WR P | EM

Wellness Resilience and Performance

WRAP EM MODULE 14

Leadership

A Synopsis by Shahina Braganza

Introduction

Leadership is one of the hallmarks of an effective team.

Leadership is complex to define. However, one tends to know when one experiences or observes good leadership – and also its absence.

This module aims to explore the concept of leadership, to deconstruct the elements that comprise it, and to provide a framework in which it can be considered.

The good news is that, while it is recognised that there exist some inherent or innate attributes that predispose to being a good leader, it is clear that there also exists the ability to acquire and enhance skills in this sphere.

Ultimately, leadership - at the head of, and within a group - leads to the formation and sustenance of an effective team that understands its core purpose (the Why), and that works in concert to fulfil specific but fluid roles (the How), in order to achieve its ultimate goal (the What) – which is the delivery of excellent health care to our patients and community.

Acknowledgement of source

This synopsis has been compiled by weaving my personal experience and observation with ideas and research adapted from the following two sources:

(1) Educational Leadership, McKimm J and Swanwick T, Association for the Study of Medical Educaton (2007), www.asme.org.uk

(2) Wikipedia!

https://en.wikipedia.org/wiki/Leadership

Further references are embedded within the text.

Goals and Objectives

Goal: At the end of this module, participants will be able to define the concepts of Leadership and Professionalism (cognitive), establish the meaning of these concepts for themselves as individuals and within teams (affective), and manifest Leadership and Professionalism more deliberately and effectively within their contexts and environments (psychomotor).

Objectives:

At the end of this module, the participant will be able to:

1. Understand and describe the relationship between leadership and management.

2. Describe various models of effective leadership in context: eg; transformational; transactional; collaborative; phronetic.

3. Understand the paradigm of leadership - 'The Doctor as Team Leader'.

4. Identify potential barriers to leadership development and synthesise strategies to resolve(mitigate) them. Then potentiate their own leadership development in their workplace.

Leadership – opening statements

Leadership is a matter of intelligence, trustworthiness, humaneness, courage, and discipline ...

Reliance on intelligence alone results in rebelliousness. Exercise of humaneness alone results in weakness. Fixation on trust results in folly. Dependence on the strength of courage results in violence. Excessive discipline and sternness in command result in cruelty. When one has all five virtues together, each appropriate to its function, then one can be a leader. – Sun Tzu*

*Chinese general, military strategist, and philosopher who lived in the Spring and Autumn period of ancient China. Sun Tzu is traditionally credited as the author of *The Art of War*, a widely influential work of military strategy that has affected both Western and Eastern philosophy.

Statue of Sun Tzu in Yurihama, Tottori, in Japan

Image - https://commons.wikimedia.org/wiki/File:Enchoen27n3200.jpg#/media/File:Enchoen27n3200.jpg -

It was traditionally assumed that leaders were born, not developed ie. that leadership is rooted in the characteristics of certain individuals. This idea that leadership is based on individual attributes is known as the "trait theory of leadership". (*Lord, R. G.; De Vader, C. L.; Alliger, G. M. (1986). "A meta-analysis of the relation between personality traits and leader perceptions: An application of validity generalization procedures". Journal of Applied Psychology.* ***71*** *(3): 402–410. doi:10.1037/0021-9010.71.3.402.*)

Subsequently, it has been recognised that leadership is not an enduring individual trait, as it was noted that individuals are capable of being effective in certain situations, but not in others.

Over time, the focus shifted away from *traits of leaders* to an investigation of the **leader behaviours** that were effective.

Emerging research into leadership revealed the following:

Individuals are capable of emerging as leaders across a variety of situations and tasks.

Leaders are more likely to possess individual traits like:

Intelligence

Adjustment

Extraversion

Conscientiousness

Openness to experience

General self-efficacy

However, these traits must be harnessed in conjunction with:

Cognitive abilities

Motives

Values

Social skills

Expertise

Problem-solving skills

As such, when we consider a person's ability to lead, we consider the person as an integrated combination of these characteristics, acting fluidly within a given context, rather than a summation of static individual traits.

