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# **Learning about leadership through critical reflection and practitioner-academic co-inquiry**

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## **About the authors**

Kathy Molloy works as an Orthopaedic Trauma Nurse Coordinator at Barts and the London National Health Service (NHS) Trust, a large hospital providing a range of specialist health care services for patients living locally, nationally and internationally. She is currently completing an MSc in Nursing and has undertaken modules relating to leadership and psychology at work.

Kathryn Waddington is Director of Interprofessional Practice programmes at City University London. Her primary research interests include the role of emotion at work, how gossip can inform professional awareness within organizations, and leadership in the nursing and health care sector.

## **Abstract**

This article is a critical reflection on learning about leadership and putting leadership theory into interprofessional practice. It is based around reflection upon a leadership intervention experienced in practice in a U.K. hospital setting, undertaken as an assignment task for a leadership module. Critical reflection and co-inquiry involves unsettling previously held beliefs and assumptions about learning, practice and disciplinary knowledge. This has meant discarding our traditional ‘practitioner’ and ‘academic’ roles, and re-positioning ourselves as co-authors and editors of our social worlds. The article concludes with reflections upon the role of Work and Organizational Psychologists in interprofessional collaborative working.

*In an interestingly coincidental way the action of cutting edge effective leadership mirrors the principles of co-inquiry and honoring learning derived from lived experience, and is open to diverse ways of thinking.*

(Yorks, Aprill, La Don, Rees, Hofmann-Pinilla & Ospina, 2007:493)

## **Introductions**

*Kathy:* When I undertook the module *Leadership for Practice and Service Delivery* I was working as an orthopaedic nurse practitioner in a professional context of acute hospital nursing, and not in my current role/NHS Trust. My role at the time encompassed teaching, supporting and developing ward-based staff to deliver high quality nursing care to patients with musculo-skeletal disorders and injuries. This included the use of evidence-based clinical guidelines and I was working as a clinical leader, an expert nurse and a role model for more junior staff.

*Kathryn:* I am a Work and Organizational Psychologist and lead the above module; my professional discipline is nursing and I describe myself as a ‘practice-based academic’. My role as Director of Interprofessional Practice Programmes is predominantly about enabling professionals from different backgrounds to learn with from and about each

other (Freeth, Hammick, Reeves, Koppel & Barr, 2005), and this includes my own learning. This article draws upon the module assignment task which requires critical reflection and analysis of a leadership situation experienced in practice, and the application of theory to practice. In order to preserve confidentiality some of the details of the leadership situation have deliberately been changed, without altering the key learning points. We have also used the terms ‘they’ and ‘their’ rather than he/she and his/hers to ensure anonymity.

The article is written partly in the first person, as we critically reflect upon our learning about leadership and how to put leadership theory into practice. Italicized narrative is inserted at selected points in the text to illustrate reflexive engagement with theory and experience, and also openness to diverse thinking as advocated by Yorks et al. (2007) in the above introductory quote. The position we adopt is primarily one of *practical* self-reflexivity, drawing on critical perspectives to: ‘Examine our values and ourselves by exercising critical consciousness... [and] question our core beliefs and our understanding of particular events’ (Cunliffe & Jun, 2005: 229; Waddington, 2010a). First we outline approaches to critical reflection and the context of current leadership perspectives within the NHS in the U.K. This is followed by reflection upon an emotionally-charged leadership incident and discussion of the nature of co-inquiry in professional education and practice. We conclude by exploring aspects of interprofessional learning and collaborative practice and the implications for Work and Organizational Psychology.

### **Approaches to critical reflection**

As Fook & Gardner (2007) note, the literature in this area is vast, spanning a range of fields and disciplines such as education, professional learning, social theory and management. Citing Cressey’s (2006) concept of ‘productive reflection’ they argue that critical reflection:

[h]as no central academic core in a singular disciplinary approach but takes a position which crosses *accepted* academic boundaries. Because of this it is an unsettling concept and the journey leads writers into unfamiliar territories whose

correspondence may not at first glance seem obvious (Fook & Gardner, 2007: 13, emphasis added).

