Leadership and management in medical and health professions' education: Why do I need to lead?

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Section 6

Leadership and Management in Medical and Health Professions' Education: Why do I need to Lead?

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Introduction

In this section we explore leadership and management in medical and health professions' education using a typical situation in which many people have found themselves: taking on a leadership role without much preparation.

Scenario

Over the years, Dr Gina has become an excellent teacher, well-liked by both her peers and students. As a senior clinician, she first started teaching students in practice and was appointed as a teacher in the School fourteen years ago. Since then, she has been involved in many initiatives, twice won an award for her teaching and recently led a successful review of the undergraduate nursing curriculum. In light of her many contributions to the School, six months ago she was appointed as the Dean of Learning and Teaching, responsible for the oversight and development of the School's undergraduate and postgraduate medical and health professions' programmes.

Dr Gina had been offered and had taken the role, despite having no formal qualifications in learning and teaching or educational management, as it was felt she was ready for the next stage of her career and that she could really make a difference to health professions' education in the School. However, she is finding the additional role overwhelming. Her relationship with her peers seems to have changed overnight; there is so much paperwork; she feels she hardly sees students, and feels out of her depth in high level university meetings where everyone else is so confident and knowledgeable. She is finding it increasingly challenging to prioritise and manage her workload and roll out new initiatives, including the new nursing programme which she really enjoyed developing. She is not finding as much enjoyment in her job as before and is at a loss as to what she could do about the situation in which she finds herself.

She happens to be talking with a colleague one morning and explaining how she is feeling. Her colleague suggests that she attend a short leadership course which is happening in a week or two. He suggests that this might help her learn more about what is expected of her and give her some ideas about next steps.

What is happening to Dr Gina is very common, not only in universities and health professions' education, but in many organisations around the world. Widespread evidence exists that leadership and management are key to organisational success and efficiency, particularly in the VUCA (Volatile, Uncertain, Complex, Ambiguous) world in which we live (1,2). Effective leadership promotes a positive culture and climate and is central to the student learning experience, quality and improvement but targeted leadership development and purposeful succession planning is typically either patchy or non-existent. Most of us are not 'born' into leadership, and we are certainly not born into leadership or management positions. We therefore need training on the requirements of the role and professional development geared specifically around leadership and management. However, although there is much more recognition that leadership and management development is required for those in leadership positions, this is often either offered only when someone is in a leadership post or not at all.

The three chapters consider various aspects of leadership and management and what this means in practice. The first chapter defines leadership and its components and then considers various factors

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that help explain how and why Dr Gina has found herself in this situation. We next look at the skills and qualities that leaders working in health professions' education need, drawing on research from within medical and health professions' education as well as the wider leadership literature. Finally, we take a number of typical situations that health professions' education leaders have to deal with and offer practical strategies for coping with these.

1st Chapter: Why? – Why does this happen?

Before we start to discuss why situations like this happen and what can be done about it, it is helpful to define what we mean by leadership. The leadership course Dr Gina attended provides some of the theory and breaks it down into different aspects.

A model we have developed takes the ever-growing literature on leadership and condenses this in to sets of 'three's', the 'petals' of a daffodil. The 'Swansea daffodil' is based on the national flower of Wales, reflecting the Canadian CanMEDS 'daisy' framework which describes the roles and competencies of a doctor (3). Each of the three elements in the daffodil petals summarise key aspects of leadership that have been identified from the literature and in practice. In the centre are the three core skills sets of **leadership, management and followership** that educational and clinical leaders need, we have called this the 'leadership triad' as it comprises the three interwoven components that are needed to be and become an effective leader (4).

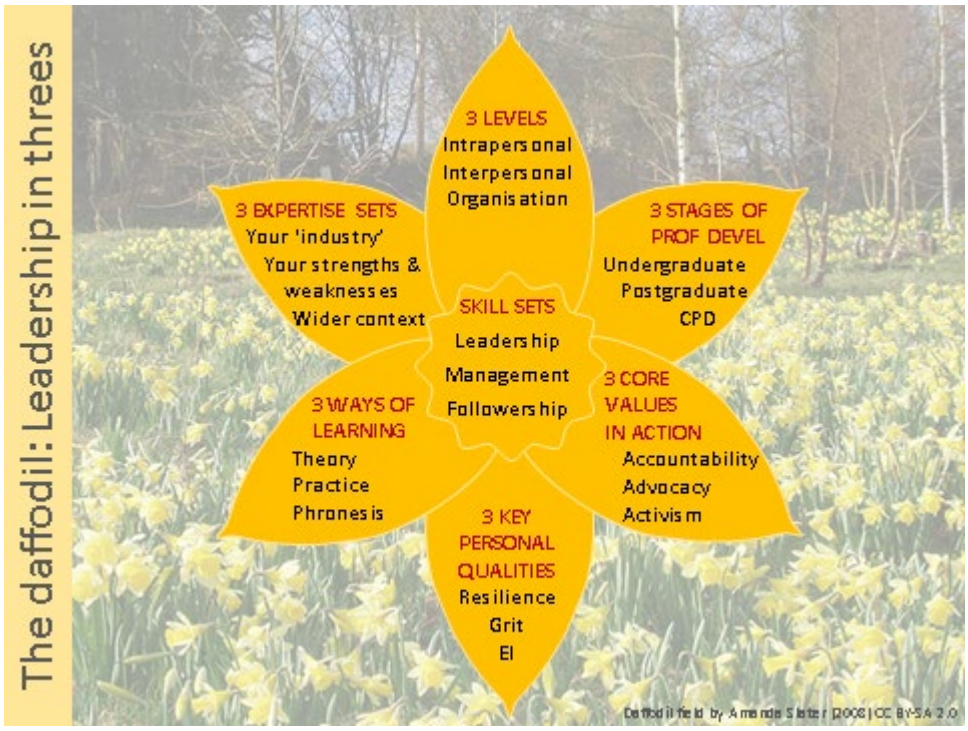

Figure X.1 The Swansea daffodil: Leadership in threes

Thinking of the activities of a leader in terms of this triad is much more helpful and realistic than thinking that all 'managers' do is 'manage' and all that 'leaders' do is 'lead', because in practice everyone carries out some management and some leadership activities within their roles.

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Organisations, teams and situations need both leadership and management in varying amounts depending on the context. Management is about efficiency, planning, providing stability and order, whereas leadership is about effectiveness, change, setting direction and adaptability. Drucker suggests that organisations need both a management perspective, including 'doing things right' (efficiency) coupled with the leadership perspective of 'doing the right things' (effectiveness) (5). He makes the point that it is no use being highly efficient if you are doing the wrong things. For example, a health professions' programme might be managed very well and run like clockwork but, if it is out of date and does not meet regulatory standards, then educational leadership is needed to create a vision for the right change needed, and both leadership and management are required to ensure the vision for a new programme turns into reality. Mowbray makes a helpful distinction in noting that 'processes need managers and management, people need leaders and leadership' (6 p2). So, in our health professions' programme example, whilst it is important to ensure that the new programme is mapped to the professional standards, that the timetable activities are achievable and that assessments can be managed with existing resources (management activities), it is the people involved who will make the programme come to life, and through it will motivate and nurture the health professionals of tomorrow, and that requires good leadership.

Finally, we do not lead all the time, however senior we are in an organisation or profession. There are always people who are more expert or better at certain things than we are ourselves, so being able to be a good 'follower' (who is supportive, active, questioning and helpful) is vital to ensure groups, teams and organisations function smoothly. And leaders need to be able to communicate with and motivate their own 'followers', both team members and those who they influence more widely. Denhardt and Denhardt talk about leadership being an art (a 'dance') which involves fluidity, rhythm, passion, expression, improvisation, interpretation, focus, discipline and an awareness of space, time and energy. We also like to think of this 'dance of leadership' as involving a deft, seamless stepping in and out, forward and back, between leadership, management and followership (7). So we see part of the art of leadership as about knowing when and how to manage well, when to follow, and when you or others need to step up and take leadership.