The most effective leaders have well-developed self-awareness coupled with knowledge of and insight into the strengths and abilities of their 'followers'.

Leadership in healthcare occurs within an environment of high complexity. Effective leaders have to work across multiple boundaries: organisational, cultural, professional and departmental. At any given time, there are multiple stakeholders to be considered.

In medical training, from student to consultant (and beyond), opportunities for leaderful conduct and modelling abound.

As a medical student, one is often thought of as being "at the bottom of the food chain". To some extent this is true, and this is largely a learning phase. However, one should never under-estimate one's ability to influence their local environment. While careful considerations must be made around hierarchy and one's own sense of behaving respectfully and somewhat deferentially, a student may be capable of leadership and of elevating a sense of professionalism. This may occur either subtly by not engaging in conversation that may be ill thought out or demeaning towards other staff or patients, or overtly by calling out inappropriate behaviours.

Once one graduated to internship or residency, they acquire a greater sense of responsibility to uphold the skills and the values of the medical profession. A junior doctor may often find themselves as the first responder in a clinical setting, leading the initial

resuscitation of an unstable patient, directing a team of inter-disciplinary staff, and coordinating care.

As registrars supervising junior doctors and students, this responsibility becomes more imperative, more overt and more structured, and indeed constitutes important criteria in the in-training assessment process.

As consultants, we are expected to be the vanguards of leadership and professionalism, but this time in the wider arena across the department and the organisation. We demonstrate this clearly in the clinical setting, whether related to a single-patient context (eg resus) or a whole-of-department context (eg shift leader). We also demonstrate it in the non-clinical setting where we work continuously to improve systems and efficiency, advocate for our staff and our patients, and collaborate with our colleagues in order to provide excellent health care at community level.

At every stage, one is constantly learning, adjusting and adapting to suit their role within the context.

Leadership is about being and doing – talking the talk and walking the walk.

Objective 1

Understand and describe the relationship between ‘leadership’ and ‘management’ while recognising that the concepts are intertwined.

Leadership vs Management

Leadership and strategic management are inextricably intertwined.

There are many definitions of leadership. Leadership theory looks at individual traits and behaviours, but also at the relationship between leaders and followers, AND the context or situation in which they operate.

It is useful to distinguish between management and leadership. Although there is considerable overlap and interdependency, differentiating between the two concepts helps us explore what leadership is.

Managers are often described as performing *functions* in organisations. Generally they hold a formal title or role. They tend to be concerned with planning, organising, coordinating, commanding or controlling the activities of staff, thereby providing order and consistency. As such they are focused on the WHAT and HOW of departmental or organisational business. They tend to work within existing established paradigms, solve problems and manage people. As a broad generalisation, examples of managers in our healthcare setting include Nurse Unit Managers, Roster Managers, Senior Administrative Officers, and some Medical Directors.

Leaders, by contrast, aim to influence and guide others into pursuing particular objectives or a vision of the future, and to motivate them into wanting to follow, thereby producing change and movement. As such their mode of operation is communicating the WHY of departmental or organisational business. Leaders tend to create new paradigms, challenge systems, seek new opportunities and lead people. As another broad generalisation, think here of people whom you’ve come across who work to

energise team members or followers into striving for excellence. You may think of a Director of Emergency Medicine, or a senior nurse to whom staff turn in times of crisis, or an Administrative Officer who seems to innately know how to "get the job done".

Leadership is the process of influencing others to *understand and agree* about what needs to be done and how it can be done effectively, and the process of facilitating individual and collective efforts in order to accomplish the shared objectives. (Yukl G (2002), Leadership in Organisations (5e), Prentice Hall, New Jersey).

Note, however, that it is often the same person who operates in both capacities – the most effective people in organisations are both managers and leaders. And often in the context of a healthcare workplace, they have to be both and do so effectively.