This capacity to unsettle and challenge previously held beliefs and traditional disciplinary boundaries involves a deeper examination of the assumptions upon which thinking, actions and emotions are based. The process of reflection becomes critical when connections are made between assumptions, and the social context in which they occur, as a basis for changed actions. This approach therefore is underpinned by the theoretical traditions of reflective practice, reflexivity, post-modernism and deconstruction, and critical social theory (Fook & Gardner, 2007).

### **Reflexivity**

Reflexivity is a complex and contested concept, and space precludes detailed discussion here. In research terms, reflexivity is used to acknowledge the role, influence, subjectivity and visibility of the researcher. More broadly, reflexive practice is about working with our subjective understandings as a starting point for thinking more critically about the impact of our assumptions, values, and actions on others. However as Alvesson, Hardy & Harley (2008) note, without critical interrogation, reflexivity runs the risk of becoming a pointless exercise with the potential to generate large amounts of uninteresting text.

In this article we have adopted a position of *practical* reflexivity which enables us to ‘to understand ourselves, our ways of relating to others, and how to participate in our social world (Cunliffe & Easterby-Smith, 2004: 35-36). In this context, Kathy participates as a leader and learner in a clinical world of nursing, Kathryn participates as a leader and learner in an interprofessional and interdisciplinary world of practice-based academia. However we also exist in other social worlds outside of our work, recognizing that reflexivity encompasses the ability to understand how all aspects of ourselves and our contexts influence the way in which we create knowledge (Fook & Gardner, 2007; Waddington, 2010a).

*Kathryn: I have grappled with the: ‘Who/what am I?’ question in relation to my role as a practitioner; at times discarding a professional nursing identity, privileging that of*

*psychologist and scientist-practitioner, then returning to a practice-based academic identity via the role of professional educator. I now feel comfortable with my 'mixed-race' academic identity which is a creative hybrid of skills, insights, intuitions, knowledge and ideas. I could theorise this in terms of personal, professional and career development and role identity, but choose not to in this reflexive narrative. Rather, I am curious about how much easier it seems to transfer and apply disciplinary knowledge and ideas from psychology (and other disciplines) to professional practice than it is to transfer and apply practice-based professional knowledge and ideas to disciplinary practices. In my experience there is a paradox: in theory, theory and practice should relate to each other, but in practice they don't.*

### **The NHS leadership context**

Within the NHS there is, and has been for some time, a great emphasis on the need for leadership (DH, 2000; 2008), but there is not always an adequate definition of what this means. For healthcare practitioners the requirements of leadership across professional, clinical and organizational boundaries can appear daunting. The current NHS leadership development agenda has its roots in the *NHS Plan* (DH, 2000) and the need for leadership to deliver radical change and modernized healthcare services. Evaluation of subsequent leadership development initiatives demonstrated positive change in clinical leadership capability and competence (e.g. Hancock, Campbell, Bignall & Kilgour, 2005). The most recent NHS white paper *Equity and Excellence: Liberating the NHS* signals arguably the most difficult yet potentially most exciting period of transformation (DH, 2010; Maben & Griffiths, 2008). However, without associated change in organizational and professional cultures to support and embed leadership capability and competence, investing in change at the individual level is potentially a recipe for failure.

Looking back over the last decade, it is evident that sustainable leadership development was elusive, often despite significant financial investment (Waddington, 2010b). The important question then is this: what theories, frameworks and skills are needed to enable

individuals to advance in their role as practitioners, partners and leaders within healthcare?

### **Leadership and nursing**

There are many definitions of what a leader is and what leadership truly means, particularly in the public sector. Within nursing and healthcare organizations Hersey and Blanchard's (1977, cited in Luna & Jolly, 2008: 20/21) situational leadership approach has been viewed as relevant and applicable. Briefly, four leadership styles are identified which effective leaders can adopt, based upon their judgement of the situation, and the followers or people being supervised:

1. *Directing Leaders*: define the roles and tasks of the 'follower', and supervise them closely; decisions are made by the leader and announced, so communication is largely one-way;
2. *Coaching Leaders*: still define roles and tasks, but seek ideas and suggestions from the follower; decisions remain the leader's prerogative, but communication is much more two-way;
3. *Supporting Leaders*: who pass day-to-day decisions, such as task allocation and processes, to the follower; the leader facilitates and takes part in decisions, but control is with the follower;
4. *Delegating Leaders*: are still involved in decisions and problem-solving, but control is with the follower; the follower decides when and how the leader will be involved.

