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DOCTOR OF PHILOSOPHY

Conceptualising, Narrating and Enacting Leadership in the Interprofessional Healthcare Workplace

Exploring Complexity Using Qualitative Methods

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CONCEPTUALISING, NARRATING AND ENACTING LEADERSHIP IN THE INTERPROFESSIONAL HEALTHCARE WORKPLACE: EXPLORING COMPLEXITY USING QUALITATIVE METHODS

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Submitted for the degree of Doctor of Philosophy in Medical Education

Centre for Medical Education

University of Dundee

December 2014

For 'my boys', Iain, Dougie and Fergus with ALL my love

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Excerpt Title
IAO_Clinical leadership
IAO_Educational leadership
IAO_Administrative leadership
IAO_Change leadership
Diabetic meeting
Ward round
Negotiating change for the community hospital
Informal interactions

List of Abbreviations

Abbreviation	Full Term
AandE	Accident and Emergency
AHP	Allied Health Professional
ASME	Association for the Study of Medical Education
CAQDAS	Computer Assisted Qualitative Data Analysis Software
CAS	Complex Adaptive System
CCT	Certificate of Completion of Training
CLT	Complexity Leadership Theory
CMDN	College of Medicine, Dentistry and Nursing
CN	Charge Nurse
DNACPR	Do not attempt cardio-pulmonary resuscitation
DNR	Do not resuscitate
FY	Foundation Trainee
GMC	General Medical Council
GP	General Practitioner
HCA	Health Care Assistant
IAO	Influential Act of Organising
LMX	Leader-Member Exchange Theory
MDT	Multi-disciplinary Team
MERE	Medical Education Research Executive
MIU	Minor Injuries Unit
MLE	Metaphoric Linguistic Expression
NES	NHS Education for Scotland
NHS	National Health Service
NOTTS	Non-technical Skills for Surgeons Scale
ODA	Organisational Discourse Analysis
OT	Occupational Therapist
OTAS	Observational Teamwork Assessment of Surgery
PIN	Personal Incident Narrative
RQ	Research Question
SCN	Senior Charge Nurse
SCSN	Scottish Clinical Skills Network
SHO	Senior House Officer
SLI	Surgical Leadership Inventory
SMERC	Scottish Medical Education Research Consortium
ST	Specialty Trainee
SW	Social Worker
TPR	Temperature, Pulse, Respiration chart
UK	United Kingdom
VRE	Video-reflexive ethnography
WHO	World Health Organisation

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Declaration

I, Lisi Gordon, declare that I am the author of this PhD thesis entitled, ‘Conceptualising, narrating and enacting leadership in the interprofessional healthcare workplace: exploring complexity using qualitative methods’. This thesis is a record of research work that I, Lisi Gordon, have undertaken and this work has not been previously accepted for a higher degree. Finally, unless otherwise stated, I declare that I have consulted all references cited within this thesis.

Signed

Lisi J Gordon

Summary

Current theoretical thinking asserts that leadership should be distributed across many levels of healthcare organisations to improve the patient experience and staff morale. Much medical education literature on leadership focusses on the training and competence of individuals. Little attention is paid to the interprofessional workplace and how its inherent complexities might contribute to the emergence of leadership. Underpinned by complexity theory, this research aimed to explore how leadership emerges in the interprofessional healthcare workplace.

Epistemologically grounded in social constructionism, this research was undertaken in two phases, using narrative inquiry and video-reflexive ethnography (VRE) [1] methodologies. Phase 1 involved nineteen individual and eleven group interviews with 67 UK medical trainees at all stages of training and from a range of specialties. Narrative interviewing techniques were employed to capture medical trainees' conceptualisations and lived experiences of leadership and followership. In Phase 2, a work-based study was undertaken utilising VRE to explore how leadership is enacted in the interprofessional healthcare workplace. This occurred in two UK clinical sites: one GP practice and one hospital ward. Participants came from the entire interprofessional team. Multiple complementary forms of analysis were used across both phases including: thematic framework analysis; big 'D' Discourse analysis; structural narrative analysis; and interactional analysis (including little 'd' discourse analysis).