Definitions and theories of leadership, management and followership

Having said that it is essential that leaders (and managers) can perform a mix of different activities, the well-established literature often distinguishes between leadership and management, with followership having a much more recent history. More recently, leadership theorists are thinking (as discussed above) that whilst there are distinctions between leadership and management activities, it is the continued interplay of these activities by and within individuals and teams that makes organisations most effective. Leadership, management and followership are all social constructs, they are shaped by socio-cultural influences and the zeitgeist of the time, and are constantly being mediated, reshaped and reconstructed.

Leadership

Kurt Lewin said that 'there is nothing as practical as a good theory' and in this section, we select some of the most relevant leadership theories (from the many that exist) and explain their real-world practical application to practice in health professions' education (8). Many writers (including ourselves) have written about leadership theories, and the literature is vast, so here we provide a summary of theories, a framework for thinking about them, and refer to others throughout the section where relevant. Table X.1 below sets out some of the major theories and approaches, and

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you may well have already heard of some of the more common ones, such as Situational Leadership, Transformational Leadership and Emotional Intelligence. Some of these theories have been criticised for being 'leader-centric', seeing the leader as the focus in terms of their influence, power and control, rather than the interplay between followers and leaders, but they remain very dominant.

Adaptive, complex adaptive leadership	Implicit leadership theories (ILTs)
Affective leadership	Inclusive leadership
Authentic leadership	Leader-member-exchange (LMX) theory
Charismatic leadership, narcissistic	Ontological leadership
Collaborative, collective, shared leadership	Person-centred leadership
Contingency theories	Phenomenological leadership
Destructive, Toxic (the dark triad) leadership	Relational leadership
Dialogic leadership	Servant leadership
Distributed, dispersed (shared) leadership	Situational leadership
Eco leadership	Spiritual leadership
Emotional intelligence (EI)	Trait theory, 'Great man' theory
Engaging leadership	Transactional leadership
Expert leadership	Transformational leadership
Followership	Value led, Moral leadership

Table X.1 Major leadership theories and concepts

Key: Red - primarily intrapersonal; Purple – primarily interpersonal; Green – organisation or system

As set out in the Daffodil model, we find it helpful for people to make sense of the theories and apply them to their own development and situation by categorising them broadly into three levels, although some theories fall into more than one. These are described below, in broad chronological order, and it should be noted that, as in education, new theories do not replace former ones, but our thinking about leadership is reframed as we look through different 'lenses'. So, theories that have been very influential in the past still continue to frame our thinking about leadership today.

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1. Understanding yourself as a leader

These theories focus on the personal qualities or personality of the leader as an individual and help us get to know ourselves better, develop self-insight into why we do things a certain way, understand our strengths and weaknesses, and how we respond under pressure.

Early theories of leadership focussed on the 'great man' or 'heroic leader', one (usually a man) who was authoritative and acted as a figurehead for their organisation, cause or country. These people became leaders by virtue of their position in society, sometimes this was bestowed upon them through heredity (e.g. monarchy) although more often it was based on their actual and perceived skills, qualities and abilities as a leader (e.g. in industry or government, religion, the military). Whilst cultural variations exist, certain personality traits, personal qualities and behaviours were subsequently seen as more 'leaderful' than others. The qualities ascribed to leaders therefore arose from a combination of factors, see Table X.2.

How traditional perspectives on leaders and leadership emerged	**Impact on our understanding of leadership and leaders**
Socio-cultural beliefs about the place of certain groups and individuals in society, which vary between cultures and over time, including: • Social stratification e.g. social class, caste systems, where some are at the 'top' (leaders) and the rest are at the 'bottom' (followers) • That women's place is 'in the home' and men are 'breadwinners' • That leadership relates to the world of 'work' • A belief that leaders were somehow 'born' not 'made'	This varies between cultures and over time, but in general has led to some individuals and groups believing and acting as they were destined for leadership, others that they could never become leaders.
Symbolism around leadership and leaders	Throughout history, in art (paintings and sculptures), speech and theatre, leaders have been portrayed as and celebrated for being 'larger than life', 'heroic' and 'godlike'. Such symbolism around leaders and their powers is highly pervasive and leads to the belief that leadership is all about seniority, power and 'big L' leadership
Legacies from tribal times, including social and neurobiological influences	Certain personality and physical traits and qualities became associated with leaders, e.g. height, strength, 'perfection', charisma, confidence, good communicator
Who leaders actually were at various times in history – the visible leaders were not necessarily representative of the whole population	Because the visible 'great' leaders were men, typically high-born or seen as having leadership bestowed upon them by a higher power, people who did not fit these characteristics could not be leaders

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Table X.2 Traditional perspectives of leadership and their impact on our understanding

These traditional views persist today, although they have been tempered by more recent theories and concepts, some of which challenge these traditional views, others which complement them. A key shift was that, from the 1960s onwards, many writers started to challenge the idea that leaders and managers were born (to certain positions, or with certain characteristics) and began to highlight not only that different leadership styles or approaches could be adopted, contingent on different situations or contexts, but also that leadership could be 'learned' (9-11). Underpinning this shift were developments in the social and behavioural sciences which started to see personality traits and identity as not necessarily fixed from birth or early childhood, but which could be and are modified and adapted throughout life. More recent literature focuses on this growth and development through life, for example Nonaka and Takeuchi's concept of the 'wise leader' emphasises that a leader: (12)

- Needs more than knowledge alone
- Can practise moral discernment
- Can sum up complex situations quickly and grasp key essence of problems
- Creates the context for organisational learning
- Communicates effectively
- Exercises political power judiciously
- Fosters development of practical wisdom in others

The wise leader therefore needs to have developed their own 'practical wisdom' (phronesis), which can only be achieved through experience, reflection and personal growth. The Japanese concept of Ikigai (meaning 'reason for being') (13,14), Sinek's (15) work on finding your 'why' (your core purpose) and Duckworth's concept of 'grit' (16), also see leadership as being centred within a person's whole life, involving combinations of passion, core purpose, resilience, direction, perseverance, values, achievement and self-worth. Recent leadership research in this area, drawing from linguistics, philosophy and psychology, moves away from what a leader 'does' to what they 'are': the 'being and becoming' a leader (ontology). This includes work on leader identity formation; notions of power, authority and control (17); dominant leadership discourses, and ontological leadership. For example, Souba suggests that four ontological pillars underpin the 'being' of leadership: awareness, commitment, integrity and authenticity (18) whereas McKenna and Rooney (19) focus on leaders developing 'ontological acuity', being aware of organisational knowledge systems and discourses.

In health professions' education, our work is predominantly 'people work', involving emotional labour with learners and faculty, requiring 'affective leadership' (building strong emotional connections and relationships) and therefore a highly controlling 'hero leader' approach is often counter-productive. The idea of 'Servant leadership', a concept first coined by Greenleaf, has gained traction in recent years with its strong connection to values and public service. Core personal principles in servant leadership such as to wanting to serve first and make a difference to people's lives; take a facilitative approach; focus on caring, wellbeing and healing, and stewardship (taking care of something that is not yours, improving it and handing it on to your successor) are very relevant to education and healthcare (20). Value-based and moral leadership are also closely linked

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to servant leadership, where the leader takes a moral stance, whose values are transparent and which underpin their behaviours and actions. Whilst the 'expert' leader is highly prized for their leadership around their specific expertise, we cannot be an expert in everything, so learning to listen and value those around you for their strengths and expertise is vital in our context. Theories which focus on an individual's emotional intelligence, authenticity and values as core leadership strengths help explain why some leadership approaches 'work' and others do not. Seeing these leadership qualities as strengths allows us to accept leaders who are imperfect, human and who make mistakes - fallible leaders - as long as these leaders have the emotional intelligence to recognise this, listen to others and change.

2. Leading and working with others

These theories relate to the way in which a leader interacts with others. They help us work in and lead teams, and communicate with and influence others more effectively. The influential shift towards thinking that leaders and leadership could be developed led to a wide range of general literature, research and development activities aiming to identify the issues that aspiring and existing leaders needed to address to become 'successful'.