However, as Alimo-Metcalfe & Alban-Metcalfe (2004; 2006) note, U.S. derived models of heroic/distant leaders are limited in their application to contemporary healthcare practice. They propose instead a research-based model of 'nearby' leadership based on day-to-day leadership behaviours elicited from men and women at every organizational level from a range of cultural and ethnic backgrounds. The 'nearby' leadership model emphasizes valuing of individual difference and working in true partnership, which aligns well with the current drive for interprofessional practice and collaborative working (Waddington, 2010c).

Adoption of a critical approach to leadership is also important because: ‘critical thinking skills are *the* pre-requisite leadership skills required promoting sustainable emancipatory change within organizations (Western, 2008: 9; emphasis added).

*Kathy: For the purposes of the assignment task I chose to critically reflect on an incident that involved the incorrect use of clinical guidelines. Within the incident I became extremely angry, raising my voice on the open ward area. One of my personal beliefs of leadership is that effective leaders do not ‘lose it’ and as such, I was disappointed with my actions during this incident. I wished to explore this further as I believe that the negative emotions involved during the interaction were harmful and unhelpful to both the other practitioner and me (Goleman, Boyatzis & McKee, 2002). Using a reflexive approach I initially examined styles of leadership and the behaviours and qualities of a leader whilst reflecting on my own behaviour within the interaction with my colleague. Before embarking on the journey of using reflexivity to critically analysis the incident, it was necessary to examine myself as a leader using available leadership assessment tools and frameworks.*

### **Leadership frameworks**

The NHS Institute for Innovation and Improvement provides a 360 degree assessment tool for leadership skills and abilities as part of the *NHS Leadership Qualities Framework* (LQF)(NHS, 2006) The LQF comprises three clusters: (i) Personal Qualities; (ii) Setting Direction; and (iii) Delivering the Service. Each quality is broken down into a number of levels which help to identify the key characteristics, attitudes and behaviours required of effective leaders at any level of the service. Unsurprisingly because the NHS is such a large and complex organizational system there is a plethora of frameworks and models describing the skills and behaviours required of leaders.

Such frameworks mark an important transition in the understanding of leadership in healthcare because they have been specifically designed for the NHS, and clearly articulate standards for outstanding leadership in service delivery and patient care. There are, however, two critical points to note. Firstly, it has been argued that such competency frameworks are either too conceptually or methodologically flawed, or too simplistic to



be of significant benefit on their own (Alimo-Metcalfe & Alban-Metcalfe, 2006; Bolden, Wood & Gosling, 2006). Secondly, leadership competencies and development programmes are either atheoretical, or grounded uncritically in theoretical perspectives that may not necessarily be wholly relevant to healthcare. For example, Gilmartin & D'Aunno's, (2007) review of 60 empirical research studies concluded that:

[L]eadership is positively and significantly associated with individual work satisfaction, turnover, and performance. Despite these important results, however, we argue that researchers are missing opportunities to develop general leadership theory in the health sector, for example, by (a) examining the role of professionals as leaders and (b) developing understanding of the role of gender in leadership (p. 387).

There is therefore a need to question whether leadership development activities that focus solely on development of leadership competence are 'fit-for-purpose'. Alimo-Metcalfe, Alban-Metcalfe, Samele, Bradley & Mariathasan (2007) used the Leadership Climate & Change Inventory (LCCI)<sup>TM</sup> to assess the quality of leadership in a longitudinal study of Mental Health Crisis Resolution Teams in England. The LCCI has two sets of items: those that assess leadership competency and those that assess transformational or engaging leadership behaviours. Their study concluded that leadership competencies alone did not predict effective performance. Rather, an organizational culture of 'engaging' leadership was the most significant predictor of organizational performance.

