# FOLLOWERSHIP, CLINICAL LEADERSHIP AND SOCIAL IDENTITY

Mannion, H., McKimm J., O'Sullivan H.M.

Hester Mannion, Graduate Entry Medicine Student, College of Medicine, Swansea University

Professor Judy McKimm, Professor of Medical Education and Director of Strategic Educational Development, College of Medicine, Swansea University

Professor Helen O'Sullivan, Professor of Medical Education, School of Medicine, University of Liverpool

## CONFLICTS OF INTEREST

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*This article explores how the concepts of followership, social identity and social influence help clinical leaders and followers better understand how leadership processes function within and between individuals, teams and complex organisations.*

## INTRODUCTION

Health professionals commonly work in teams to deliver healthcare to patients and communities across various organisational, professional, service and social settings. West and Lyubovnikova (2013) describe real team working as an 'illusion', the idea that teams work effectively as stable entities is a misconception, as in reality they are fluid and differ greatly in character depending on the situation and team composition, with most health workers working in 'pseudo teams'. As health and social care service delivery becomes more complex, the traditional hierarchical uni-professional structures and lines of authority are becoming increasingly ineffective and outmoded (Martin, 2011). The doctors' role as 'head of the healthcare team and commander of considerable resource' (Tooke, 2008) does not necessarily apply in all situations which means that traditional conceptions of 'command and control' type leadership are rarely applicable.

This fluid, dynamic reality makes leading and working in teams more difficult and complex than may appear on the surface and for which formal medical and healthcare education poorly equips students (Barrow et al, 2014). Recent studies and policy rhetoric emphasise a shift towards collective or shared leadership (West et al, 2014) but in practice there is a lag between expectations and practice, with ineffective teamworking contributing to the majority of patient safety concerns and medical errors (Studdert et al, 2002).

In the light of this, we explore whether too much emphasis is being paid to the development of clinical 'leadership' without due consideration for 'followership'. A similar question has recently been posed in the generic leadership literature (Uhl-Bien et al, 2014; Oc and Bashshur, 2013) and a deeper understanding of the importance and impact of followership may well enable doctors (and other health workers) to work more safely and effectively in a range of teams and situations. Without followers, there would be no leaders and followers' relationship with and influence on leaders is currently the subject of much research and scrutiny. How professionals conceptualise themselves in terms of both their professional identities (e.g. as doctors, as anaesthetists, as midwives) and as leaders, managers or followers is an essential consideration in working with others in intra- or inter-professional teams. This article describes the interlinked concepts of followership, leadership and social identity formation and how our understanding of these applies to clinical practice and leadership.

## UNDERSTANDING FOLLOWERSHIP

'Our understanding of leadership is incomplete without an understanding of followership' (Uhl-Bien et al, 2014, p.84). Leaders need followers; followers can be seen as not only influencing leaders' behaviours but as actively co-constructing and moderating leaders' behaviour and the leadership process (Uhl-Bien et al, 2014). The vast majority of leadership research is 'leader-centric', i.e. it sees leaders as having organisational and group power which they use to affect outcomes and change processes. This leads to stereotypical (but widely held) views of effective leaders being inspiring, motivating, charismatic individuals, followers as passive, obedient subordinates and organisations as designed in terms of formal hierarchies, with roles or positions reflecting status as a leader or follower. The term 'follower' (rather like the term 'manager') is then perceived as somewhat derogatory or secondary to that of 'leader'. From this perspective, leader effectiveness is explained in terms of personality traits, behaviours or styles and contexts or situations and the most dominant theories used to explain or research leadership are those of charismatic and transformational leadership (Bass and Riggio, 2006). In practical terms, leaders need to learn which behaviours are most helpful and which are not in working with their followers. Leaders will be adaptive and modify their behaviours depending on the relationship between the leader and follower(s), what they want followers to do and in different situations.

Research into followers considers the way in which followers construct leaders and leadership, these are 'follower-centric' approaches. From a follower-centric perspective, it seems that followers need leaders just as much as leaders need followers, particularly in times of crisis, instability or rapid change. Uhl-Bien et al's (2014) review of the research on followership described two theories that help explain this: the 'romance of leadership' and

'implicit leadership theories' (ILTs). The romance of leadership concept (Meindl et al, 1985) suggests that Western cultures often focus on the leader as the main element in group processes and that there is a fundamental attribution error in that followers may over-attribute causality for group outcomes to the leader. Charismatic leadership theory and attribution processes are linked to help explain the 'social contagion' that happens when followers are stressed or excited, they imbue leaders with more charisma, importance and influence than they may actually have – similar to a hero leader (Bligh et al, 2004). Of course, as long as the leader is functioning as followers expect, then these processes are positive for all involved. However, leaders are human and therefore fallible, they make mistakes and they may not act or look as followers might expect. This can lead to problems, mistrust, a perpetuation of certain leader types and, in extreme cases, the downfall of leaders.

