated that they were based in the Metropolitan area.

How do you know a clinical team leader?

The survey sought to explore the qualities and characteristics of a clinical leader. Respondents were offered a list of 54 attributes or descriptive words taken from a wide range of literature describing leaders. They were asked to indicate with a "tick" those characteristics/attributes they saw as "most" identifiable with clinical leaders. Box 1 shows the most commonly selected attributes.

Box 1. Qualities and Characteristics "most" identified with clinical leaders:

Qualities and Characteristics	%
is clinically competent	96.2%
is approachable	96.2%
has integrity and is honest	93.3%
is a role model for others in practice	93.3%
is supportive	91.3%
is a mentor	90.4%
is consistent	90.4%
is an effective communicator	89.4%
is a critical thinker	88.6%
directs and helps people	88.6%
can be a decision maker	86.5%
is visible in practice	85.6%
inspires confidence	85.6%

Other terms that may have been expected to be associated with leadership roles such as vision (a term commonly affiliated with leadership) and creativity (associated with transformational leadership) were selected much less commonly. With vision rated as important by only 51% and creativity and innovation by a modest 61% of respondents.

The qualities and characteristics least attributable to a clinical leader were sought in the same way. Respondents were offered the same list of 54 attributes or descriptive words and asked to indicate with a "cross" those characteristics/attributes they saw as "least" identifiable with clinical leaders. Box 2 shows the attributes seen as "least" related to clinical leadership.

Box 2. Qualities and Characteristics "least" identified with clinical leaders:

Qualities and Characteristics	%
is controlling	84.1%
works alone (should be part of a team?)	68.8%
is conservative	56.8%
is artistic / imaginative	52.3%
is an administrator	51.1%
deals with reward and punishment	47.7%
is responsible for others duty / responsibilities	45.5%
takes calculated risks	44.3%

Respondents were also asked to suggest other qualities or characteristics not on the list of 52 attributes. Many additional words were suggested (although some respondents repeated words already on the list offered) (see Box 3).

Box 3. Other Qualities and Characteristics identified with clinical leaders:

Additional Qualities and Characteristics	
Trustworthy	Visibility
Responsible	Enthusiastic
None judgemental	Pro-active
Ambitious	Experienced
Ethical behaviour	Friendly / approachable
Not a dreamer	Knowledgeable
Humble	Reliable

Respondents were asked if they saw themselves as clinical leaders, with most respondents (59.5%) answering "no". Most respondents that answered "no" said it was because they thought they needed more training, more education, more knowledge, more skills, better communication skills, more confidence, more experience, more leadership experience, or simply did not want the responsibility.

Respondents were asked if they thought their paramedic/ambulance role allowed them to engage in leadership and collaboration with 65.2% indicating that it did. Many then said this was because they worked with new people, including students, were involved in training, influencing others in various ways, strove to improve their practice, provided feedback to others, saw themselves as a clinical presence, were involved in asking questions, had a mentor role, saw themselves as setting high standards, sharing knowledge and sharing their experiences.

When asked if they thought that their colleagues saw them as clinical leaders most (75%) said "no". The reasons offered for this indicated that they had not had enough time in job, were inexperienced, were not academic enough or not qualified. Others said they had no passion to be seen as a leader, that leadership was related more to higher level roles and management and not people on ambulances.

Of the few respondents that thought their colleagues did see them as a clinical leader, most suggested it was because they had the experience, had their colleagues' respect, had the education and the experience in the service, that their work reflected best practice and related clinical experience. They also said it was because people asked for their opinion and advice, because they were approachable and knowledgeable, had valuable experiences or because they supported people.

Respondents were also asked to consider if there were any barriers that hindered effective clinical leadership, with 59.6% stating that barriers existed for them (see Box 4). When asked to elaborate on the reasons for barriers that hindered effective clinical leadership, a number of responses were offered (see Box 5).

Box 4. Clinical Leaders in the Ambulance Service

Do you see yourself as a clinical leader?	Yes (41.5%)	No (59.5%)
Are you able to engage in leadership and collaboration?	Yes (65.2%)	No (35.8%)
Do your colleagues see you as a clinical leader?	Yes (25%)	No (75%)
Do you think there are barriers that hinder effective clinical leadership? (One person was not sure 1.2%)	Yes (59.6%)	No (39.2)

Box 5. The reason for the barriers that hindered effective clinical leadership

resistance from colleagues to change	no opportunity
old ways of doing things	no recognition
organisational structures that get in the way	poor level of training or training that was lacking
the lack of a degree	a lack of experience
no real clinical pathway	people's egos
unclear processes for advancement	current management culture
inability to deal with (poor managers)	a lack of transparency (within the organisation)
"working with crusty old farts"	cost of training / studies
poor organisational support for progression	poor organisational support for progression

Perceptions, experiences and understanding clinical leadership

A number of questions sought to explore the respondents understanding, perceptions and experiences of clinical leadership. As such a 10 point Likert scale was used to gauge if respondents saw issues as "not relevant" or "not important" or "very relevant" or "very

important"[7]. With each question, between 3 and 5 respondents did not answer so responses are from only between 99 and 101 people or 95.1% to 97.1% of the sample. To simplify the results, responses were grouped into statistical sets of responses for Likert scale points at 1-3, 4-7 and 8-10 (Box 6).