*Kathy: I was thinking about my learning about leadership in the context of Alimo-Metcalfe et al.'s (2007) concept of 'engaging with others', which includes face-to-face communication and being prepared to modify ideas and decisions after listening. Five trusted colleagues within my multidisciplinary team were asked to give me feedback, based on their assessment of my skills and abilities. Using both reflection and the feedback from colleagues, I was able to understand how others perceive me and react to my behaviours; knowing myself (McNichol & Hamer 2007).*

*The results of this initial probing were enlightening and I was genuinely surprised by the responses of my colleagues. I was able to reach the conclusion that my preferred leadership style is one of coaching, a style which is common within ward managers*

(Kenmore, 2008) and is also a situational leadership style. However, this was certainly not the approach I originally took in this particular incident. Developing others is very important to me as I feel that this ultimately improves my own performance and that of others. (Goleman et al., 2002). I identified that I use degrees of situational leadership depending on the different work situations I find myself in, yet prefer to use all situations as learning points. Leaders who embrace into their practice reflection on their values, actions and thinking tend to detect and correct problems with their own effectiveness (Peck, 2009). Armed with this knowledge, I then began to critically examine the incident in an attempt to better understand my behaviours and actions as a leader.

### **Critical incident analysis**

Using reflexivity as a model for analysis, I critically challenged myself with questions about the interaction. Using the characteristics of critical thinking (Waddington, 2010b), summarized in Table 2 below, I began to ask difficult questions about myself as a leader within the interaction.

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**Table 2          The Characteristics of Critical Thinking**

(Source: Waddington, 2010b:229)

- *Having an open-mind*: appreciating alternative perspectives, understanding different cultural/professional values to gain insight into self and others
- *Being inquisitive*: curious and enthusiastic, seeking to know how systems work even if the application or relevance are not immediately apparent
- *Truth' seeking*: being courageous about asking difficult questions, and hearing answers, obtaining new/different knowledge and perspectives
- *Using critical analysis*: appraising verifiable information from multiple sources, application of reason and evidence
- *Being systematic*: appreciating a focused and rigorous approach to problems at multiple levels of complexity
- *Challenging*: questioning and unsettling values, assumptions, power bases and ways of thinking
- *Self-confidence*: trusting one's own reasoning, skills, insights and judgements

*Kathy: When I had established the practitioner had not followed the clinical guidelines, thus causing a patient to suffer discomfort, my anger had given way to what Goleman (1996) describes as anger which builds on anger. In other words I was angry about being angry, however, using reflection I needed to reappraise the situation and examine the root cause of my anger. Critical thinking and questioning led me to explore what events and what personal actions prior to this could have contributed to the situation. For a period of time prior to the incident, I had been taking the lead in the teaching of correct care and management of patients to whom these particular clinical guidelines applied. My initial anger may well have stemmed from my own feelings of being an ineffective leader (Kellerman, 2004) given the time and effort I had invested into a hospital-wide teaching programme. On speaking with the other practitioner, my angry attack seemed to merely make them defensive. They began to make excuses for their actions and evaded responsibility for the incident; confirming - to me - that they were no longer receptive to me as a leader.*

Covey (1989) suggests the lowest form of any communication is characterised by defensiveness and protectiveness; this arises from low trust situations and is not effective as it creates a 'lose-lose' situation for everyone. A far more constructive approach as a leader would have been to offer empathy whilst using constructive criticism (Goleman, 1996). Constructive criticism is criticism given in a kindly manner with the goal of improving an area of another's work.

### **Applying theoretical perspectives**

Trait theories argue that leaders share a number of common personality traits and characteristics, and that leadership emerges from these traits. These traits are displayed by born leaders, qualities that you either have or don't have (McNichol & Hamer 2007). However, this theory leaves no room to explore whether the skills and qualities of a leader can be learnt or indeed developed. It also underestimates the nature of the task and the followers' reactions (Kellerman, 2004). Adair (2003) describes the characteristics of

a leader as: enthusiasm, integrity, warmth, courage, judgement and tough, but fair. Anger on the other hand is seen as a negative emotion and is viewed as being demoralising for followers and indicative of 'bad' leadership (Goleman et al., 2002).

To deny 'bad' leadership is misguided and limiting leadership characteristics to 'good' leadership is also problematic as many definitions of leadership are value free. While good leadership is desired by many, by looking at and exploring what constitutes bad leadership we can also learn lessons (Kellerman, 2004). For example, by examining the way that some leaders exercise power or use their influence in ways that are detrimental to either the individual or the team, one can enhance ones own practice through processes of reflection and clinical supervision (Hawkins & Shoheit, 2006).