Just as leader-centric views are widely held, which diminish the influence and importance of followers, so too are preconceptions of what leaders should be like. Implicit Leadership Theories (ILTs) suggest that followers have beliefs and schemata for leadership behaviour that influence their perception of 'good' and 'bad' leaders. These schemata or prototypes are developed through experiences, the media and socialisation and are used to match leaders' behaviour or attributes against. These 'folk theories of leadership' (Sivasubramaniam et al, 1997) or 'philosophies of leadership' (Schyns and Meindl, 2005) are highly influential in shaping followers' acceptance and tolerance of different types of leader (Uhl-Bien et al, 2014). ILTs help to explain some of the struggles faced by leaders who do not 'fit' into their followers' schemata, based not on leadership skills but on general attributes such as gender, profession, sexuality, disability, age or race. In practical terms, this means that some leaders may have to work much harder to overcome deeply held (but not always articulated) beliefs about what leaders should look like and behave. Over time. as health professionals (and their leaders) are drawn from a more diverse pool and leadership is dispersed at all levels of organisations, these attitudes should change.

Finally, more recent research has shifted from a focus on individuals to exploring followership behaviours as they help to co-construct leadership processes, these include the social identity and relational approaches (Hogg, 2001; Uhl-Bien, 2006) and complex adaptive leadership (DeRue, 2011). These theories see leadership and followership as socially constructed processes, mediated through relational interactions between people (Oc and Bashshur, 2013). The organisation is therefore best understood in terms of a complex, dynamic system (McKimm and Till, 2015; DeRue, 2011). Hollander (2012) suggests that from this perspective, the leader is part of the collective leadership process (and may be highly influential) but is only one of possibly many individuals involved. From a systems perspective, leadership is the product of the interaction between leaders' and followers' self-schema, culture, and relational, information-processing and task systems. Understanding this complexity is essential if the NHS is to support both leaders and

followers to deliver the huge culture shifts required in the wake of the raft of reports into poor care (West et al, 2015). Followers may need to be prepared to follow non-traditional leaders as work patterns and roles change, leaders may need to be adaptive and change their ways of working to attract, motivate and retain a range of different followers and all may need to be able to rapidly shift into both leader and follower roles as leadership becomes more collective and dispersed.

## PROFESSIONAL AND SOCIAL IDENTITY, FOLLOWERSHIP AND THE CLINICAL ENVIRONMENT

Despite the need for fluidity of health systems and health workers described above, roles in the health professions remain well-established along traditional lines both professionally and socially, with expectations inside and outside the clinical environment mutually influencing one another. For doctors, these expectations typically involve competition with their peers, authority over other professionals in the workplace and some relative autonomy in decision-making once in positions of seniority (Horsburgh et al. 2006). This cultural dynamic is reinforced in undergraduate and postgraduate training, as medical students and doctors are encouraged to stand out, compete for positions and aspire to leadership roles (Barrow et al, 2014). This fundamentally informs and influences relationships between doctors as well as relationships between doctors and other health professionals.

Professionals work hard to maintain their social identity which is intrinsically tied up with strong emotions relating to 'selfhood' (Curtis et al, 2015). If this is perceived as being threatened, then defensive behaviours and 'groupthink' can emerge which can lead to difficult challenges for both leaders and followers. Souba (2011) suggests that one way of addressing these issues is for healthcare leaders to use an ontological perspective which involves developing action-focussed access to human nature, this is about *being* a leader, not simply focussing on doing leadership activities. *'Action focussed access to leadership allows leaders to get their head around the essence of leadership and their arms around the way it is exercised'* (Souba, 2011, p1241). This involves paying purposeful attention to language and meaning, your own and others' behaviours, thought patterns (e.g. stereotypes or schema about other health professionals) and limiting self-beliefs ('I can't possibly be a leader/follower/manager, I'm too young/old/different etc.') and may help to address some of the issues encountered in clinical practice.

Although the GMC states the importance of both teamwork and leadership skills in medical students (General Medical Council, 2007), the culture within the medical profession actively encourages aspiration to leadership and personal career progression over team success, with many teams existing in name only (West and Lyubovnikova, 2013). As a result, doctors become very experienced in self-promotion but are not encouraged to engender the

attributes that will make them effective followers. This has important implications not just for efficient service provision but also for patient safety (Moneypenny et al, 2013). While a team cannot function without leadership, leadership cannot exist without followership. As Lee notes 'working in teams does not come easily to physicians, who still often see themselves as lone healers. Nonetheless, developing teams is a key leadership function for healthcare providers of all types' (Lee, 2010).