MANAGEMENT	LEADERSHIP
Produces order and consistency	Produces change and movement
Planning/Budgeting: - *agendas* - *timetable* - *resource allocation*	Establishing direction - *vision creation* - *big picture* - *strategies*
Organisation/Staffing - *structure* - *job allocations* - *rules and procedures*	Aligning people - *communication of goals* - *commitment seeking* - *building of team and alliances*
Controlling/Problem Solving - *incentives* - *creative solutions* - *corrective action*	Motivating and Inspiring - *energizing* - *empowerment*

Northouse P (2004) Leadership: theory and practice (3e). Sage, London.

Objective 2

Describe various models of effective leadership in context

Leadership Styles

Leadership styles are categorised according to various structures. One broad categorisation separates leadership styles into the following:

1. Autocratic or authoritarian

2. Participative or democratic

3. Laissez-faire or Free-rein

4. Task-oriented and relationship-oriented

(Some of these overlap and parallel with the concepts of Transactional/Managerial Leadership and Transformational Leadership, *Bass, B. M.; Avolio, B. J.; Atwater, L. E. (1996). "The transformational and transactional leadership of men and women". Applied Psychology: an International Review.* ***45****: 5–34.* *doi:10.1111/j.1464-0597.1996.tb00847.*)

A leadership style is a leader's style of providing direction, implementing plans, and motivating people. It is the result of the philosophy, personality, and experience of the leader.

Different situations call for different leadership styles. In an emergency when there is little time to converge on an agreement and where a designated authority has significantly more experience or expertise than the rest of the team, an autocratic leadership style may be most effective.

By contrast, in a highly motivated and aligned team with a homogeneous level of expertise, a more democratic or Laissez-faire style may be more effective. The style adopted should be the one

that most effectively achieves the objectives of the group (for us, delivering good health care to a patient) while balancing the interests of its individual members (the recognition of ability to contribute).

Furthermore, the styles are not necessarily mutually exclusive or in competition with each other – there can be overlap.

REFLECTION - Consider the following scenarios:

The role of the medical team leader in a Resuscitation (adult multi-trauma patient, unstable).

Consider the above role where the team consists of an ED-only team.

Consider the above role when a Trauma Call Service is available and an Anaesthetist, Surgeon and Intensivist also comprise the team.

The role of the medical team leader during a busy evening shift with high patient volume and access block.

The management of a frequent presenter in ED (clinical setting) vs their management as part of a long-term management plan dialogue.

Consider also our role as the designated Leader of the ED team but also as the Leader in the context of interaction with patient and family as followers. Consider the scenarios that involve shared decision making with these stakeholders:

eg whether to perform a lumbar puncture in a 50yo lady with headache to investigate for subarachnoid hemorrhage (benefits vs risks, etc)

eg the family discussion around an Advanced Resuscitation Plan for a patient in whom a ceiling of treatment may be appropriate.

Consider these scenarios again after reviewing Leadership Styles and reflect upon which style/s may be effective in each setting.

1. Autocratic or authoritarian

Under the autocratic leadership style, all decision-making powers are centralized in the leader, as with dictators.

Autocratic leaders do not entertain any suggestions or initiatives from subordinates. Autocratic management provides strong motivation to the manager. It permits quick decision-making, as only one person decides for the whole group and keeps each decision to themselves until they feel it needs to be shared with the rest of the group.

Some may describe members of a hospital executive management team in this regard.

Does a medical team leader sometimes employ this style of leadership in a critical resuscitation setting? Perhaps occasionally, but likely in short bursts only.

2. Participative or democratic

The democratic leadership style consists of the leader sharing the decision-making process with group members by promoting the interests of the group members and by practicing social equality. This has also been called shared leadership.

We often use this mode of leadership in healthcare when we conduct multi-disciplinary team meetings. Also consider meetings with patients and/or their families.