Goleman et al. (2002) argue that the defining characteristics of successful leaders are that they have high levels of emotional intelligence (EI) and the ability to work with others and lead change. EI is characterized by high levels of self awareness, self regulation, motivation, empathy and social skill (McNichol & Hamer 2007); notably these are also the characteristics of skilled nursing practice. The actions and behaviour within the incident were not those of an empathic or self regulated leader and were certainly not reflective of my usual coaching style of leadership as identified by my colleagues. Low levels of EI are highly detrimental to leadership (Owen, Hodgson & Gazzard, 2004) and I was left feeling very disappointed that my clinical leadership was affected by my emotional response to the situation.

*Kathy: Having recognised my anger and accepted responsibility for it, it was then necessary to understand how to deal with this extreme feeling which could pose a threat to productive relationships in the future. When encountering similar situations again, it is important that I learn to manage my behaviour to be an effective leadership role model and motivate others through difficult situations.*

*Owen and colleagues (2004) suggest that exposure through life to prejudice affects the ability to treat people as equals. Thus, I began to examine whether I indeed held any*

*particular prejudices regarding the other practitioner. My anger had been intensified on learning that, as an experienced practitioner, they were responsible for the incorrect use of clinical guidelines. I explored whether I was judgemental in my thoughts that they should have a greater knowledge of how their actions could be detrimental to others, and that they should possess the professional confidence to stand up for their beliefs and knowledge. Following the steps suggested by Owens: (i) recognising the feeling; (ii) dealing with prejudices; (iii) telling the person their behaviour has evoked anger; and (iv) being positive by telling them how they can change their behaviour, I can begin to learn how to change my behaviour when faced with difficult scenarios in the future.*

Shadow beliefs are suggested by Cashman (2008) to be deep underlying dynamics that can turn a leader's strengths into weaknesses. Consequently, the more limited the self understanding, the bigger the shadow cast, while the more conscious the self awareness, the more light a leader brings. By using reflexivity, I was able to acknowledge that my disproportionate emotional response to the nurse may have been the target of a shadow belief.

Situational or contingency theory incorporates using either task orientated or relationship orientated styles of leadership to best suit the situation that the leader is in to obtain the best outcome (Luna & Jolly, 2008). Whilst task orientation is usually one-sided communication, relationship orientated style is very much a two-way process (Handy, 1993). Within the incident, I became too emotionally involved to allow two-way discussion to take place.

Transactional leadership provides direction and rewards positive behaviours, focusing on the personal power between the leader and follower; transactional leadership is very much about the hierarchical position of the leader (McNichol & Hamer, 2007). Whilst this may not always appeal as a style of leadership, it may be useful in an organization as a way to get things done on a day-to-day basis. Leadership is about giving direction, but it must be the right direction and this calls for practical intellectual ability and critical thinking (Western, 2008).

Transformational leadership also focuses on the relationship between leader and follower, but from a position of personal power (McNichol & Hammer, 2007). Leaders adopting this style are able to articulate their vision to others and encourage intelligence and inspiration. This particular style of leadership is suggested as being favourable to the art of nursing, crucial to shaping engaging and challenging professional practice environments.

*Kathy: The practitioner had stated that whilst they knew it was poor practice to ignore clinical guidelines, they had done this because a doctor had instructed them to do so. They admitted that they had questioned the doctor and had told them that their instructions would be contraindicated in this particular clinical scenario, yet when the doctor insisted that their request be carried out the practitioner did so. I was surprised that an experienced and senior practitioner felt compelled to carry out the task, knowing it was not good practice, simply because they were told to do so. This led me to reflect on the power that the doctor seemingly held over them and led to further reflection on the whole incident.*

### **Professions, power and emotion**

As Gilmartin & D'Aunno (2007) note, practitioners, managers and leaders in the health sector must deal with powerful professionals, especially physicians, who continue to dominate many aspects of day-to-day work in healthcare organizations. While professionals of all types may have notoriously ambivalent relationships with each other, medicine is probably the most powerful of all the professions. Powerlessness is often a state of mind related to problems with taking up authority (Obholzer & Roberts, 1994). Some organizations tend to discourage people to ask for help, or some people fear that their bosses will look less favourably on them if they do ask for help, creating isolation and demoralisation of the work force. Senge (2006) suggests that everyone has a propensity to find someone or something outside of ourselves to blame when things go wrong. It is only when focusing on our own position are we able to see how our actions

extend beyond the boundary of that position. When those actions have consequences that come back to hurt us, we can misperceive these new problems as externally caused.