Findings identified that leadership is not a single thing 'possessed' by individuals but rather leadership involves many processes. This research showed that the ways in which leadership is conceptualised, narrated and enacted is affected by many aspects including individuals, context, relationships and the systems in which leadership exists. The findings of this thesis therefore indicate a need to redefine the way that medical and healthcare educators facilitate leadership development and argues for new approaches to research in this field which shift focus away from *leaders* to, focusing instead, on *leadership*.

[1] VRE refers to a technique that occurs in 3 stages: 1) video footage is recorded of real workplace practice; 2) this footage is then compiled and edited; and 3) the edited footage is then played back to the interprofessional team, providing them with the opportunity to reflect on and discuss their practices

Preface

This thesis provides a novel exploration of the process of leadership in the interprofessional healthcare workplace. Leadership and leadership development for healthcare professionals, in particular medical trainees, is an area that has come to the fore in recent years, with reports (for example, the 'Frances Report' in the UK and the 'Garling Report' in Australia) highlighting what is perceived to be fundamental failures in traditional hierarchical leadership practices (Garling 2008; Frances 2013). Martin and Learmonth (2012) state that:

> *'… there has been a notable shift in terminology to describe one area of activity in the running of the health service from "administration" to "management" to "leadership"… this label of "leadership" has been applied by the activities (actual or aspirational) of increasingly heterogeneous actors ... Leadership is no longer something to be exercised by those in formal positions of authority alone … it is something to be brought out in actors across and beyond the health service and which is fundamental to the success of ambitions to raise NHS quality. What this means in practice, though, is not so clear'* (p. 286).

Thus, healthcare professionals need to be capable of responding locally to wider issues in healthcare services and take more responsibility for service development, both uni-professionally and interprofessionally, in order to contribute to cost effective, high quality and safe patient care (McKimm and O'Sullivan 2011; Warren and Carnall 2011).Thus, it is acknowledged and endorsed by medical bodies globally that leadership development should be incorporated at all stages of a medical career

(Gundermann and Kanter 2009; McKimm and O'Sullivan 2011; Abbas et al. 2011; Gabel 2012; 2014).

At a personal level, during my early career as a practicing physiotherapist (1993-2002), I observed the way leadership was enacted in a workplace and its impact on a workplace culture and personal job satisfaction. This was further emphasised as I moved into physiotherapy education (2001-2006) and was charged with the responsibility of undergraduate workplace learning[2]. This role revealed how the workplace context and the relationships between clinicians and students could fluctuate. Again, I was struck by how the local culture of a workplace, affected by leadership processes, could be different in adjacent wards.

When given the opportunity to undertake PhD study within the Centre for Medical Education at the University of Dundee in January 2012, I drew on these early workplace experiences to select a research focus. I found 'a happy marriage' between what interested me and a field that is currently very prominent in healthcare and healthcare education dialogue. Thus, this thesis is a record of this research journey in which I explored how leadership emerges in the interprofessional healthcare workplace.

My thesis begins in Chapter 1 by exploring in depth the different Discourses of leadership theory that scholars have debated over the years, followed by a more in depth focus on healthcare and healthcare educational research into leadership. Through this review, I identify gaps in the literature that informed my research questions, introduced at the end of the chapter. In Chapter 2, I focus on the overarching theoretical underpinnings of my thesis, complexity and multiplicity. I

[2] In the UK physiotherapy students have to complete 1000 hours of work-based learning in a variety of clinical settings as part of their preregistration training.

also discuss my epistemological perspective, social constructionism and how this led to the methodological choices of narrative enquiry and video-reflexive ethnography (VRE). Also included in this chapter is an account of my own place within this research and how my own ontological and epistemological perspectives affected the choices I have made; the ethical considerations that were specific to my research; and how I addressed research quality. Chapter 3 provides a detailed description of the methods of both phases of my research study. These included medical trainee individual and group interviews in Phase 1 and a VRE study within two clinical workplaces in Phase 2. This chapter details participant recruitment and data collection methods and the different methods of data analysis.