3. Laissez-faire or Free-rein

In Laissez-faire or free-rein leadership, decision-making is passed on to the sub-ordinates. The sub-ordinates are given complete right and power to make decisions to establish goals and work out the problems or challenges.

To me, this holds the risk of being a 'no leader' model that potentially leads to chaos and lack of coordination. However it also poses an opportunity for followers to develop and assert leadership.

Examples in our ED setting may include an exam study group or perhaps a staff social group?

4. Task-oriented and relationship-oriented

Task-oriented leadership is a style in which the leader is focused on the tasks that need to be performed in order to meet a certain goal. Task-oriented leaders are generally more concerned with producing a step-by-step process for a given problem or goal, making sure deadlines are met, and results and targets are achieved.

Relationship-oriented leadership is a contrasting style in which the leader is more focused on the relationships between group members and is generally more concerned with the overall well-being and satisfaction of group members. Relationship-oriented leaders emphasize communication within the group, show trust and confidence in group members, and show appreciation for work done.

Because task-oriented leaders are typically less concerned with catering to individuals, and more concerned with acquiring a certain solution to meet a goal, they typically achieve deadlines. However their group members' well-being and engagement may suffer.

Relationship-oriented leaders are focused on developing the team and the relationships in it, thereby creating team members who are more motivated and have support. However, the emphasis on relations as opposed to getting a job done might make productivity suffer.

A personal story:

A few years ago, I agreed to fill the role as Director of Clinical Training at our hospital. I did this part-time, while retaining my part-time position as a Emergency Physician. A seven-week stint evolved into three years.

When I began in the role I knew almost nothing about the theory of Medical Education, and the systems and processes involved in intern training and assessment. It was a steep learning curve. My

teachers were the team members already in the Unit – the Medical Education Officers and the Administration Officers. They were my coaches and my supporters and very quickly we established a "flat-hierarchy" dynamic that was deeply respectful and based on camaraderie.

I was determined to be a Director who was flexible and accommodating of team members' needs and preferences. I even used catch phrases such as "I don't mind how we do our work – eg what time we start and finish – as long as two things happen: (1) The job gets done, and gets done well, and (2) We are accountable for the hours we are paid to work". (Another catch phrase was "We need to take our work seriously, but not ourselves").

Over time, however, as team members' personal and professional circumstances evolved, I developed an unease that one or two team members may not have complete integrity over reciprocating the goodwill we had been determined to establish. It took me many months, but I needed to evaluate the balance between maintain relationships while achieving outcomes and goals, and then act upon this. The process was lengthy and it was uncomfortable for me, but I realised that it needed to happen.

I even had one team member feed back to me: "Shahina, you've changed. And, to be honest, this new style doesn't suit you". Unusually I had the temerity to respond: "Sarah*, I've needed to adapt, and –actually - it doesn't suit <u>you</u>". (*Not her real name, obviously).

I've learnt that flexibility and accommodation (and personal connection) are valuable attributes of a leader, but one then needs to be very careful in employing this approach towards selective followers who are trustworthy and reliable.

Task-oriented and relationship-oriented leadership somewhat parallel with transactional and transformational leadership, respectively.

Bernard Bass and colleagues developed the idea of two different types of leadership: Transactional - involving exchange of labor for rewards and Transformational - based on concern for employees, intellectual stimulation, and providing a group vision.

B. M. Bass, "From Transactional to Transformational Leadership: Learning to Share the Vision," Organizational Dynamics, Vol. 18, No. 3, 1990, pp. 19-31. http://dx.doi.org/10.1016/0090-2616(90)90061-S

The transactional leader is given power to perform certain tasks and either reward or punish the team's performance. The group agrees to follow the leader to accomplish a predetermined goal in exchange for something else. Power is given to the leader to evaluate, correct, and train subordinates when targets are not achieved, and to reward effectiveness when they are. (Burns, J. M. (1978). Leadership. New York: Harper and Row Publishers Inc. ISBN 978-0060105884)

Transactional leadership, also known as managerial leadership, focuses on supervision, organization, and performance. Unlike transformational leaders, the transactional approach is used not change the future, but rather to keep things the same.