*Kathy: My initial anger then subsided quickly as I began to empathise with the other practitioner and I found myself in a coaching and supporting role once again. On bringing them to a quiet, private area I began to question why they had felt the need to comply to the doctor's instructions when equipped with the knowledge for good practice that was provided in the clinical guidelines. At this stage, they became visibly upset and less defensive, apologising profusely, repeating that the doctor had told them to act in contra-indication to clinical guidelines. It was clear that they were extremely upset over their actions, and I found myself switching back into coaching mode. This enabled me to explore why they had felt it necessary to ignore their own professional opinion in favour of the doctor's instruction. Whilst coaching exemplifies the EI competence of developing others, my initial actions were negative towards the other practitioner. A learning point for me is to listen first before reacting, without judgement.*

I critically examined my style and behaviour within a leadership intervention to enable a deeper understanding of my ability and skills as a leader. It is clear from the literature and the analysis of the incident that the best style of leadership to adopt is one that suits personality preference allowing people to play to their strengths. What is also clear is that leaders cannot lead unless there is someone who is happy to 'buy in' to their particular kind of leadership and people have certain expectations of leaders, recognising 'good' and 'bad' leadership

I concluded that whilst losing my temper in the incident was not appropriate behaviour for my leadership style, by using elements of EI, I can learn how to deal more effectively with these situations in the future. A high degree of interpersonal sensitivity is valued in nursing leadership, yet it may also represent a degree of vulnerability. EI offers personal and professional development through learning from experience (Akerjordet & Severinsson, 2008). Using EI to shape my responses to similar situations would certainly fit extremely well and enhance my personally preferred coaching style of leadership.

## Learning through a process of co-inquiry

The above analysis of Kathy's leadership incident illustrates how theoretical leadership perspectives were applied to practice in the professional context of acute hospital nursing. This is a leadership environment that is complex, messy, stressful, uncertain and unstable and which requires new approaches to thinking about learning (Yorks et al., 2007). As McWilliam (2005) argues, traditional learning habits are useful only when the conditions in which they work are predictable and stable. She goes on to identify seven 'deadly habits of pedagogical thinking that are ripe for unlearning' (p. 5):

1. The more learning the better;
2. Teachers should know more than students;
3. Teachers lead, students follow;
4. Teachers assess, students are assessed;
5. Curriculum must be set in advance;
6. The more we know our students the better;
7. Our disciplines can save the world.

Implicit in this list of deadly habits is the compelling notion of 'teacher' and 'student' as co-creators of value, both mutually involved in assembling and disassembling cultural products. Thus the teacher is: '*in there doing and failing alongside students, rather than moving like Florence Nightingale from desk to desk or chat room to chat room, watching over her flock, encouraging and monitoring* (McWilliam, 2005:11, original emphasis).

*Kathryn: After re-reading and engaging with - not assessing - Kathy's learning about leadership I am struck by the way it has encouraged my thinking about co-inquiry, the values we bring to theoretical constructs and the nature of leadership-followership. EI has led to many sweeping and often unsubstantiated claims and debates in the academic literature, yet it was evidently a useful device with which to interrogate and critically reflect upon leadership practice. I am also unlearning some 'deadly disciplinary habits'*



*and making new connections. For example the idea of ‘teacher’ and ‘student’ as co-inquirers and co-creators of learning aligns with thinking about leaders and followers as co-creators of meaning. I now find myself questioning the use of ‘service delivery’ in the module title, and reflecting further on interprofessional learning and leadership.*

The term ‘service delivery’ is an uncritically adopted term, overused in the public sector. The metaphor of ‘delivery’ when used to characterise professional practice, which is complex, uncertain and unpredictable, is simplistic at best, and fundamentally flawed at worst. The notion of service delivery implies a passive acceptance of what is delivered, how, where, when how often and to what standard and with little scope for the co-creation of value and meaning. Arguably those who lead and those who ‘deliver’ a service should work in a leader-follower partnership, based on sharing information and trust (Hollander, 2009; Wong & Cummings, 2009), which are increasingly important aspects of interprofessional learning and collaborative practice.