Understanding the motivations and composition of followers in the clinical environment can serve to inform more effective leadership, more cohesive team working and, ultimately better patient care. Tee et al (2013), in their discussion of followership from a social identity perspective, describe the 'high-identifying' follower as one who identifies closely with the leader and the rest of the group, socially and professionally. High-identifiers have high expectations of their leaders in terms of procedural fairness, they also 'are more likely to be affected by group level emotions, attitudes, and behaviours' (Tee et al, 2013). As it is the cultural norm in the medical profession to aspire to leadership roles, most doctors following a clinical leader may not only identify closely with their clinical lead but imagine themselves in their superior's shoes at some point.

The situation for nurses may be somewhat more complex, where they may identify closely with fellow nurse in authority but are unlikely to identify closely with medical clinical leadership. Barrow et al (2011) describe how nurses were more resistant to the 'sovereign' power wielded by their medical colleagues and use sophisticated knowledge of systems and hierarchies to find their way around it. In spite of the high social and professional identification, doctors who are trained to stand out and get ahead, perhaps at the expense of their colleagues, are arguably less likely to show group loyalty, not least because they aspire to lead from the front rather that be part of an influential followership, driving for a personal rather than a group goal. Nurses have a strong collective professional group identity and solidarity, perhaps leading to a stronger more cohesive followership (Croft et al, 2015; Barrow et al, 2011). Both groups of professionals however, consider their 'home team' to be constructed of their professional peers, not of an inter-professional group and are less likely to identify (and indeed value) leaders outside their home team/profession (Barrow et al, 2011). A greater recognition of the importance and influence of followership as well as leadership in the training of health professionals may encourage doctors to appreciate the influence they can have as followers, promoting team goals of delivering good service as well as personal professional achievement. For nurses, an understanding of influential followership might help to foster a more cohesive and equal working relationship with doctors they may find it otherwise difficult to relate to.

It would be unfair however not to recognise as qualities some of the drive and aspiration particularly espoused by medical students and doctors in training, these characteristics need not be at odds with good followership. In the first chapter of *The Art of Followership,*

Robert E. Kelley describes five basic styles of followership: the sheep, the yes-people, the alienated, the pragmatics and the star followers (Riggio et al. 2008 ):

> *'Star followers think for themselves, are very active, and have very positive energy. They do not accept the leader's decision without their own independent evaluation of its soundness. If they disagree, they challenge the leader, offering constructive alternatives that will help the leader and the organization get to where they want to go. Some people view these people as really "leaders in disguise," but this is basically because those people have a hard time accepting that followers can display such independence and positive behaviour.' P.8*

Motivated and engaged doctors may fulfil such followership roles, provided it was culturally acceptable to put energy and time in to a pursuit that might not result in a leadership role or personal recognition over team success.

Burak et al (2013) propose that 'followers with higher position or personal power exert greater social influence on leaders' (p.924). If doctors are indeed high-identifiers who engage closely with their leadership, and perhaps star followers who are active in their influence over decision-making they are more likely to fall in to the category of persuasive rather than supportive followers. However, supportive followers may exert greater influence over time as they are rewarded by their leader for loyalty and consistency. Where the leader is a doctor the role of supportive follower in location-based teams is more likely to be fulfilled by nurses who stay, having completed their training, unlike doctors in training who are relatively transitory (Barrow et al, 2011). This may lead to difficulties for trainees who are trying to develop leadership roles whilst still moving locations on a regular basis when many of their potential followers are nurses who have a great influence both on the environment and more senior leaders.

## IN-GROUPS, OUT-GROUPS AND 'PROTOTYPICALITY: WHY LEADERS NEED TO MAINTAIN CLINICAL WORK

In light of the apparent importance of social and professional shared identity within teams, the concepts of 'in-groups' and 'out-groups' in the clinical environment is also relevant. Tee et al (2013) assert that, not only do groups turn against members who are perceived as dissimilar but also that a group will support a leader more strongly when they explicitly oppose an out-group. In the context of clinical medicine, this concept can be applied to the attitude of health practitioners to non-clinical management (Barrow et al. 2011). The perceived close proximity of leadership roles and management, still viewed as the 'dark side' in clinical culture, results in a reluctance of clinical leaders to be identified with their management colleagues (Spurgeon et al. 2011). Group identity is reinforced by the clinical expertise that set clinical leadership apart from management, it is doubly reinforced by the identification of an out-group who are not only very different but who can be blamed for