For many years, the focus was on developing the individual leader's skills and understanding, with the leader being seen as the most powerful and influential actor in encounters. We call these 'leader-centric' approaches. Some of these have been discussed above, such as developing higher social or emotional intelligence and adopting the 'right' leadership style or approach for different contexts or situations. Other theories or concepts, prominent in the health and education contexts focus on the leader's role in leading change through and with people, the importance of building and sustaining relationships, and the generation of positive dialogues and discourses. Transformational leadership, for example, is grounded in humanistic psychology and is about leaders inspiring and motivating others towards higher order goals or values. Bass talks about the 'four I's' of transformational leadership:

- Idealised influence - involves the leader influencing through acting as a good role model
- Inspirational motivation – motivating others through inspiring them to better things
- Intellectual stimulation – motivating people by stimulating them intellectually
- Individualised consideration – paying attention to the needs and aspirations of individual team members. (21)

This contrasts with transactional leadership which involves exchange of effort for reward (e.g. you work for an employer and you get paid). Of course, many work encounters are transactional, but the approaches in which leaders achieve meaningful change whilst also developing people have been highly influential, despite the difficulty of being truly 'transformational' within the midst of austerity, managed systems, targets and performance measures.

More recently however (see below) more attention is being paid to the interaction of leaders and 'followers', acknowledging that such interactions are part of complex dynamic processes, not linear or one-way. Reflecting this, approaches that embody the belief that leadership needs to be a collective process in which people are central have emerged. Such approaches include distributed, shared, collective and collaborative leadership. These approaches are different, but have common features:

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- Leadership is seen as a process: teamwork and co-creation is important, only by working together will improvement be made
- Power shared gives more power for all to use
- Rather than focussing just on individual leader development, building social capital and leadership capacity throughout the organisation is essential – leadership and expertise is distributed at all levels
- Leadership is emergent and boundaries are open so that knowledge and learning is shared

Two relatively recent approaches which seem very relevant to health professions' education are 'person-centred' leadership and 'inclusive leadership' (22,23). Person-centred leadership involves operating from your strengths and allowing others to compensate for your limitations, encouraging others around you, and building a culture around a shared vision by knowing and sharing why you do what you do (15). Inclusive leaders build relationships with others that can accomplish things for mutual benefit; do things with people rather than to people – the essence of inclusion; values, promotes and encourages diversity, and actively addresses unconscious and implicit biases through training, development and challenging inappropriate behaviours. Both these approaches emphasise organisational empathy; valuing people for who they are, as well as for what they do; they take a moral stance, and incorporate values-based leadership. Finally, 'caring' (24), 'courageous' (15) and 'compassionate' leadership (25,26) have been applied to healthcare and other settings, again these approaches would seem to be the sort of leadership we might strive towards in our context.

3. Leadership in Organisations or Systems

This group of theories seek to explain leadership behaviours in relation to the environment or system, much of which draws from management and organisational psychology literature. They guide us in learning about and understanding the wider systems and organisations in which we work, understanding politics and processes, and determining strategies for managing and leading change and improvement initiatives. As mentioned, servant, values-based and moral leadership are all very relevant approaches, involving 'making a difference' through engaging with the moral purpose and values of an organisation. The recent concept of 'eco-leadership' builds on these approaches, emphasising the concepts of stewardship, and environmental, societal and organisational sustainability (27). This is crucial for healthcare and education, echoing the United Nations' seventeen Sustainable Development Goals, developed to address global challenges faced by the international community, including poverty, inequality, climate, environmental degradation, prosperity, and peace and justice, so that no-one is left behind (28,29).

It is becoming increasingly clear we are living in a VUCA (Volatile, Uncertain, Complex, Ambiguous) world which requires leaders to have a growth mind set, and organisations which are flexible enough (in their structures, people and organisations) to adapt to changing conditions (2,30). The most effective leaders have therefore learned to understand and navigate organisations and systems; they are boundary-spanners; they can take a systems-thinking approach and are flexible, adapting to both internal and external change drivers. 'Adaptive leadership' describes leaders who are comfortable working in complex, uncertain systems and times and can adapt their ways of working to develop solutions to new or 'wicked' problems (problems with no clear solution) (31,32). Bolman and Gallos suggest that one way academic leaders can do this is by looking through different lenses or 'frames' (the structural, human resource, political and symbolic frames) to provide different perspectives on their organisations and tackle issues in different ways (33).

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Management

The practice and theories that underpin modern management have a long history. Management was first conceptualized in efficiency studies in the 16th Century, further developed as industries and factories were introduced and refined as service industries became prominent. Management is primarily about planning and order, relating to the structures, co-ordination, organisation and administration of a business's activities to achieve its goals or objectives. Management activities therefore include developing strategy and policy; controlling the means and processes of production; finances; innovation, marketing and promotion. It involves managing resources, be they physical (buildings, equipment), human (people), natural (water, oxygen) or technological (computer and other systems).

Most organisations have three levels of management:

- Senior managers (e.g. the chief executive, president, finance director etc.) who carry out the more strategic aspects, setting and planning a strategy and objectives, and who decide how the organisation will operate. They delegate and manage the next tier down.
- Middle managers who act as the interface and communication channel (sometimes the buffer) between the senior managers and the frontline managers. These would include department heads, programme directors or directors of administrative units.
- Lower managers, frontline managers or supervisors, such as heads of assessment, course or module leads. These oversee the work of others and often have a frontline aspect to their work, dealing directly with customers, students or patients.

In health professions' education, many individuals hold a number of roles and tasks which overlap and cut across structural lines of responsibility and accountability. Swanwick and McKimm set out the key management skills which health professions' educators need to be able to do, which can be summarized as follows: (34)

- Understanding, controlling and managing budgets
- Human resource (people) management
- Physical resources and facilities
- Business planning (e.g. strategic, departmental and operational plans)
- Curriculum/programme management and timetabling
- Project management
- Understanding the internal environment
- Understanding the external environment
- Understanding and developing management systems (including IT) and processes
- Educational quality, evaluation
- Time management (self and others)
- Chairing or being involved in committees

For example, the assessment lead of an undergraduate course might be responsible for planning assessments and managing others to carry out the essential tasks, chairing meetings and producing examination papers. They might also lead on a module relating to their specific discipline and

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therefore attend curriculum or programme management meetings, as well as be an academic mentor for some first year students. In the light of their assessment expertise they might also be part of a national body, again with different responsibilities, and also be the principal investigator for a multi-centre research study, holding a national grant.

We like to think of management as maintaining stability and order, enabling forward planning of resources and activities, and a means to monitor and evaluate successes and failings. In curriculum terms, the management required includes the strategic development of the programme, mapped against internal and external benchmarks and standards, and a realistic and feasible programme design in light of educational needs and available resources. For example, it is no good planning an intensive case, problem or inquiry based course which requires many small group teaching rooms and facilities, if these are not available or of insufficient quality. Curriculum mapping and assessment blueprinting are also essential management activities which assure yourselves and the regulators that learning outcomes are taught, learned and assessed appropriately. Whilst these activities will require some leadership, they also require management skills, which can be learned over time (35).

As you can see, there is no point having a great vision and ideas if these cannot be translated into a reality that works on the ground. Indeed, Gosling and Mintzberg go further, saying that '*the separation of management from leadership is dangerous. Just as management without leadership encourages an uninspired style, which deadens activities, leadership without management encourages a disconnected style, which promotes hubris. And we all know the destructive power of hubris in organisations'* (36 p.1). So, management and leadership skills are both needed for objectives to be met, but in various amounts by different people in different contexts. Those with a formal designation of a 'manager' will still lead people and tasks, and those with a leadership role need to be able to manage work flow and outputs (37).