We might consider that many hospital CEOs need to operate in this fashion.

However this leadership style also works effectively in crisis or emergency setting, and a Disaster situation may call for this type of leader.

The transformational leader works with followers to identify needed change, creating a vision to guide the change through inspiration, and executing the change in tandem with committed members of a group. Transformational leadership serves to enhance the motivation, morale, and job performance of followers through a variety of mechanisms: connecting the follower's sense of identity and self to a project and to the collective identity of the organization; being a role model for followers in order to inspire and engage them; challenging followers to take greater ownership for their work, and understanding the strengths and weaknesses of

followers, allowing the leader to align followers with tasks that enhance their performance.

The followers of such a leader feel trust, admiration, loyalty and respect for the leader and are generally willing to work harder than expected.

These outcomes occur because the transformational leader offers followers something more than just working for self-gain; they provide followers with an inspiring mission and vision and give them an identity. In addition, this leader also empowers followers to be innovative in their approach to improving their environment and the systems within it.

This leadership style is seen in some reputable Directors of Departments, especially during periods of growth or evolution.

In addition, think of members of your team who might not hold formal positions of authority, but who simply exude energy that inspires those around them to have a positive approach to the team's work, simply by "setting the tone". It may be a wardsperson in the ED or an administrative officer in the back office. These are the empowered followers who influence their environment – and in doing so, they exert they own brand of leadership.

The four "Is" of transformational leadership	
Idealised influence	Developing a vision, engendering pride, respect and trust
Inspirational motivation	Motivating by creating high expectations Modelling appropriate behavior and using symbols to focus efforts
Individualised consideration	Giving personal attention to followers, giving them respect and responsibility
Intellectual stimulation	Continually challenging followers with new ideas and approaches

Adapted from Bass B and Avolio B (1994), Improving Organizational Effictiveness Through Transformational Leadership. Safe, Thousand Oaks, Ca.

PHRONETIC (“WISE”) LEADERSHIP

https://hbr.org/2011/05/the-big-idea-the-wise-leader

Phronetic leadership is a meld between Japanese and Western philosophy and focuses on the *judgement* behind the process of leadership.

Phronesis is a term that was derived by Aristotle, meaning practical wisdom and prudence – the habit of making the right decisions and taking the right actions in context. It is the relentless pursuit of excellence for the common good.

A phronetic approach begins by asking the organisation – do you have a moral purpose? It deems that profit – or healthcare “targets” are a side result not a goal.

This approach encourages the leader to be a **pragmatic idealist** – to stretch moral purpose and then translate this into the operation of achieving purpose. It also describes a distributive leadership which evolves organically from the top down, or rather from the centre outwards.

A phronetic model needs close human interactions to cultivate these capabilities, almost via apprenticeship. This is particularly apt for medical practice and training, whereby we acquire and improve our skills via modelling and mentorship.

The six attributes of phronetic leaders are ability to:

1. Judge goodness – they make decisions only after they figure out what is good for the organisation and society.

2. Grasp the essence – and intuitively fathom the nature and meaning of people, things and events.

3. Create shared contexts – formal and informal – between senior executives and employees to construct new meaning through their interactions.

4. Communicate the essence- use metaphors and stories to convert the essence of their actual experiences into tacit knowledge for individuals and groups.