service failings. It is reasonable to suggest that the identification of a non-clinical out-group may in fact improve team cohesiveness between doctors, nurses and allied health professionals, and further bolster interprofessional working, however, it is questionable whether, in this context, a shared 'clinical identity' is enough to overcome more powerful differences in professional identity. Dangers exist in maintaining an out-group to sustain group identity particularly if health services require a collective leadership approach in order to make fundamental culture changes. Gosling and Minzberg (2003) remind us of the risks in separating leadership from management in that leaders may become disconnected and arrogant and managers may stifle innovation, but the risks in separating clinicians from management and leadership roles are equally (if not more) important in healthcare. These risks are well documented in reports into failing health services and calls for doctors and other clinicians to engage fully in leadership and management (West et al, 2014; Spurgeon et al. 2011).

Croft et al's (2015) study of nurses on a leadership development programme highlighted the tension, identity conflict and emotional transition needed to construct leader identities. As the nurses moved into their new roles, they struggled to maintain their identity as nurses and credibility of their followers as their leader identities were not congruent with the nursing social group (Croft et al, 2015). These issues pose some key questions: (1) might health professionals, and clinical leaders and managers have more than one social identity, some more predominant than others at various times? (2) is belonging to one's 'own' professional group more important in maintaining identity than other social identities? (3) if there were a better rapport and working relationship between clinical leadership and non-clinical management, might there be a threat to clinical group identity (if such a thing exists)? (4) is it necessary to have an opposing force or can a new group identity be fostered from a positive common goal: to provide a service of excellent, timely and safe care to patients. The latter is what West et al (2015; 2014) would hope for in their call for collective leadership in the NHS.

The concepts of social identity, in-, and out-groups help to provide some answers to these questions as they serve to explain the importance of clinical work to health professionals in clinical leadership. More than simply staying in touch with the reality of service delivery and innovations and medical technologies, maintenance of clinical expertise reinforces what is described as 'prototypicality'.

> *'To date, robust evidence exists to support the proposition that leadership effectiveness, under the social identity model, is dependent on the extent to which followers perceive leaders (1) to be representative of the group's identity, i.e. prototypical . . . and also (2) to be engaging in behaviours that are perceived as being beneficial to upholding the salient group identity, i.e. group-serving behaviour* . . .' Tee et al (2013) p.904

This may be particularly important in healthcare environments where social and professional identity are so deeply connected. Tee et al (2013) go on to say that leaders who fail to preserve salient group identity through prototypicality will be collectively disapproved of by their followers. Prototypicality is not enough however to constitute leadership. Procedural fairness by the leader and the attribution of successes to followers are both essential for group loyalty, particularly for 'high identifying' followers. This exposes a contradiction in professional culture particularly among doctors. While the implicit emphasis is on personal professional success, once in a position of authority, a leader who is perceived as self-serving, will fail to gain the trust of the followership. With regard to social identity, the increased focus on professionalism (Hafferty and Castellani, 2010) has shone a spotlight on values, behaviour and public trust in doctors. Doctors have never been so sensitive or aware of the importance of the perception of integrity and probity in their practice, as such, leaders who fail to behave in an exemplary manner do more than just alienate individuals who have lost out but threaten the salient identity of the entire group.

## CONCLUSION

This article has explored specifically how an understanding of followership, prototypicality, social identity and social influence theories can help us understand the roles and difficulties of individuals, teams and organisations as they strive to provide high quality care. Research into followership has been ongoing for some time and the importance of followers to leaders' effectiveness (and even existence) is well recognised, but new approaches, drawing on a range of theories are now providing additional insights. We argue that clinical leaders and those responsible for leadership development need to focus on these insights and theories as they provide ways forward for addressing key healthcare issues and assisting teams, health professionals and managers to work more effectively together. In particular, raising awareness of the relational nature of leadership and followership and the influence followers have on leaders can help leaders adapt and develop new ways of working in complex systems and organisations.

## KEY POINTS

- Leadership cannot be understood or explained without consideration of followership;
- Leaders need followers, but followers also need leaders, especially in times of crisis, rapid change or excitement – leadership-followership is relational;
- The social identities of different professional groups provide powerful forces both for support and for resistance to leaders;

- Leaders who do not meet followers' expectations or beliefs as to leadership attributes or actions (i.e. are not prototypical) may be collectively disapproved of by followers;
- Maintaining clinical work contributes towards prototypicality, social identity and leadership acceptability.

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