Followership

Followership is the most recent of the three concepts comprising the 'leadership triad'. For many writers, the focus on 'leadership' (the 'leader-centric approach') has led to a paucity of research into followers and followership. The predominance of the individualized concepts of leadership described above (e.g. the 'hero leader', 'great man', charismatic and transformational leadership) conceptualized followers either as subordinates, as passive recipients of and responders to leaders' actions, influence and instructions, or as constructors of what leaders and leadership mean. (38) As leadership became conceptualized in terms of a social construct and process, created and mediated through interaction and relationships between people, so followership is seen as essential, as without followers, there are no leaders (38). The study of followership however, is relatively recent, with most studies having been carried out in the last fifteen years.

Role based approaches consider followership in terms of formal hierarchical roles (e.g. subordinate, deputy), 'seeing followers as causal agents and leaders as recipients or moderators of followership outcomes' (38 p85). This perspective has contributed towards the term 'follower' having a negative connotation, which privileges and romanticizes leadership and subordinates followership. The most recent writers therefore make a distinction between 'leaders' (who exert social influence over others) and 'followers' (who are willing to defer to and interact with others). From this perspective, the 'exemplary' or 'star' follower is an engaged and active agent, willing to collaborate in a common

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purpose, supporting their leaders yet speaking out when they think things are wrong (39,40). Chaleff suggests such followers are 'courageous' as they willing to 'stand up to and for leaders' and are accountable for their actions (41).

Most of the research on followership sees followership behaviours either in terms of a relationship between deference and dominance (the follower 'agrees' to defer to or be influenced by the leader for various reasons) or, from a constructivist perspective, that the follower takes on a follower 'identity' and grants the leader a leader 'identity' (42). Implicit followership theories (IFTs) suggest that, just as we hold implicit theories of leadership, which are socially constricted and mediated and often held unconsciously, so too do we hold unconscious but pervasive ideas about what, who, why and how we should follow some leaders, but not others. This often leads to a categorisation of leaders as either 'good' or 'bad'. Such judgements affect the way followers interact with various leaders, and how followers interact with one another. From a social identity perspective, this can lead to the development of collective emotion, including support for and movements against leaders or the development of in-groups and out-groups in which some followers feel that they belong, whereas others feel or are marginalised or excluded (43,44).

Probably, most leaders try to do the best they can given the circumstances and the teams in which they find themselves. However, some leaders are perceived by their followers as toxic or destructive because of their behaviours, actions and inactions. Some leaders are destructive because they are out of their depth or feel they have to do everything themselves. This can lead to followers feeling micro-managed, or alternatively abandoned. Leaders who are weak or who don't know what they are doing do not gain the respect of their followers and, once trust is lost (e.g. through breaking promises, poor communication, ineptitude or lack of knowledge), then it is virtually impossible to regain. Other leaders are toxic because of their personality traits or other variables. Such toxic leaders may display a lack of empathy and understanding of others' wants and needs; may be arrogant and self-serving; sabotage or take credit for others' work or achievements; may have favourites amongst the group; may bully and harass people, or be unpredictable. The 'dark triad' of personalities describes three overlapping, offensive but non-pathological personalities: Machiavellianism, subclinical narcissism and subclinical psychopathy (45). In leadership, this leads to interesting paradoxes for both leaders and followers:

- Leaders need to be (and appear to be) self-confident and have strong self-belief - but not appear arrogant, grandiose, entitled, superior or dominant i.e. display narcissistic behaviours;
- Leaders need to be seen as calm, be able to make tough (sometimes unpopular) decisions, appear strong (which may involve disciplining or firing people) , and be able to take calculated risks - but not appear emotionally cold, lacking in empathy or anxiety, or show high impulsivity and thrill seeking i.e. display psychopathic behaviours;
- Leaders need to be able to work the politics of the organisational 'jungle' and 'manage' people - but not be seen as manipulative, i.e. display Machiavelliansim.

Leaders who don't have the personalities which include one or more components of the dark triad (hopefully most) therefore need to be aware how their behaviours might appear to others and this is where the more person-centred and inclusive approaches can be used.

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Summary

In this chapter, we take the three levels at which leadership operates: the intrapersonal, interpersonal and the organization or system level (identified in the 'Swansea daffodil') and explore some of the useful leadership, management and followership skills at each level, noting that some things do not fall easily into one level. We have looked at some of the theories underpinning leadership, management and followership and highlighted how these can help our understanding and started to use the Swansea 'Leadership in threes' daffodil to explore some of the various facets of educational leadership as they relate to Dr Gina's situation.

In the next two chapters, we look at the skills that leaders need and how to use these in practice at the three levels and explore the approaches, knowledge, skills and competencies leaders can use to both develop themselves and become an effective leader.

Practice Highlights

- Moving into a leadership role poses challenges and dilemmas as well as opportunities for growth and challenge
- The many theories and concepts of leadership that exist can help us develop as health professions' education leaders
- Our activities and development occurs at three levels: the intrapersonal, interpersonal and the organisation/system
- Leadership involves a combination of leadership activities, management tasks and being a follower

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2nd Chapter: What? – What are the useful tools/skills for a leader?

Scenario

Dr Gina has had many thoughts after attending the leadership course. Moving into a more senior position, whether you want it or not, involves some customisation of our social identity as we adapt to being seen differently by others and having to develop 'leaderfulness'. This is challenging, and Dr Gina is displaying what is commonly termed 'imposter syndrome': she feels as if she an imposter in the Dean's role and that everyone else knows more and is more of an expert than she is. It is rather like the tale of 'the Emperor's new clothes', we feel under-equipped for or not worthy of the role, that everyone is just waiting for us to reveal that we are an imposter, and we will be found out. Dr Gina is also very conscious that she has no formal teaching or educational qualifications, which will exacerbate feeling like an imposter in the new role. Building credibility as a leader takes time and confidence, and whether Dr Gina is aware of it or not, she will have her own beliefs about what 'good' senior health professions' leaders do and don't, what they look like and what they don't. Internationally, women are under-represented at senior levels in a range of organisations, including universities. If there are few women role models in such jobs in the university, then it can be difficult if you 'don't fit the mould', feeling as if you have to prove yourself over and over again.

Dr Gina is struggling with feeling overwhelmed with the volume of work and rapidly finding out just what a heavy managerial and administrative burden these academic roles entail. Not only is she having to attend meetings, manage people and think more strategically, but she is also still working clinically, whereas often these roles are taken by academics who work full time in the university. We call this the 'double burden' of health professions' leadership. What also happens when people move into new leadership positions or roles is that, because they are taking on new responsibilities, they usually need to give things up. All change therefore involves some type of loss as well as gain and, while a role transition is happening, this can be psychologically uncomfortable, particularly when the things we are 'losing' are the things that brought us into the job in the first place. For Dr Gina these were a love of students and teaching as well as curriculum development. Dr Gina is also in a transition period in which she will (almost inevitably, but hopefully temporarily) lose competence and confidence until she finds her feet in the new role.

Dr Gina knows the organisation and its culture well as she has worked there for many years, and this is an advantage. However, she has now moved up the hierarchy and has more organisational positional power and authority amongst her peers than she did before. Managing this shift can be difficult, as her colleagues (and students) may feel differently about her and will have to renegotiate their formal 'work' relationship. This can lead to feelings of isolation and, coupled with Gina feeling out of her depth, is probably contributing to her loss of enjoyment.

Dr Gina is encouraged by attending the leadership course and feels she understands more about leadership, what it is and what it isn't, and she is keen to learn more about some of the specific tools and skills that she will need in her new role.