Chapters 4 to 7 are my results chapters. In Chapter 4, entitled ‘Conceptualising Leadership’ I explore how medical trainees conceptualised leadership and followership during their interviews. Within this chapter I use the different leadership Discourses I identified in the theoretical literature in chapter 2 to help make sense of my analysis. In Chapter 5, entitled ‘Narrating Leadership’, I explore narratives of leadership and followership that were collected across the data-set. Chapter 5 begins by providing an overview of the narratives before narrowing my focus to undertake detailed structural narrative analyses of three exemplar narratives. Chapters 6 and 7 focus on the VRE study. In Chapter 6, entitled ‘Enacting Leadership I: A wide angled view’ I provide broad analysis of the video-observational data I collected from the two clinical sites. In Chapter 7, entitled ‘Enacting Leadership II: A close-up view’, my lens narrows to explore, in detail, four video-excerpts through both my own analysis alongside that of my participants (within the video-reflexivity sessions). Finally, Chapter 8 brings my results together and discusses them in relation to previous research and the theoretical literature. My

thesis concludes with consideration of educational implications and suggestions for future directions for research in the field drawn from the study findings.

Various chapters from this thesis have been presented at local, national and international conferences, summarised below. This provided me with opportunities for feedback on my research from out with the immediate supervisory team.

Presentations:

Chapters 2 and 3:

MESMAN J, **GORDON L,** 2014. *Using video-reflexivity in healthcare research*, CMDN workshop, University of Dundee, June 2014

AJJAWI R, **GORDON L,** 2014, *An introduction to visual methods in simulation-based research*. Workshop, ASPiH/SCSN conference, Glasgow: April 2014

GORDON L, URQUHART L, 2013. *Working with video-methods in healthcare education research: ethical, technical and epistemological issues*. CMDN workshop, University of Dundee, Dundee, 11th December 2013.

GORDON L, SMITH J, URQUHART L, AJJAWI R, 2013.*The camera never lies? Using video methodologies to make the invisible visible to learners in the healthcare workplace*. Symposium, 8th International Conference: Researching Work and Learning, Stirling Management Centre, University of Stirling, 19th-22nd June 2013.

GORDON L, REES C E, KER J, CLELAND J, 2012. *How does Leadership Emerge in the Inter-professional Workplace? A PhD Study Employing Visual Methodologies*. ASME: Researching Medical Education Conference, RIBA, London, 21 November 2012.

GORDON L, REES C E, KER J S, CLELAND J, 2012. *How does leadership emerge in the interprofessional workplace?* NES Second Scottish Annual Medical Education Conference, Edinburgh, 1 May 2012.

GORDON L, REES C E, KER J, CLELAND, 2012. *How does Leadership Emerge in the Interprofessional Workplace? A PhD Study Employing Video Reflexivity*.

Presented at “Using visual methodologies to research medical education”, Cardiff University, Cardiff, UK, 9 May 2012.

Chapter 4:

GORDON L, REES C E, KER J S, CLELAND J, 2014. *Medical trainees' conceptualisations and experiences of leadership in the interprofessional healthcare workplace*. Seminar presentation, Centre for Health Communication, University of Technology, Sydney, Australia: 10th February 2014.

Chapter 5:

GORDON L, REES C E, KER J S, CLELAND J, 2013. *“If it was monkeys in the zoo, there's one person who's very much…the alpha male”: A metaphorical analysis of medical trainees' talk about leadership and followership.* ASME: Annual Scientific Meeting, 10-12 July 2013: Edinburgh.