Box 6. Perceptions, experiences and understanding clinical leadership

Qu.	Question	1-3	4-7	8-10
7.1	Do clinical leaders have the skills and resources necessary to perform tasks?	1%	12%	87%
7.2	Do you think clinical leaders are able to observe on the job activity without involvement?	7%	30%	63%
7.3	Do you think clinical leaders are able to work with a team?	0%	11%	89%
7.4	Do clinical leaders encourage initiative, involvement and innovation from co-workers?	4%	11%	85%
7.5	Do clinical leaders recognise optimal performance and express appreciation in a timely manner?	3%	15.2%	81.8%
7.6	Do clinical leaders initiate care and lead action and procedures?	9%	28%	63%
7.7	Do clinical leaders have a high moral character and act accordingly on what was right or wrong?	2%	16	72%
7.8	Would clinical leaders be willing to take risks for things they believed in?	16.2%	36.3%	47.5%
7.9	Are clinical leaders able to communicate effectively?	0%	8%	92%
7.10	Are clinical leaders as flexible, responsive and able to improvise?	0%	12.9%	87.1%

Clinical leadership defined

Another question asked respondents to define clinical leadership. A great number of responses were provided, with most respondents simply using a set of descriptive words to describe their "ideal" clinical leader. Many of these were then repeated in response to the question "What skills do you have, or need, to facilitate you to become a clinical leader?" or copied from the list of 52 words offered in question 1.

Further views on clinical leadership

Other questions sought to explore the respondents' experiences, perceptions and understanding of clinical leadership. The same Likert scale used in previous questions was used again and the analysis again grouped responses into three areas of the Likert scale 1-3, 4-7, 8-10. (Box 7)

Box 7. Perceptions, experiences and understanding clinical leadership

Qu.	Question	1-3	4-7	8-10
10.1	Do you think clinical leaders can influence organisational policy?	4%	45%	51%
10.2	Can clinical leaders influence the way clinical care is delivered?	1%	29%	70%
10.3	Are clinical leaders involved in staff development education?	3%	29.8%	67.2%
10.4	Do clinical leaders support other staff?	1%	29.8%	69.2%
10.5	Are clinical leaders seen as being available across shifts?	12.1%	34.4%	53.5%
10.6	Do you see clinical leaders as having road side experience of greater than 5 years?	1%	26%	73%
10.7	Should clinical leaders need to have advanced critical care training?	7%	23%	70%
10.8	Should clinical leaders have advanced critical care experience?	3%	28.7%	68.3%
10.9	Should clinical leaders have tutorial / teaching experience?	3%	33.3%	63.7%
10.10	Should clinical leaders have tutorial / teaching training?	4.2%	36.8%	60%
10.11	Is it important for a clinical leader to have international paramedic clinical experience?	41.6%	44.9%	13.5%
10.12	Is having local Perth or WA paramedic experience important for a clinical leader?	13.4%	36.1%	50.5%
10.13	Is research training a requirement for a clinical leader?	17.3%	45.9%	36.8%
10.14	Is research experience a requirement for a clinical leader?	19.4%	43.8%	36.8%
10.15	Is an undergraduate degree a significant requirement for a clinical leader?	16.5%	49.5%	34%

Respondents were also asked to add "any other comments" and while few were received, most revisited the previous research areas. Although one respondent added "High qualifications and experience while useful are not essential, many talented leaders have little or none, attitude and the ability to motivate and inspire is more important."

Discussion

Participants

The return rate was 41.6% offering a reasonable insight into the topic under investigation. Results indicated that the respondent's average length of service with the St. John Ambulance service was just under 7 years and that there was an almost 60/40 ratio of male/female respondents. The study participants can be said to offer a fair profile of the St. John Ambulance service in WA. However, the regional respondents made up only a small proportion of the sample at 7.4% and it is acknowledged that this ratio could have been higher.