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Understanding yourself: your strengths and weaknesses

As part of the follow-up activities on her course, Dr Gina had completed a number of self-development activities on these topics and she felt that, although some of the results were a little confronting, her self-assessment of her strengths and areas for development was pretty accurate. One of the useful things she learned was the importance of having a positive approach to life, which, as a teacher and leader, is really important. Seligman's PERMA model comprises five core elements that underpin psychological well-being: Positive emotion (being optimistic about the past, present and future); Engagement (in activities that we enjoy and which absorbs us in the moment); Relationships (and strong social connections); Meaning (and finding purpose in our life and work), and Accomplishments (goals, ambitions and achievements) (46). From undertaking a series of self-development activities, she also learned that she had a 'growth mindset' rather than a 'fixed mindset' i.e. her view of the world is positive; setbacks are seen as temporary, not permanent; she has an underpinning belief that she can continue to learn and develop, and that effort will lead to achievement (47). Table X.3 has some more descriptions of characteristics of the different fixed and growth mindsets. Reflecting on how these concepts applied to her, Dr Gina realised that having a growth mindset and a good sense of psychological well-being had probably contributed to her achievements as a clinician and teacher, and that she was operating successfully as a *'little 'l''* education leader already. She was starting to feel much more optimistic about her future role (48).

Characteristic	Fixed mindset	Growth mindset
Skills/intelligence	I'm not good enough	What am I missing?
Goals	I need the outcome to be success	I want to grow and learn.
Feedback	I take feedback personally and get defensive	I like feedback and use it to learn
Challenges	If something is too hard, I give up	I keep trying even when I'm frustrated
Mistakes	It's not my fault- it was someone else's	Mistakes help me learn

Tab X.3 Characteristics of fixed and growth mindsets

Alongside these concepts which relate to the general population, the leadership literature identifies many personal qualities of effective leaders (e.g. integrity, humility and charisma) as well as the harmful effect of *toxic* or *destructive* leadership. However three qualities consistently emerge from studies of successful leaders: **resilience -** the ability to 'bounce back' from adversity or challenge (49); **emotional intelligence** (EI) – a combination of self-awareness, empathy, social awareness, self-motivation and self-management (50,51), and **'grit'** – a combination of resilience, passion, hard work, perseverance, determination and direction (16). There is a lot of cross-over between all these theories and concepts, with a sense of purpose, a positive mindset and a willingness to work hard being crucial to all. For example, Sinek talks about leaders finding their 'why', the core purpose that drives and motivates them, and a core aspect of maintaining resilience is being able to draw from spirituality, your beliefs, values and sense of purpose (15).

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Writers are still debating the extent to which these are types of personality traits or cognitive functions. For example, emotional intelligence has been described in two different (but not mutually exclusive) ways. Salovey and Mayer define 'ability emotional intelligence' as the cognitive ability to monitor one's own and others' feelings and emotions, and to use this information to guide thinking and actions, whereas Petrides et al describe 'trait EI' as involving emotion-rated self-perceptions, similar to a personality trait of self-efficacy (52,53). However, whilst some people may appear more 'naturally' resilient, emotionally intelligent or 'gritty', research on neuroplasticity suggests that these can all be developed further, once people become aware of what they need to do and apply themselves to such learning (54). We suggest that it is helpful to think of this as an integrated developmental process (*three A's*) in which leaders learn to develop *awareness* of their emotions and feelings, identifying what is happening both in their heads (e.g. feeling angry) and their bodies (e.g. clenching fists, increased heart rate); *accepting* that they are feeling such emotions, and then deciding (using rational cognition) what (if anything) to do about it (*action*).

Building credibility

Some of the main things that followers want from their leader are to be valued, acknowledged and praised, and for their potential to be spotted, nurtured and developed: in other words, to be emotionally intelligent. And an inclusive, person-centred leader involves their followers in activities, allowing them to compensate for their weaknesses. However, before a leader can do this, they need to feel self-confident, it is hard to admit weakness or fallibility when you are unsure of yourself. Another aspect to this is that, influenced by implicit leadership theories, both followers and leaders may expect leaders to demonstrate certain characteristics: such as being strong, expert, authoritative and outgoing. So from a followership perspective, this is all about being credible as a leader as without this, followers simply won't follow you. Through our work with developing doctors in training in leadership, we suggest three expertise sets can help build your credibility (55). These are at the top left of the Daffodil model.

First by understanding your **'industry'** (e.g. healthcare education):

- know how healthcare and education systems, structures, funding and programmes work;
- possess clinical and educational knowledge, so you can speak the languages (medical and education jargon);
- understand the wider socio-cultural, political and economic context, to keep abreast of trends and policies.

Secondly, becoming an **'expert'** in your area, project or initiative helps to build credibility, particularly when your power and influence is relatively low because of position in the organisation and professional hierarchies. Although Dr Gina feels she lacks an educational qualification, she has good experience of the curriculum review process in the university, and is a highly experienced teacher, so this is what she needs to draw on. It could be that Dr Gina decides that having a formal qualification in education will give her more credibility (particularly in terms of learning theories), but in practice that might not be needed as she already knows a lot and could read around relevant subjects.

Finally (as with all professional roles), understanding your **strengths and weaknesses** helps you to work in and build effective teams and structure your leadership development.

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Communications and conversations

Many of the skills and approaches discussed above relate to the leader's interaction with others and communication skills. For example a core component of EI involves relationship building and managing which includes influencing skills; coaching and mentoring; teamwork; conflict management, and inspirational leadership (51). In order to effect change, motivate and inspire others, leaders need to be able to influence others, by expressing themselves clearly in different situations and contexts. Influencing involves a combination of advocacy, persuasion and negotiation, adapting your approach and style so that what you are saying appeals to others, engages them and helps build relationships. Some people will appreciate a rational style, with facts and figures, some will be influenced by your values, others will need a combination of approaches. Learning as much as you can about your team and the people you need to influence is vital, so that you can get people on your side or persuade them to your way of thinking.

Of course, not all communications are straightforward and this is where having self-insight is also important, so that you can recognise your effect on others. In the previous chapter, we looked at the traits and behaviours of 'toxic' leaders and mentioned the 'dark triad'. Understanding the impact of potentially destructive behaviours on others (such as undermining, not trusting, playing people off against each other or micro-managing) is helpful so we can try to avoid this. Recently, researchers have identified what they call the 'light triad' of personality (56). Like the 'dark triad', this also involves three dimensions: Humanism (valuing the dignity and worth of each individual); Faith in humanity (believing in the fundamental goodness of humans) and Kantianism (treating people as ends unto themselves, not as mere means to an end). Aspects of the light triad fit well with some leadership approaches, with the healthcare and education contexts, and with what learners and colleagues expect from us. For example, Kouzes and Posner talk about leaders making an inner journey in which they learn about themselves and what they care about, with this knowledge they can then lead and encourage other from their 'heart' and with kindness (57). This reflected in the healthcare leadership literature in terms of 'caring' (2,26) and 'compassionate' leadership (25). So a leader must be able to articulate their own values clearly, relate these both to the organisation's and team's needs and goals, and demonstrate that they do care about people through purposeful and intentional behaviours and actions: person-centred leadership.

Leading and working with others in teams and groups is probably where most of a leader's energy and time is expended, and this is essential for team formation and bonding, and for being able to delegate with confidence. The early literature on team-working focussed on group dynamics and the leader's role in facilitate effective group formation and working (e.g. Tuckman's theory of the stages groups go through ('forming'; ''storming', norming', 'performing')(58). This was complemented by a focus on team roles which suggested that effective teams needed members to take a combination of roles which can be divided into *People oriented* roles (which consider group harmony and the needs of team members), *Action oriented* roles (which focus on making things happen and achieving goals) and *Thinking oriented* roles, which bring ideas and expertise to the team (59).

Culture

"Culture is a set of living relationships working towards a shared goal". (60)

The influence of leaders on culture has had increasing emphasis in the literature and especially in the new generation of leadership theories. Thinking explicitly and working on culture will help a

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leader be more effective. In the recent book by Daniel Coyle, The Culture Code, he looked at highly successful teams across all industries from sport, the defense forces and hospitals to find out what they had in common. From his research he identified three skills that leaders had to emphasize to build a successful team: (60)

1. Build safety for everyone to feel comfortable in working together.

Belonging needs to be continually refreshed and reinforced. Building safety includes listening (really listening), creating safe places where every one's voice is heard, valuing people and giving them a sense of belonging. Often a leader inherits a team which has history and relationships that may have broken down in the past, and where they have been 'led' autocratically and with punishment when things didn't go well. It can be particularly hard to establish psychological safety in such a scenario, and the first step is recognizing it. The team is not dysfunctional, they just don't trust the leader or the process. Practical steps a leader can take include: asking in one-to-one meetings 'What is one thing that I currently do that you would like me to continue to do? and What is one thing that I don't do frequently enough that I should do more often?'. Leaders need to create safe spaces for working together, where everyone is heard, and allow people to have fun at work as well as being serious.