5. Exercise political power – to bring together people with conflicting goals and spur them to action.

6. Foster practical wisdom in others – especially employees on the front line, through apprenticeship and mentoring.

Emotional Intelligence in Leadership

This content is taken from:

Howell, Jon P. (2012). Snapshots of Great Leadership. London, GBR: Taylor and Francis. pp. 16–17

*Sy, T.; Cote, S.; Saavedra, R. (2005). "The contagious leader: Impact of the leader's mood on the mood of group members, group affective tone, and group processes" (PDF). Journal of Applied Psychology. **90** (2): 295–305. doi:10.1037/0021-9010.90.2.295.*

*George, J. M. (2000). "Emotions and leadership: The role of emotional intelligence". Human Relations. **53** (8): 1027–1055. doi:10.1177/0018726700538001.*

*Bono, J. E.; Ilies, R. (2006). "Charisma, positive emotions and mood contagion". The Leadership Quarterly. **17** (4): 317–334. doi:10.1016/j.leaqua.2006.04.008.*

Leadership can be perceived as a particularly emotion-laden process. In an organization, the leader's mood sends signals to their group, affecting how their group thinks and acts. These effects can be described in three levels:

1. **The mood of individual group members**. Group members with leaders in a positive mood experience more positive mood than do group members with leaders in a negative mood. This occurs via the mechanism of emotional contagion. Mood contagion may be one of the psychological mechanisms by which charismatic leaders influence followers.

2. **The affective tone of the group**. Group affective tone represents the consistent or homogeneous affective reactions within a group – the *aggregate* of the moods of the individual members of the group. Groups with leaders in a positive mood have a more positive affective tone than do groups with leaders in a negative mood.

3. **Group processes like coordination, effort expenditure, and task strategy**. Leaders signal their goals, intentions, and attitudes through their expressions of moods. For example, expressions of positive moods by leaders signal that leaders deem progress toward

goals to be good. The group members respond to those signals cognitively and behaviorally in ways that are reflected in group actions.

Since employee behaviour and productivity are directly affected by their emotional states, it is imperative to consider employee emotional responses to organizational leaders. Emotional intelligence - the ability to understand and manage moods and emotions in the self and others - contributes to effective leadership within organizations.

Individuals with high emotional intelligence have increased ability to understand and relate to people. They have skills in communicating and decoding emotions and they deal with others wisely and effectively. Such people communicate their ideas in more robust ways, are better able to read the politics of a situation, are less likely to lose control of their emotions, are less likely to be inappropriately angry or critical. As a result, they are more likely to emerge as leaders.

What about IQ?

Individuals with higher intelligence exhibit superior judgement, higher verbal skills (both written and oral), quicker learning and acquisition of knowledge, and are also more likely to emerge as leaders. However, groups generally prefer leaders that do not exceed intelligence prowess of the average member by a wide margin, as they fear that high intelligence may be translated to differences in communication, trust, interests and values

In summary, an effective leader needs EQ and IQ

GENDER INFLUENCES

(taken from https://en.wikipedia.org/wiki/Leadership)

Another factor that covaries with leadership style is whether the person is male or female. When men and women come together in groups, they tend to adopt different leadership styles.

Men generally assume an *agentic* leadership style: they are task-oriented, active, decision focused, independent and goal oriented. When asked, they tend to describe themselves as influential, powerful and proficient at the task that needs to be done. They tend to place more focus on initiating structure within the group, setting standards and objectives, identifying roles, defining responsibilities and standard operating procedures, proposing solutions to problems, monitoring compliance with procedures, and finally, emphasizing the need for productivity and efficiency in the work that needs to be done.

Women, on the other hand, are generally more communal when they assume a leadership position. They strive to be helpful towards others, warm in their approach, understanding, and mindful of others' feelings. In general, when women are asked to describe themselves to others in newly formed groups, they emphasize their open, fair, responsible, and pleasant communal qualities. They give advice, offer assurances, and manage conflicts in an attempt to maintain positive relationships among group members. Women connect more positively to group members by smiling, maintaining eye contact and responding tactfully to others' comments.

As leaders, men are primarily task-oriented, but women tend to be both task- and relationship-oriented. However, it is important to note that these sex differences are only tendencies, and do not manifest themselves within men and women across all groups and situations.