GORDON L, REES C E, KER J S, CLELAND J, 2013. *Medical trainees' lived experiences of leadership and followership within the inter-professional workplace learning environment.* ASME Annual Scientific Meeting, 10-12 July 2013: Edinburgh.

GORDON L, 2013. *Speaking from experiences: How do medical trainees in Scotland perceive leadership?* University of Dundee, College of Medicine, Dentistry and Nursing Research Symposium, Crieff Hydro, Crieff, UK, 7th February 2013.

GORDON L, REES C E, KER J S, CLELAND J, 2013. *Medical trainees' experiences of leadership within the interprofessional workplace learning environment.* Presented (by C Rees) at the 5th International Clinical Skills Conference, Prato, Tuscany, 19th-22nd May 2013.

GORDON L, REES C E, KER J S, CLELAND J, 2013. *Medical trainees' experiences of leadership within the interprofessional workplace learning environment.* 8th International Conference: Researching Work and Learning (RWL8), Stirling Management Centre, University of Stirling, 19th-22nd June 2013.

CHAPTER 1: LEADERSHIP THEORY AND RESEARCH

1.1 Introduction

Drivers for leadership education of health care professionals, particularly for doctors, were introduced briefly in the preface. This chapter will explore those drivers in more depth by analysing and synthesising the vast body of literature that exists within the field of leadership. Exploration and critical analysis of the literature, facilitated my theoretical understandings, methodological concepts, study design and data analysis techniques (Silverman, 2010).

This chapter presents a narrative literature review of leadership theory and research with a focus on healthcare and healthcare education[3]. Initial searching of various databases was undertaken including: MEDLINE; CINAHL; PsychINFO; SCOPUS; and EBSCOhost. Using the initial search term 'leadership', it became clear that a large body of literature already existed in the area. Thus my search focus was narrowed using search terms: 'leadership AND healthcare'; 'leadership AND medicine'; 'leadership AND medical education'; 'leadership AND learning environment'; and 'leadership AND healthcare AND education'. Initial screening of titles and abstracts revealed that much of the literature comprised opinion and discussion papers, descriptions of leadership models or frameworks, descriptions of leadership training programmes and programme evaluations. Empirical research was identified and themes were explored and developed alongside evolving theoretical understandings. As the literature became familiar, focussed searching of reference lists and key journals within the field (for example Medical Education; Academic

[3] For transparency, the search strategy is presented within this section. To clarify, whilst the approach to literature searching had structure, this is not a systematic review and therefore is not set out in this way. The epistemological grounding of this thesis (discussed in Chapter 3) is not aligned with a systematic review.

Medicine; Journal of Nursing Administration) ensued. Grey literature was also searched to identify key healthcare policy documents related to leadership in healthcare and medical education. This provided a sense of the current strategic discussion within healthcare and medical education.

Alongside initial literature searching in healthcare and medical education, through exploration of the leadership literature, I became more familiar with the theoretical concepts relating to leadership. As these theoretical understandings developed, focussed searching of the literature beyond healthcare and healthcare education was undertaken. Thus, through exploration of the theoretical literature, seminal works from outwith healthcare were identified. Once again, reference lists and key journals within the field (for example, Leadership Quarterly and Leadership) were explored for relevant empirical work. Study of the theoretical literature and identification of the key themes within this, facilitated my analysis of relevant healthcare and medical education research.

This chapter is split into two sections: first, in Section 1.2 a Discourse analysis of the theoretical literature is presented. This section finishes with a discussion about how the leadership Discourses identified within the theoretical literature relate to current healthcare and medical education discussions about leadership. Second, in section 1.3, using the Discourse analysis as a basis, empirical literature from healthcare and medical education (and beyond) are analysed and related to current theoretical thinking about leadership in healthcare. Finally, within this chapter, gaps in the literature are highlighted and the chapter concludes by stating the aim and research questions this thesis addresses.