2. Share vulnerability to show no one needs to (or is) be perfect

Embrace failure as learning, many assume that to show vulnerability one would have to established trust first. However, research suggest that showing and sharing vulnerability leads to trust and has been describe as a vulnerability loop leading to contagious cooperation. Many of these aspects align with Brené Browns research on leadership, which highlights courage and vulnerability (61). Her TED talk (62) has been viewed by over 35 million viewers. She emphasizes having courageous conversations and leaning into vulnerability in her book 'Dare to Lead' (63). Much of this is about accepting the emotion and uncomfortableness that one can feel in certain situations. She describes how that unease lasts on average 8 seconds, whereas when you do not have the discourse needed, the unease can last for weeks! The sharing of vulnerability must start with the leader, for example, acknowledging when they have made a mistake, asking if anybody has any ideas to help them and explicitly sharing the risk. Some organisations have a 'failure wall', where people reveal their failures, reflecting vulnerability and sharing learning.

3. Establish purpose through a common goal and a clear path to get there

Over communicate priorities. As a team, you are working in the 'now' towards a future common goal. The goal must be articulated, and the picture painted about how everyone is going to get there. Naming and ranking your top priorities is important, as well as identifying the team roles in achieving them. Catch phrases are helpful for explaining your values and can become common parlance, one of this chapter authors uses '*sprinkling kindness like confetti'* to espouse the value of kindness, which has been adopted by their team.

These three skills which leaders would develop in a successful team can be summarized as 'we are safe, we share risk, and we know what it is all for.'

Culture and conflict

Leaders need to promote a culture in which cognitive diversity and inclusivity is valued, but that this should not be too 'nice' a culture in *which 'challenge, debate and heated discussion with a range of voices and opinions are not common for fear of upsetting the niceness balance and a desire to remain*

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comfortable' (64). Conflict can occur when people have different perspectives or beliefs (they disagree), they misunderstand a situation, or they have a different understanding of it (they see it differently). Some conflict is task related (cognitive or substantive) involving different views on how to make a work-based decision or carry out an activity, others are affective (interpersonal or relationship-based) characterised by interpersonal negative emotions, such as anger or frustration. Of course tasks involve people working together, but poor relationships can undermine teams and activities. A key aspect of building and sustaining teams is therefore to develop trustful, safe relationships, not only so that teams can work productively but also have a space where 'fierce conversations' can be held and where substantive conflicts can be resolved. Interpersonal conflicts should be managed outside the team structure. Leaders need to be able to 'manage' and defuse conflict situations when they become unhelpful and The King's Fund suggests seven strategies:

- 'Cultivate a growth mindset
- Welcome conflict as healthy
- Create psychological safety
- Encourage cognitive diversity
- Get comfortable with emotion
- Make development central to everyone's job
- Focus on creating a culture of dignity and respect for all' (64)

Leaders also need to be aware of the sources of their power. 'Power' is often seen in a negative light, and of course abuse of power is harmful, but we think it is more helpful to think of power in terms of where leaders draw their energy from. Raven suggests that there are six bases of social power we can draw from in different situations: expertise, reward, coercion, legitimacy, reference and information (65). In a 'nasty' culture, power is overtly used to shut conflict and unpleasant conversations down through fear and intimidation whereas in a 'nice' culture, power is used covertly to stop people engaging in conflict because they want to belong to the 'in-group' and not make trouble (64).

An important component of becoming and being a leader involves a redefining of your role as a follower. Being able to follow 'well' is vital as leaders need the support of those above them, and they also need to influence their leaders when needed. This might involve 'upwards' delegation - *'taking the problem to the problem owner'* – knowing when your boss needs to deal with something instead of trying to deal with it yourself. A useful model to help leaders work out what needs to be done in various situations and who should do it is a responsibility assignment tool, a RACI matrix (66). RACI stands for Responsible (who is responsible for doing the activity); Accountable (who has overall accountability); Consulted (who provides and who needs to be given information - a two way process), Informed (who needs to be told what is going on – a one way process).

Coping with and managing change

Part of being resilient and 'gritty' is coping with change. This involves both a psychological aspect and a more technical aspect. All change, even a positive change, involves some loss, both of competence (as you learn new skills or about a new environment) and of what you had before. It can be helpful to envision the changed, improved future, accept that any change takes time and that you might go through the stages of loss and grief (e.g. frustration, anger or withdrawal). Leaders therefore need to be able to recognise and acknowledge the psychological aspects of change in order to cope with their (what might be unexpected) feelings, as well as manage the transition

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process. Research into bereavement and grieving sheds an interesting light on this. For example, Klass et al suggest that, instead of thinking of death as a complete ending, it might be helpful to maintain a continuing bond with the deceased person. It might be helpful therefore for Dr Gina to not see the move into a new role as a complete loss of what went before, but instead an opportunity to take forward and grow and develop existing relationships and experiences (67).

Being able to manage and lead change is one of the hallmarks of successful leaders, and leaders who can adapt well to changing circumstances tend to be more long-lasting. Alongside the psychological aspects of change, leaders need technical skills. A large number of change management tools and techniques are available which can be helpful to use in curriculum design, development and delivery (68). We can divide change initiatives and techniques into three types: linear (useful for technical change, project planning and management); iterative, changes which require some revisiting and which do not have a clear path, and complex change. Change leaders will need to use different approaches depending on the scale, timeframe and complexity of the task. Project management tools are useful for physical or building projects (e.g. moving offices) and curriculum implementation e.g. timetabling and allocating resources. For change projects at an earlier stage, which involve more people and complexity, models such as Kotter's '8 steps' help provide a checklist against which change projects can be planned and analysed (69). These models emphasise the importance of engaging stakeholders at an early stage, setting and communicating a vision and empowering people to take action and deliver the change.

Kotter also emphasises the importance of embedding the change in the culture, so that people don't revert to the old ways (69). This involves a leader developing a deep understanding of the formal and informal organisation in which they work. The formal aspect includes the structure (who does what and who reports to whom), policies and procedures, and the 'front face' of the organisation. The informal or hidden aspects include the culture (the 'way we do things round here') and sub-cultures (professional and departmental 'tribes and territories'); politics and power structures; values and beliefs; history and stories, and rituals, routines and symbols. *'Bolman and Deal (70) suggest that change leaders need to step back and take different perspectives or 'reframe', so as to help them see the organisation or change process from different people's points of view…. the four frames are structural, human resource, political and symbolic. Reframing can help explain why things are happening as they are, and help leaders devise new ways of working by 'looking through different lenses' to view what is happening'* (68 p.3). This would also reflect what Senge calls a 'learning organisation', where leaders develop personal mastery, shared mental models and vision, team learning and systems thinking (71).

When developing and implementing change across organisations or systems, e.g. a new health professions' curriculum, we cannot ignore the complexity. Such a programme operates across multiple organisations, involves many stakeholders, and needs to function on both the education and health systems. Complexity theories can help our understanding, suggesting that leaders need to use 'cognitive complexity' and systems thinking to think in multiple dimensions and relationships, use their networks, recognise ambiguity, and connect people, processes, tool and goals. An adaptive leader will be able to step back and see a system as complex ('get off the dance floor and onto the balcony' and back again) set boundaries, define simple rules, and create the conditions for change (72), rather than attempting to 'manage' the change. Stacey suggests that working in the complex zone involves high uncertainty about the change and its implications and/or disagreement about

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what should be done. Whilst leaders can stimulate change by introducing uncertainty or disagreement into a process (perturbing the edge of chaos), in order to embed the change, they need to work with stakeholders to bring the change into the complicated or simple zones, so it can be managed (73).