Objective 3

Understand the paradigm of leadership - 'The Doctor as Team Leader'.

Recognise an ability to manifest leadership at all levels within a hierarchy:

Pearl

You're never too low down the food chain to be a leader – influence those "below" you (eg students) but don't underestimate your influence upon those "above" you. You are constantly modelling via your behaviour and conduct – whether positive or negative. Recognise your influence and power, if only to "set the tone" about you.

Developing Leadership

Leadership - including clinician leadership - courses abound. You should be able to access one via your health service intranet. Their value and relevance is variable, but it is worth canvassing opinion from your colleagues. Some years ago, I completed a Medical Leadership in Action course, and found it to be valuable – arguably more for my Director of Clinical Training role than for my work in Emergency Medicine, because at the time, my leadership growth was more evident in the former role.

It can be argued that Leadership evolution is a journey and not a destination. As such, it is difficult to create a "recipe" for leadership. However here is one approach by James Scouller, who wrote about The Three Levels of Leadership (*Scouller, J. (2011). The Three Levels of Leadership: How to Develop Your Leadership Presence, Knowhow and Skill. Cirencester: Management Books 2000*).

Scouller proposed the Three Levels of Leadership model - Public, Private and Personal leadership.

The first two – public and private leadership – are "outer" or behavioral levels. These are the behaviors that address what Scouller called "the four dimensions of leadership", including group purpose, action/results, team spirit, individual motivation. Public leadership focuses on influencing a group of people. Private leadership covers the influence of individuals one to one.

The third – personal leadership – is an "inner" level and concerns a person's growth toward greater leadership presence, knowhow and skill. Working on one's personal leadership requires: (1) Technical knowledge and skill (2) Developing the right attitude toward other people – which is the basis of *servant leadership* (3) Psychological self-mastery – the foundation for *authentic leadership*.

Scouller describes that self-mastery is the key to:

- growing one's leadership presence,

- building trusting relationships with followers, and

- dissolving one's limiting beliefs and habits, thereby allowing flexibility and adaptability as circumstances change, while staying true to one's core values (ie remaining authentic).

To support leaders' development, he introduced a new model of the human psyche and outlined the principles and techniques of self-mastery, which include the practice of mindfulness meditation.

There exists a freely-accessible online tool which accompanies the book: http://www.three-levels-of-leadership.com/tool-downloads.

Activity: Plot a leadership journey pathway for yourself. Depending on your level of training, you may want to focus on the next year, or the next 5 years, or next 10 years.

Some more pearls –

(1) Leadership from the centre is arguably more effective than leadership from the top.

This engenders the sense of a flat hierarchy, and enhances one's ability to share the Why, ahead of the How and What:

Why are we here? Because our patients need us to provide good and reliable care.

How will we achieve this? Working together to each fulfil our roles effectively.

What do we do now? The detail…

(2) Leadership is about Connectivity.

Connect people with the Why…

(3) Lead with humility. The concept of the (imperfect) servant leader.

Accept imperfection.

Accept risk.

Back your followers. Own the responsibility for their actions. The victories belong to the team; the failings belong to the leader.

Ask for help and guidance. Out your own gaps and failings.

Accommodate followers' needs outside work – you'll the get the best out of them.

(4) Be consistent about Expectations.

Set expectations around effort rather than result. (Again, the Why ahead of the What). Hopefully the result will follow. "Numbers can be forgiven; but values and attitude cannot".

Seek strength in each player. Work them to their strengths.

(5) Be resilient – and don't be overwhelmed or discouraged by failure (for long).

Objective 4

Identify potential barriers to leadership development and synthesise strategies to resolve (or mitigate against) them.

Then potentiate your own leadership development in your workplace.

Let us begin by exploring some myths about leadership.