1.2 Leadership theory: the past, present and a possible future

There are said to be as many different theories of leadership as people who write about them (Haslam et al. 2011). Writings on leadership date back 3000 years (Grint 2011). The intention of this section is not to detail every leadership theory that has existed but to present an overview of the broad 'Discourses' of leadership theory. This section provides foundation for the following section, which explores leadership research both within and outwith healthcare and medical education.

To begin, the word 'Discourse' with a capital 'D' means adopting the Foucaldian view that Discourse is a system of thought that is historically situated (Allvesson and Karreman 2000; Bryman 2011; Fairhurst 2011). Using Discourse in this way characterises a way of thinking and talking about a concept (such as leadership) that appears in a range of contexts (for example, in research literature or policy documents) at a given time (Hall 2001). Thus, within the leadership theory literature, I identified four broad Discourses of leadership which can be described with increasing levels of complexity: *individual, contextual, relational (early and current)*, and *complexity* Discourses. Table 1.1 summarises the different theoretical Discourses discussed in the following section.

1.2.1 Historical leadership theory: an individualistic Discourse

Historically, leadership theories could be described as leader-centric[4] (Haslam et al. 2011; Fairhurst and Uhl-Bien 2012; Northouse 2013). Broadly speaking, these theories can be split into three approaches: traits; skills; and styles (Haslam et al. 2011). Scholars of this *individualistic* leadership Discourse would focus on the ways

[4] 'Leader-centric' means that the focus of leadership is on the characteristics of the leader (traits, behaviours, skills etc.).

in which these traits, skills and styles are perceived to enable leaders to exert influence and "power" over others to meet leader-focussed goals (Northouse 2013).

Table 1.1 Overview of leadership theoretical Discourses

Discourse	Definition	Example Theories
Individualistic	Focus is on leaders as individuals exerting 'power' over others to meet leader-defined goals.	-Trait theory (Stogdill 1974; Zaccaro et al. 2004) -Skills theory (Katz 1955) -Styles theory (Mumford et al. 2000)
Contextual	Context determines how a leader behaves: either leader 'flexes' to context or context 'flexes' for leader.	-Situational leadership theory (Hersey et al.1976) -Least preferred co-worker theory (Fiedler 1964; 1995)
Early relational	Focus on the leader-follower relationship. Relationship is either based on 'exchanges between leader and follower (transactional) or the ability of the leader to 'inspire' a follower to act (transformational).	-Leader-Member exchange theory (Graen and Uhl-Bien 1995; Gerstner and Day 1997) -Transformational leadership theory (Avolio et al. 1999)
Current relational	Leadership is a process generated through interactions between team members. Leaders are thus socially constructed through this interaction. Leadership is available to all. Included in this are follower-centric theories.	-Shared leadership (Offerman and Scuderi 2007) -Distributed Leadership (Gronn 2002) -The romance of Leadership (Miendl 1995)
Complexity	Leadership is an emergent process occurring within complex adaptive systems. The leadership process is affected by relationships, context, systems (local and organisational) and time. Leadership is distributed across an organisation at all levels.	-Complexity leadership theory (Uhl-Bien et al. 2008).

Included in this individualistic Discourse is the traditional (and still popular) concept of the "great man" (Grint 2011; Haslam et al. 2011). Appealing and as popular in ancient historical texts as modern biographical texts and Hollywood films, leadership is conceptualised as a set of characteristics that individuals are typically "born" with

that sets them apart from more 'mediocre' others. These conceptualisations are most typically male (Haslam et al. 2011; Carli and Eagly 2011).