### **Interprofessional learning and collaborative practice**

Development of collaborative approaches to practice is now seen as an imperative way of working in many sectors (Freeth et al., 2005; Waddington, 2010c). Furthermore, it is likely to gain momentum as its potential to contribute to efficiency savings is fully appreciated (NAO, 2006). Suter & Deutschlander’s recent (2010) knowledge synthesis of the literature linking educational, practice and organizational interprofessional (IP) interventions to clinical and workplace outcomes is significant. The review concluded that in healthcare there is now sufficient evidence that IP interventions improve workplace quality by creating a collaborative culture and increase job satisfaction by improving provider roles, interprofessional collaboration and quality of care. The overarching aim of IP interventions is to work and learn collaboratively *with* others in the spirit of co-inquiry, with a commitment to learning and practice development at individual practitioner, profession/disciplinary-wide levels of analysis. However despite the evident benefits of collaborative practice, the reality, as evidenced by numerous public inquiries into human tragedy and organizational failures, is that practitioners,

professions and disciplines often fail to share good practice, information and knowledge about what is ‘really going on’ (e.g. Laming, 2009).

### **Conclusion and final reflections**

We conclude by asking what role of Work and Organizational Psychology might play in the development of future IP interventions and collaborative practice, and also what might it learn from other professions. In the U.K. practitioner psychologists are now regulated by the Health Professions Council (HPC), and by bringing regulation of practice into this arena, psychologists, including Occupational Psychologists, play an important role in interprofessional workforce development. For example, effective and engaged leadership and sustained organizational cultural change are essential for the preparation and creation of an innovative interprofessional workforce (WHO, 2010). Work and Organizational Psychology is a key resource for applied theory and research, with scope for strong collaborative working and co-production of new knowledge.

However the difficulties in working collaboratively are often the result of deep-rooted professional, interpersonal and organizational defences, power struggles, rivalries, resentments and resistance to change. Work and Organizational Psychology is not immune to these difficulties, whilst paradoxically making an important contribution to the theoretical and evidence based understanding of such issues. A case of ‘Physician, heal thyself’ perhaps? This phrase alludes to the ability of physicians to heal sickness in others while sometimes not being able or willing to heal themselves. Work and Organizational Psychology has much to offer, but also potentially much to learn. Our ‘scientist-practitioner’ model when adopted uncritically and un-reflexively may simply replicate the emotions and dynamics of professional/medical power revealed here in the analysis of Kathy’s leadership incident. Nursing and other practice-led healthcare professions work with an interdisciplinary knowledge base which includes, *inter-alia*, psychology. There is arguably scope for fruitful interprofessional and interdisciplinary learning and research to develop inside these interesting ‘practice-theory’ spaces (see also Waddington, 2010d).

*Kathy: It was difficult when critically reflecting on the incident as it had been so highly charged and the emotion involved had left me feeling guilty that I had been a 'bad' leader. However it has also allowed me to really question the values and beliefs I held about what leadership is. I am now much more aware of my emotion at work and how they can affect others. I can recognise trigger points in my emotions when I need to step back and take time to question them. In fact, a member of my current multidisciplinary team commented that they felt I was extremely calm when dealing with difficult situations!*

*I have learnt that 'leadership' is not merely a skill that can be taught or learnt. It is also not just a practical element that you can test or assess. Leadership skills and theory can be taught, but it is how the individual uses that information and knowledge which will shape them as a 'leader'. From experience of leadership comes a deeper knowledge of it. However, unless the individual possesses the skills to use that knowledge, then that too is useless.*

*Kathryn: Knowledge about leadership, as we know from the literature, embodies knowledge about self. Learning about leadership is a multi-level iterative process which raises interesting challenges and opportunities for practitioner-academic approaches to research. Co-inquiry is just one way of working together inside the 'practice-theory' gap. Knowledge transfer in work and organizational psychology can sometimes feel like a one-way street, and as Work and Organizational Psychologists there is also scope for us to learn with, from and about the people who use and apply our theoretical endeavours and research products.*

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