This is adapted from https://en.wikipedia.org/wiki/Leadership

Leadership is innate

According to some, leadership is determined by distinctive traits present at birth eg. extraversion, intelligence, ingenuity. However, there is collective evidence to show that leadership also develops through hard work and careful observation. Thus, effective leadership results from nature (ie. innate talents) as well as nurture (ie. acquired skills).

Leadership is possessing power over others

Although leadership is certainly a form of power, it is not defined by power *over* people – rather, it is a power *with* people that exists as a reciprocal two-way relationship between a leader and his/her followers (Forsyth, D. R. (2009). *Group dynamics* (5th ed.). Pacific Grove, California: Brooks/Cole.)

Despite popular belief, the use of manipulation, coercion, and domination to influence others is not necessary or effective in leadership. In fact, individuals who seek group consent and strive to act in the best interests of others can also become effective leaders (e.g., class president; court judge overseeing a jury).

Leaders are positively influential

Group tend to flourish when guided by effective leaders. Moreover, group performance, creativity and efficiency all improve in businesses with designated managers or CEOs.

However, the difference leaders make is **not** always positive in nature. Leaders sometimes focus on fulfilling their own agendas at the expense of others. Leaders who employ stringent and manipulative leadership styles for personal gain often make a difference, but usually do so through negative means.

Leaders entirely control group outcomes

In Western cultures it is generally assumed that group leaders make *all* the difference when it comes to group influence and overall goal-achievement. This is a simplified view of leadership that tends to overestimate the degree of control leaders have over their groups and their groups' outcomes. Many other factors influence group dynamics including:

- *group cohesion*
- *communication patterns between members*
- *individual personality traits*
- *the nature of the work*
- *behavioural norms and standards*

All groups have a designated leader

Not all groups need to have a designated leader. Groups that are primarily composed of women, are limited in size, are free from stressful decision-making, or only exist for a short period of time (e.g., student work groups; pub quiz/trivia teams) often undergo a *diffusion of responsibility,* where leadership tasks and roles are shared amongst members.

Group members resist leaders

Despite the frustrations, challenges, and sometimes resentment, of following a leader, most people actually prefer to be led than to be without a leader. This "need for a leader" becomes especially strong in unstable groups undergoing conflict or change. Group members tend to be more contented and productive when they have a leader to guide them. Most followers appreciate the contributions that leaders make to their groups and consequently welcome the guidance of a leader. (Larson, J. R. Jr.; Christensen, C.; Abbot, A. S.; Franz,

T. M. (1996). "Diagnosing groups: Charting the flow of information in medical decision-making teams". *Journal of Personality and Social Psychology*. **71**: 315–330)

Leadership in Healthcare - Challenges

Leadership in the healthcare context must address several boundaries eg professional, disciplinary, organisational, departmental.

Leaders must work within (or at least be cognisant and respectful of) existing frameworks - structures, systems, funding mechanisms, cultures, norms and values.

Developing leaders may face the following challenges:

(McKimm j (2004), Case Studies in Leadership in Medical and Health Care Education: Special Report 5. Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine, Newcastle-upon-Tyme)

PERSONAL

- work-life balance/harmony (esp with domestic commitments)
- clinical + administrative role balance
- importance of retaining clinical presence for credibility
- perceived 'glass ceiling'
- further administrative training eg MBA, FRACMA

ORGANISATIONAL/CULTURAL

- understand culture and anthropology of own organisation
- "corporate knowledge" and corporate memory
- some disciplines may be advantaged eg EM interfaces with many/all clinical and administrative processes

COMPETING AGENDAS

- Rapidly changing and complex health service
- Being the leader/manager and also being at the coal-face
- Multiple 'task masters' – competing management styles, cultures, values, demands

WIDER AGENDA

- Recognise influential role in changing and improving healthcare systems/organisations/departments
- Understanding the global picture and agenda of the system
- Connection and collaboration widely and deeply – promoting diversity and innovation

During a leadership journey, these challenges tend to be fluid and continually evolving, particularly on the personal front. The journey may weave, accelerate or decelerate at times.