Vast bodies of research exist within this field as researchers search for the key elements of personality that make leaders "great". Stogdill (1948) and Mann (1959) both undertook meta-analyses of trait-based leadership research, both finding that traits predicted to relate to leadership varied widely. Over the last 50 years, ongoing research and reviews of the literature have resulted in an increasingly varied range of traits thought to be associated with leaders (Stogdill 1974; Judge et al. 2002; Zaccaro et al. 2004). Judge et al. (2002) undertook a meta-analysis of the literature pertaining to the five-factor model of personality traits related to leadership (known as the Big 5). The authors found a strong correlation between the 'Big 5' (extraversion, openness, conscientiousness, low neuroticism, and agreeableness) and leadership. Of the five, agreeableness was seen to be least predictive. The authors conclude that although the trait approach has waned in popularity, there are aspects that are still relevant. Thus, described strengths of the trait approach include its intuitive appeal; the vast body of research that supports the approach; and its potential to provide a yardstick for assessing what inherent characteristics are required within leaders (Antonakis 2011; Northouse 2013).

However, this approach has many limitations including the inability to obtain a definitive list of traits despite extensive research (Antonakis 2011). The approach also ignores contextual and relational factors, arguably an essential part of leadership[5]. From an educational perspective, based on this theoretical approach,

[5] For example, Judge et al. (2002) identified that the results of studies they included in their meta-analysis varied by setting.

leader traits are seen as inherent and thus not possible for everyone to develop (Haslam et al. 2011).

Scholars of the skills approach suggest that although characteristics of an individual leader have an effect, their leadership skills (for example, problem solving and knowledge) are more important (Northouse 2013). For example, Katz (1955) splits leader skills into three typological groups: technical (knowledge and proficiency); human (people skills); and conceptual (the ability to work with ideas). Katz suggested that where leaders are within the hierarchy of an organisation would dictate what level skills are required.

Developing this idea, and following an extensive period of research with over 1800 army officers, Mumford and colleagues (2000) developed a leadership skills model. This model had five components including: individual attributes (e.g. motivation or personality); leader competencies (e.g. knowledge or problem solving skills); leadership outcomes (e.g. performance or effective problem solving); career experiences; and environmental factors. The effectiveness of leadership within this model is said to be dependent on a leader's competencies. Scholars ascribing to the skills approach to leadership (as opposed to the trait approach above) argue that individuals can be taught how to lead through a focus on their skills (Mumford et al. 2000). Although representing a shift in thinking toward the concept that leadership could be available to all through education, the focus remains leader-centric and these theories continue to fail to take into consideration context (for example, Mumford et al.s' work focussed on the military and may therefore have limited generalisability to the healthcare context: Northouse 2013).

The final approach within the individualist Discourse is the styles approach to leadership which focusses on the behaviours of leaders (Gordon 2011). Researchers within this field have focussed on two types of behaviour: task-focussed behaviours and relationship-focussed behaviours (Northouse 2013). Blake and McCanse (1991), through their research (building on the original work of Blake and Mouton, 1985), identified five leadership styles. These included: impoverished (low task and low relationship concern); authority compliance (high task and low relationship concern); middle-of-the-road (moderate task and moderate relationship concern); country club (low concern for task but high concern for relationships); and team (high concern for both the task and relationships). Again, this approach represents a shift in thinking away from personality in that it focuses on how leader behaviours affect others in different contexts. However, the research using this approach has generated inconsistent results[6] and the approach over-simplifies complex situations that are not easily explained by either task or relationships (Yukl 2013).

Overall, despite the vast body of research drawing on an individualistic Discourse and an acknowledgement that leaders have an important role to play within a leadership process, the leader-centric nature of the research precludes important factors related to the leadership process such as context and relationships (Haslam et al. 2011). Thus, it could be argued that the picture these theories paint is partial at best.

[6] For example Yukl (1994 p. 75: cited in Yukl 2013) states that researchers have not been able to establish a consistent link between task and relationship behaviours and the outcomes including morale, job satisfaction and productivity. Thus “results from this massive research effort have been mostly contradictory and inconclusive”.