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 had formal leadership training (40.6%), and fewer still had had any formal management training or education (26%). This is not unusual and in a similar study, only half the respondents indicated that they had had any leadership and half again that they had had any management training.[7,15] These results indicate that clinical leadership effectiveness is not dependent upon formal management or leadership training,[14] although it can be argued that leadership training specifically targeted at the needs of clinical leaders can be effective in supporting change and promoting higher standards of practice.[13,19,14,20]

How to recognise a clinical leader

The results offer a clear picture of what ambulance service staff are looking for in a clinical leader. They seem to be speaking of a person that is part of a team (team member) and is visible and involved in the team. Clinical leaders should be supportive, trustworthy, approachable and a motivator. They should be an educator and guide in clinical practice. They should be able to promote change, have initiative, be innovative, have a positive impact on standards and use best practice. They should have excellent clinical skills and knowledge, be a role model, inspire confidence and lead by example. As well, they should be excellent communicators, confident decision makers and they should be guided in their practice by their values about excellent out-of-hospital care.

Other terms or functions that may have been expected to be associated with leadership roles such as management responsibilities, vision and creativity were selected much less commonly or seen as unrelated to clinical leadership functions.

Their absence from the top characteristics indicates that traditional leadership theories such as transformational leadership[4] and situational leadership[5] may not offer a base on which to understand approaches to clinical team leadership. These views are linked to concepts respondents viewed as least associated with clinical leadership, with controlling topping the list. This is absolutely constant with the research done on clinical leadership by Stanley between 2001 and 2005.[12,13,14,15] In this earlier study nurses cited "controlling" as the least desirable characteristic of a clinical leader at a percentage of 78.1% supporting a dissociation between a clinical leaders' leadership role and a management function. Clinical leaders were also shunned if they worked alone or held other attributes of a manager (administrator, dealt with reward and punishment and conservatism).

All these views were supported when respondents were asked to suggest other qualities or characteristics not on the list of 52 attributes provided in the questionnaire. None of these additional words supported a management focus and while many repeated the attributes on the list provided, additional words such as trustworthy, responsible, none judgemental, ethical behaviour, humble, reliable, enthusiastic and pro-active confirmed the view that clinical leaders were not managers, were not seen to be in management positions and led by virtue of their values and beliefs about quality service provision. Team working, visibility, effective communication skills and their desire to deliver excellent outcomes as part of their professional identity dominate the profile of a clinical leader/clinical team leader.

Who are the clinical leaders?

Respondents were asked if they saw themselves as clinical leaders. Many, (59.5%) said they did not because they thought they needed more training, more education, more knowledge, more skills, better communication skills, more confidence, more experience, more leadership experience, or simply did not want the responsibility. Many however (65.2%) saw their paramedic/ambulance role as allowing them to engage in leadership and collaboration, so that while most recognised the need for, and place of clinical leadership (a view supported by Woollard, 2006[16]), few thought they had the skills to undertake this responsibility.

Of all the respondents, only 25% thought their colleagues saw them as a clinical leader, suggesting that it was because they had clinical experience, had their colleagues' respect, had a suitable education, that their work reflected best practice and related clinical experience. They also said it was because people asked for their opinion and advice, because they were approachable and knowledgeable, had valuable experience or because they supported people. None said it was because they were skilled managers, had a vision or were able to effectively control others. These views again supported the notion that leadership and management functions were different and that management skills were unlooked for in a clinical leader/clinical team leader.

What is stopping more leadership?

Many (59.6%) respondents indicated they thought there were a number of barriers that hindered effective clinical leadership or leadership development. The types of barriers hinted at can be grouped into three main areas. These include:

1. Management/organisational issues:

   These included issues such as no real clinical pathway, organisational structures that get in the way of leadership or unclear processes for advancement. A perceived lack of opportunities, the current management culture and poor organisational support for progression, a lack of transparency and a perceived lack of recognition.

2. Resistance issues:

   These included issues such as resistance from colleagues to change, a tendency to cling to old ways of doing things, people's egos and working with people who are unhappy or unable to accept new ways of working.

3. Training issues:

   The third barrier related to a perception that training support was lacking or that the level of training was too low. Others suggested the lack of a degree, a lack of experience or the cost of training/studies could be issues that prevented their leadership development/progression.

It is not clear which of these three issues offers the greatest threat to the successful implementation or development of the clinical team leader role and the strategies for dealing with each will vary. However, it is clear that almost 60% of those surveyed felt there were issues and that for the clinical leadership to succeed addressing each of these barriers is a necessity. Addressing the training issues will be the easiest option, but it may not yield the greatest results if the organisational issues and issues of staff 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 can be an altogether tougher undertaking.