Summary

In this chapter, we have expanded some of the theories and models in relation to developing appropriate leadership skills and approaches. At the heart of this is understanding yourself, your strengths and weaknesses, and developing an open mind-set that enables you to build fruitful relationships with others (your leaders and followers). Followers need to be able to trust and respect their leader, and part of this is meeting their expectations of what leaders do and say. So leaders need to demonstrate enough professional credibility and be aware of the power they have, drawn from a number of sources including the position they hold and their expertise. Being able to communicate well and openly with your teams and individuals is essential and, when good relationships are formed, then the leader is starting to build a culture which can allow conflicts to occur and be safely resolved. Finally, we considered that leaders need to be comfortable with and be able to manage change, for themselves and for those around them.

Practice Highlights

- Leaders need to work on developing productive and meaningful relationships with their followers
- Followers need to be able to respect and trust their leaders, therefore leaders need to have credibility
- Understanding yourself is essential to becoming and being a good leader
- Leaders and followers both have a role in developing and maintaining a safe culture and climate

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3rd Chapter: How? – How to use these tools/skills?

> **Scenario**
> Dr Gina has learned a lot now in terms of the skills and strengths she already has and has identified a number of gaps in her understanding and knowledge. She is feeling much more positive and is keen to start to apply her learning and new skills to different situations.

In this chapter, we take a number of situations, theories, models and 'learning lessons' and discuss how these can be applied in practice.

'Learning leadership'

Starting at the top right petal of the 'Daffodil', leadership development can be carried out in undergraduate programmes, during postgraduate training and as part of continuing professional development (CPD). As we've said, leadership theories, practice and development can be broadly divided into three levels (34): **intrapersonal** – this is about getting to know yourself, developing self-insight, understanding your strengths and weaknesses and your responses under pressure; **interpersonal** – this involves working in teams, with other people, patients, colleagues, learning how you are seen by others through conversation and feedback. At the **organisational or system level**, leadership involves learning about and understanding the wider systems and organisations in which you work, politics, processes and how change and quality/service improvement may be managed.

So, how do we 'learn leadership'? We think there are three ways: **formal opportunities** such as short courses, workshops and longer, award bearing programmes and through **practice**, obtaining constructive **feedback** and purposeful **reflection.** Learning leadership is a lifelong endeavour: good leaders have learned from their **experiences** and gained a **practical wisdom** (phronesis) about how to behave and function in different situations. Petrie looks at this a slightly different way, suggesting we need ***'horizontal leadership',*** which gives you an evidence base (in terms of theories, concepts, models and tools) about what leadership is, how it works and ways of approaching situations or tasks. However, as we said above, you can only really learn for yourself how to lead, follow and manage effectively, Petrie calls this **'vertical leadership'** which comprises three elements: meeting challenges ('heat experiences'); 'sense-making' of the experience (through reflection and conversation) and being open to 'colliding perspectives' about what is going on (74).

Reframing and support

Talking with a colleague, Dr Gina commented that she now realised just how much of an educational leader's work is management. But management skills can be learned, and she was actually now looking forward to learning how to develop a 'Learning and Teaching Strategic Plan' for, using project management techniques to map out, prioritise and delegate activities and drawing on her previous course review experience. Dr Gina also reflected that she was started to feel more confident that she could do the job, but that she needed to continue to build her confidence: 'do some small things well'. From a leadership perspective, she feels like a servant leader, not in the role for 'quick wins' but to make a difference and leave a legacy. She also realised that her 'grit' and resilience contributed to this feeling, she is passionate about education but had got ground down in

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everyday pressures, once she had got those under control, she could think more strategically and focus on the 'long game'.

Dr Gina started to realise that she already had a lot of 'leadership skills' but had never really thought of herself as a senior leader. One of her colleagues on the leadership course had suggested that Dr Gina should find a mentor, a 'wise counsel'. Everyone needs support in a new role, and a 'guide on the side', whether a trusted peer, coach or mentor, can really help provide an outside perspective and ideas about different issues (75). A work 'buddy' can act as a critical friend to give you support and feedback on how you are performing. Through finding a mentor and working with her course group, she began to reframe her ideas of what leadership and leaders means. Before Dr Gina had thought and learned about leadership, she had held a very traditional view, thinking of leaders as big 'L' leaders who were often 'great men', or had very senior positions (76). She had also thought of 'management' as something that was a bit on the 'dark side', and certainly inferior to leadership. And she had never heard about followership. This mindset shift was instrumental in helping her to understand that an individual's credibility, personal power and influence results from a host of factors. Simply being in a senior position does not make you a good leader, and conversely, you can be a very effective 'little 'l'' leader (39).

Dr Gina was invited to join an informal group comprising the other Deans of Learning and Teaching in the University. At first she was reluctant, feeling that she would just be revealing her lack of knowledge, but her mentor encouraged her, explaining the importance of networking and collaboration to educational leaders. She was surprised to find not only that the group was very welcoming, but also that they were very impressed that she was a senior clinician and had carried out a major curriculum review. She realised that she was not alone in feeling like an 'imposter' and that most of the other Deans had also felt very out of their depth when they started in role (77,78). This was why they had formed this informal group where they could share ideas, but also get support and ask one another what they felt might be stupid questions. One of the other experienced Deans offered to let Dr Gina 'shadow' her so that she could learn more about the universities' policies and procedures, another suggested that she offer to join one of the University's working parties on curriculum development or review. She also learned about another informal group which was specifically for women in the University, a 'Lean-In group', to share issues and strategies relating to gender issues. She had never realised that all these development opportunities existed, it was collaborative, shared and distributed leadership in action.

Letting go

Following a useful conversation with one of the other Deans, who was astounded that Dr Gina managed to work clinically in addition to the Dean role, Dr Gina decided to talk with her manager, the Head of School, about her workload. She had realised that it was not that her time management was poor, it was just that the workload was too much, and 'you can't do everything'. Rather than continue to struggle on, she had come to appreciate that she needed to give some things up (79). A key issue for clinicians is that because their personal and social identity is closely tied up with their professional identity, of 'being' e.g. a doctor, nurse or physiotherapist, it is a huge identity shift to even contemplate giving up clinical work, as this is such a central part of identity. Making this decision is therefore difficult, and so because Dr Gina was aware of this, she had decided to cut down her clinical work first, rather than stopping entirely and moving into the School full time.

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Before her meeting with the Head of School, she worked with her mentor to clarify what she wanted to get out of the meeting; what her main interests were; where she saw her contribution to the School, in the short and medium term, and the formal professional development she needed to equip her for the new role. This structured and proactive approach resulted in a very productive meeting in which they set SMART (Specific, Measurable, Achievable, Realistic, Timebound) objectives for Dr Gina for the next 18 months. As part of this, they agreed that Dr Gina would drop one day clinically for the next year and then this would be reviewed; that she would undertake a one-day project management course and a one-day strategic planning course, and be nominated for the University Senior Leaders' programme; and that a part-time administrator would be allocated to her, to help with the day-to-day administration and paperwork. The Head of School reinforced to Gina that he felt she had done a great job on the curriculum review, he appreciated that there were other priorities at the moment, but that once these had been addressed, she could take on another similar project as he had every confidence in her. He also said to her to ask him or the other senior team if she needed help, that their door was always open. She came out of the meeting feeling much more valued, positive, empowered and supported, and much more appreciative of her Head of School's leadership and management skills and abilities.