1.2.2 Mid-20th Century: a contextual Discourse

Contextual leadership theorists of the 60s and 70s considered that, as well as the individual traits, skills and styles of a leader, context was important and that context determined both the leader and how they behaved (Haslam et al. 2011; Yukl 2011). Within this section, two theoretical examples within this *contextual Discourse* will be presented, after which I will discuss more recent contextual Discourses.

The first is 'situational leadership theory', the notion that leaders "flex" their style according to context, first proposed by Hershey and Blanchard (1976). This approach suggested that leaders should adapt their style to meet the needs of the current situation and subordinate ability (Yukl 2011; Haslam et al. 2011). A famous study using this theory is known as the 'Stanford Prison Experiment' undertaken in the 1970s (Zimbardo 1999). Students took part in an experiment in a simulated prison environment in which half the group were assigned as prisoners and the other half as prison officers (and therefore leaders). The experiment had to be stopped after six days due to the brutality of the 'guards' towards the 'prisoners'. The researchers attributed the extreme enactment of the guard roles to wearing the guard uniforms which emphasised their positions of power over prisoners (Zimbardo 1999). Although this is an extreme example, situational leadership theorists suggest that leaders need to change the way in which they direct or support others to meet the corresponding situational needs of the followers, focusing on their competence and commitment (Northouse 2013).

The second example is contingency theory. This theory states that leaders have a fixed "style" and therefore can only lead in certain contexts (Fiedler 1964; 1995). The modern focus of this theory is on how certain leaders (with particular personalities) will come to the fore in certain circumstances or as a result of certain

opportunities (Haslam et al. 2011; Yukl 2011). An example of contingency theory is Fiedler's (1964, 1995) least preferred co-worker theory in which effective leadership is conceptualised as a consequence of suitability of the leader to their situation. The situation is defined by the leader's relationships with co-workers, a leader's power and the structure of the task in hand (Haslam et al. 2011).

Both these theories now have long traditions of application and situational leadership theory in particular remains popular today in business contexts (Northouse 2013). Although demonstrating a distinct shift in thinking away from the individualistic leadership theories, these traditional contextual leadership theories remain leader-centric in that the focus is still on leader behaviours but recognising the impact of different contexts. Contingency theories, in particular, assume that leader behaviours remain static over time. Finally, neither theory takes into account fully how these leaders operate within a complex social context with followers (Yukl 2011).

Current contextual Discourses emphasise ongoing recognition that leadership processes cannot occur in isolation to context. Modern contextual theorists argue that context can be conceptualised in different ways; from an organisational level to a problem-focussed perspective (Osborn et al. 2002; Grint 2005). Similar to traditional contextual leadership theories, leadership requirements within these contexts are seen to be different.

Osborn et al. (2002) suggest four typologies of organisational context: stability; crisis; dynamic equilibrium; and the edge of chaos. Similarly, Grint (2005) proposes three types of problem-focussed contexts which affect how leadership is constructed: crisis; tame; and wicked. Table 1.2 summarises these proposed contexts.

This newer contextual Discourse takes into account the variability that can be present in modern organisations. It also brings to the fore that leadership can look different in different organisational contexts and has the potential to move focus away from static top-down leadership structures, introducing the possibility that leadership can be distributed across an organisation.

Table 1.2 'New' contextual Discourse of leadership

Organisation-focussed contexts (Osborn et al. 2002)		
Type of context	**Definition**	**Leadership within context**
Stability	The organisation is seen to be stable and focussed on steady trajectory to reach planned goals. Conditions are seen to be predictable.	Deeply embedded hierarchical structure which is highly predictable.
Crisis	Sudden instability and threat to what has been seen as high priority for the organisation. There is very little response time.	Hierarchical to the middle of the organisation.
Dynamic equilibrium	An organisation is in a state of change. Stability is maintained in the face of shifting priorities through endeavours to manage the change.	Hierarchical through the top of the organisation that develop strategies for ongoing change state.
The edge of chaos	The organisation is seen to be in a continuous state of transition between order and disorder.	Focus is on collective leadership distributed throughout the system, which maintains some bureaucratic stability within continuously shifting goals and priorities. Programmatic efforts for change.
Problem-focussed contexts (Grint 2005)		
Crisis	For example, a cardiac arrest scenario.	Immediate hierarchical forms of control may be justified.
Tame	Known problems.	Use of known solutions.
Wicked	Complex 'non-linear' problems, shifting goals and priorities.	Focussed on facilitating the search for a solution.