Perceptions, experiences and understanding clinical leadership

A main aim of the study was to explore the respondents understanding, perceptions and experiences of clinical leadership. The majority of respondents recognised that clinical leaders have the skills and resources necessary to perform tasks effectively, are able to observe on the job activity without necessarily getting involved, work well in a team and communicate effectively. Clinical leaders were seen as flexible, responsive and able to improvise and to encourage initiative, involvement and innovation from co-workers. As well they were thought to be able to express appreciation in a timely manner when optimal performance was recognised.

Clinical leaders were seen by most respondents to be responsible for initiating care and leading clinical actions. They were also seen to have high moral character and to be acting according to what was right or wrong. Although when it came to the application of their moral character less than half were thought to be able to take risks for things they believed in. Clinical leaders were not thought to be successful in influencing organisational policy, while 70% of respondents thought clinical leaders could influence the way clinical care was delivered. Clinical leaders were seen to be involved in staff development education and support for staff with most recognising their role in education/teaching/tutorial support although there was a hint that more effort needed to be put into gaining educational skills to support their educational/support role.

In terms of experience, what was valued was any road-side (clinical) experience. As such, clinical leaders who were visible at the road-side with high quality clinical skills were acknowledged as valuable. The majority of respondents saw clinical leaders as needing advanced critical care experience and training supporting the skills and clinical expertise focus of the clinical leader role. Stirling et al. (2007) also support the development of an advanced scope of practice for paramedics and while their study related to rural communities,[17] these and Woollard's (2006) comments support the development of greater clinical expertise for leading ambulance or paramedical staff.[16] Research skills or training were not seen as essential and only 36.8% of respondents saw research experiences as a function of a clinical leader's role. Likewise an undergraduate degree was not regarded by the majority of respondents as a significant requirement for a clinical leader to function effectively. In support of these views one respondent said, you "need to have a 'can do' attitude" and the role was "not about pieces of paper (qualifications)."

Clinical leadership defined

When asked to define clinical leadership a great number of responses were provided. Most respondents simply used a set of descriptive words to describe their "ideal" clinical leader. However, it seems that what is looked for in a clinical leader is someone that is a team developer, team worker, supporter, educator, creator of a positive environment, someone with initiative, who is innovative, who can promote change, who is vocal, knows their peers, is trustworthy, offers a bridge between on-road staff and management, has excellent clinical skills, is a guide, is there for road crews to call on, visible at the road side, an advocate for road crews, is approachable, professional, who works well under pressure, who can make quick clear decisions, who leads by example, who provides leadership and support within the realm of clinical practice, who is a motivator, maintains standards, promotes best practice, offers direction, has elite knowledge, puts the patient first, is a good listener, will stand by others, who is inspirational, and who is confident.

These descriptions are constant with other definitions of clinical leadership[5,6,7,10,14,20,21] that conclude that clinical leaders are seen as experts in their field, who are empowered and confident and impact positively on the quality of health care. Views about clinical leadership from a nursing perspective support these perspectives[3,4,9,10,11] with Cook (2001b) defining a clinical leader as, a nurse directly involved in providing clinical care that continuously improves the care through influencing others[11]. Cook (2001a) adds that it is their relationship to clinical activity that sets a clinical leader apart from a 'generic' nurse leader.[10] Stanley found that clinical leaders were present in significant numbers and that they existed across all levels of staff, but they were rarely seen in senior non-clinical or management roles.[3,4,13,14] His study also showed that contemporary leadership theories failed to explain why clinical leaders were followed and it led to the development of a new leadership theory "Congruent Leadership."[3,4,13,14]

Conclusion

The study results indicate that clinical leaders are needed in the ambulance service and that they are effective when used appropriately. They are clearly doing a significant job and are evidently leading as was intended. One respondent makes this clear: *"The clinical team leaders in Perth are the only contact that I have ever had with a clinical leader and I can only speak of my high regard for their support and knowledge within their role."* The research offers a picture of what general ambulance and parametrical staff think of the clinical team leader role and clinical leadership. There is support for this role and the direction the role should take. It is suggested that it should remain firmly focused on a clinical leadership function, with the emphasis very much on the clinical aspects of the role. Linking the role with management functions would be a mistake and weaken what can be achieved with this role.

This research supports the notion that significant benefits are being achieved with the development and application of clinical leadership. There is room for some improvement in the skill set of clinical leaders (such as, motivating skills, team building skills, change management skills, clinical decision making skills and teaching skills). However, clinical leaders in the St. John Ambulance service are recognised for their ability to work with, and in, teams, to communicate well, to offer high quality clinical skills and to support and teach other ambulance staff. Further research is required. Now that a pool of clinical team leaders have been established it is recommended that an evaluation or further study be undertaken to assess the success and impact of their role.

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