Developing the team

Learning about leadership and followership, and the different leadership approaches and styles was really helpful for Dr Gina. Developing her own self-insight, and understanding her drivers, strengths and weaknesses is essential (as is management and planning of activities), but she cannot lead all these activities without the input and support of individuals and teams. One of the most powerful things Dr Gina learned was the importance of being 'yourself' – authentic leadership. Of course you have to know yourself to be your 'best' self, but what followers want from their leader is to feel valued, included, stretched and supported. From an inclusive leadership perspective, 'making a difference' as a leader involves including and empowering others to make that difference, not necessarily doing everything yourself. Healthcare and educational work involves service (servant leadership); values and morals (value-led and moral leadership); people (person-led leadership); caring (caring and compassionate leadership), and collaboration (collaborative and shared leadership). And whilst a leader sometimes needs to take a different style in certain situations (such as authoritative or directive), it is these underpinning approaches that need to be aligned with the work being done, the people involved, the ethos and culture of organisations, and the values and beliefs of the leader themselves. Articulating, and living the values, setting the culture are all examples of authentic leadership in action.

Dr Gina decided that she would put her learning into practice and introduce her two main teams to some self and team development activities. Her aim was to build the culture of psychological safety and help team members understand one another better in terms of their strengths and weaknesses, so the members could help one another compensate for these; to have some fun so team members would bond better and become more resilient, and to develop a common 'language' to describe people's preferences and different ways of working. She decided to use different approaches with each team. The School Learning and Teaching team was a new team that Dr Gina had established to support her in her new role and many of the members were unfamiliar to Dr Gina. She decided to start with asking members to undertake a Belbin Team Role Inventory (Belbin 2012). This was really helpful both to Dr Gina and to the team, as they realised they had a good spread of team role preferences across the 'thinking', 'action' and 'social' domains, and the members really enjoyed

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learning about themselves and others. As a result, the team worked together to plan their activities for the next year, with people offering to take on various elements based on their role preferences. The Programme Directors' team was well-established and Dr Gina knew most of them from her previous role fairly well. She asked a trained MBTI facilitator to carry out a Myers Briggs Type Indicator (MBTI™) test with each of them, and then work with them as a group to learn more about the way they saw the world, and the way they liked to work. They already had clear roles and she felt that a Belbin Team Role Inventory would not give as much useful information. Following this, she could see that the team members appeared more appreciative of one another, had a common language to use and were reflecting on their decision-making differently. Both teams wanted to undertake more development as a team, and valued that Dr Gina had given them the opportunity for this professional development.

The wider picture

Dr Gina realised, whilst attending some of the senior meetings for the first time that, although she already knew a lot about her 'industry', there were some gaps in her knowledge and understanding. Taking on board the helpful 'positive self-talk' mantra, *'you can't know what you don't know'*, she decided to learn more about how funding and quality systems worked across education and healthcare by asking her Head of School who she could talk to, and where she could find out the information she needed. He offered to introduce her to the Director of Education in the main teaching hospital so she could learn about the healthcare setting and ask the Head of Quality at the University if they would send Dr Gina some useful documents and if she could spend some time observing their work, committees and processes.

Dr Gina had learned about a number of change management techniques on the course, and whilst she had really enjoyed leading on the review of the nursing curriculum, had done this without any formal training or development. She had already established two teams which would help her plan and take programme changes forward and she decided to work with them to develop the Learning and Teaching Strategic Plan, starting with developing and setting out a shared vision. She felt this would help establish an inclusive culture and demonstrate to her teams that she valued their ideas, perspectives and input, and would help share the power amongst the teams, rather than her taking an authoritative approach and using her positional power. She knew that the accountability lay with her, but (drawing on the RACI model), that the responsibility needed to be shared between the team members. She also wanted to use her 'cognitive complexity' in that, whilst she was starting to see the whole picture from a systems perspective herself ('from the balcony'), she knew that she needed the teams to come to some agreement and certainty, so that the vision could be translated into a Strategic and Operational plan which could be implemented from the complicated and simple zones. She wanted the teams have a 'quick visible win' (Kotter 2012) to keep them motivated as there were no real external pressures upon them, so she asked them to identify some short courses or activities that could be carried out this year.

Paying it forward: Embedding leadership into curricula and professional development

As you can see, our understanding of leadership is constantly shifting: it is not a static concept. Over the last few years, many health professionals and educators have become more politicised and we see a current shift in the way doctors and health professionals see themselves as leaders, combining

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accountability, advocacy and **activism**. This involves putting core values into action and incorporating these into everyday behaviours. Table X.4 sets out the three areas (Column 1 and describes how these might be displayed in action (Column 2). Training and education will need to be provided in various topics to encourage these values (listed in Column 3), and from a leadership perspective, we have highlighted some of the leadership theories or approaches that underpin these activities in Column 4. These three areas do not necessarily relate to undergraduate, postgraduate and continuing professional development, or to levels of seniority, but there is a developmental aspect to this, and it starts with accountability.

	Core values in action	**Education/training in …**	**Leadership theory/approaches**
Accountability *These values in action and training should be part of every undergraduate and postgraduate curriculum*	➢ For care of individual patients ➢ Requires clinical expertise, care, compassion ➢ For own professional conduct/clinical practice ➢ For patient safety at individual level ➢ Responsibility for self-care	➢ Clinical knowledge and expertise ➢ Communication skills ➢ Professionalism, role boundaries ➢ Self-development, self-insight ➢ Time and stress management ➢ Teamworking ➢ Patient safety	➢ Caring & compassionate leadership ➢ Resilience/grit/EI/ ➢ Emotional wellbeing ➢ Followership
Advocacy *To advocate effectively for students, colleagues, patients, healthcare and education, you need a deeper understanding of the context and cultures, plus skills to navigate, persuade and influence for change*	➢ Patient advocacy ➢ Health advocacy ➢ Community advocacy ➢ Challenging decisions ➢ Quality/service improvements ➢ Social accountability ➢ Interprofessional/ ➢ Multidisciplinary team working ➢ Preventive care, public health perspective ➢ Care of others (patients, colleagues, learners)	➢ Service and organisational systems, structures, functions and funding ➢ Public health, preventive care ➢ Integrated service approaches ➢ Conflict resolution ➢ Negotiation, persuasion and influencing skills ➢ Leadership and followership	➢ Dispersed/distributed leadership ➢ Shared/collaborative leadership ➢ Inclusive leadership ➢ Relational leadership ➢ Compassionate/caring leadership
Activism *Not everyone will (or should?) become an activist, but when we feel very strongly, sometimes we have to put our heads above the parapet and*	➢ Increased politicisation ➢ Willingness to become involved ➢ Challenging 'authority' ➢ Whistleblowing	➢ Diversity, inclusivity and unconscious bias ➢ Power dynamics ➢ Political awareness and astuteness ➢ Strategic management ➢ Systems thinking and complexity science	➢ Inclusive leadership ➢ Collective leadership ➢ Complexity and systems thinking ➢ Adaptive leadership ➢ Servant leadership: ▪ legacy building ▪ Stewardship

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work actively with power and politics in complex systems		➢ Value based healthcare	

Table X.4 Leadership development activities

Summary

Dr Gina has now been Dean of Learning and Teaching for five years. In that time she has learned a lot about herself and the organisation, is working well with an expanded team across the School on many new projects and is mentoring some of the less experienced staff, developing them as 'little 'l' leaders'. With a lot of sadness she gave up her clinical work three years ago, but it meant she could focus on the development of new programmes for the School including a distance learning masters' degree and a Physician Associate programme. She has developed a *'health professions' leadership and management'* curriculum which is now embedded into all the programmes and has received national acclaim. She was recently approached by two junior members of staff to mentor them, so they could be prepared to be able to move into leadership positions for the future. Occasionally she still feels a bit like an 'imposter', and certainly not the expert people seem to think she is, but most of the time she loves her work and feels she is working at the right level. She is so pleased she didn't give up all those years ago, and is very grateful to all her colleagues who supported and mentored her into becoming a health professions' education leader.

Practice Highlights

- Leadership learning is a lifelong endeavour and development happens through a combination of formal learning, experience and reflection
- Having support from colleagues and building a network helps provide perspective on what leadership actually involves
- Moving into a new position or role usually involves giving something up, this can be difficult
- Building a strong team which values diverse ideas and perspectives is also vital
- Leadership and management are starting to be embedded into health professions' curricula at all levels

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