1.2.3 Relational leadership Discourse

In the 80s and 90s theorists turned to the relationship between leader and follower (Haslam et al. 2011). This *relational* leadership Discourse proposed that leadership is a process involving influence, occurring in groups as an interaction between leaders and followers (Avolio et al. 1999; Northouse 2013).

1.2.3.1 Late 20th century: 'early' relational Discourse

Traditional relational leadership theories include transactional leadership theories such as Leader-Member Exchange theory (LMX) and transformational leadership theory (Graen and Uhl-Bien 1995; Gerstner and Day 1997). These theories place the leader-follower relationship at the centre and focus on either the quality of "exchange" relationships between leaders and their individual followers (transactional) or how a leader can "inspire" followers to move toward common goals, with both leaders and followers being "transformed" in the process (transformational: Bass et al. 1996; Avolio et al. 2009).

Transactional leadership theories such as LMX focus on the development of exchange-based relationships in which the quality of the relationship will have an impact on outcomes (Gerstner and Day 1997). Leadership occurs when leaders and followers develop successful relationships that are mutually beneficial (i.e. the leader will reward the follower in some way[7] for allegiance: Uhl-Bien 2006). Thus, it is suggested that a leader-follower relationship defined as 'high quality LMX'[8] could predict and result in higher levels of leader-follower performance (Graen and Uhl-Bien 1995).

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[7] Examples of reward include: financial; recommendation for promotion; additional training opportunities etc.

[8] For example, a high quality LMX is seen in the literature to be more likely when the subordinate is seen to be competent and share values and attitudes with the leader and the leader is seen to be supportive and more consultative, with a mentoring, rather than monitoring relationship (Yukl 2013).

Transformational leadership is a well-established relational leadership theory, which shifts focus from the quality of the leader-follower ‘exchange relationship’ (seen in transactional theory) to the leader’s ability to “inspire” (Avolio et al. 2009). Followers are seen to be affected by a leader’s actions and are responsive to leader behaviours, with both leaders and followers transformed by the process. The focus within transformational leadership is on ensuring follower’s emotional allegiance to the goals of the leader (Uhl-Bien et al. 2014).

Transformational leadership theory, plus more recent relational leadership theories that focus on leader characteristics and behaviours (such as servant or authentic leadership), therefore, have echoes of an individualistic leadership Discourse (Avolio et al. 2009). These theories have come under criticism for their focus on dyadic leader-follower relationships without recognising the context and wider systems in which these relationships are situated (Yukl 2013). These theories also make an assumption that the position of leader and follower is static and reported research in this field continues to be leader-centric (Uhl-Bien et al. 2007; Uhl-Bien et al. 2014).

Critics of these traditional dichotomous leader-follower relationships suggest that they ‘prescribe’ rather than ‘describe’ the division of labour (Gronn 2002; p. 428). This is seen as unreflective of modern organisational division of labour which are derived from new tasks, the demands of these new tasks and changing technologies (Gronn 2002).

Also in recent years, the concept of ‘destructive leadership’ has been articulated as a potential negative consequence of transformational leadership. Krasikova et al. (2013) define the concept of destructive leadership as:

> *'volitional behaviour by a leader that can harm or intends to harm a leader's organisation and/or followers by (a) encouraging followers to pursue goals that contravene legitimate interests of the organisation and/or (b) employing a leadership style that involves the use of harmful methods of influence with followers, regardless of justifications for such behaviour'* (p. 1310).

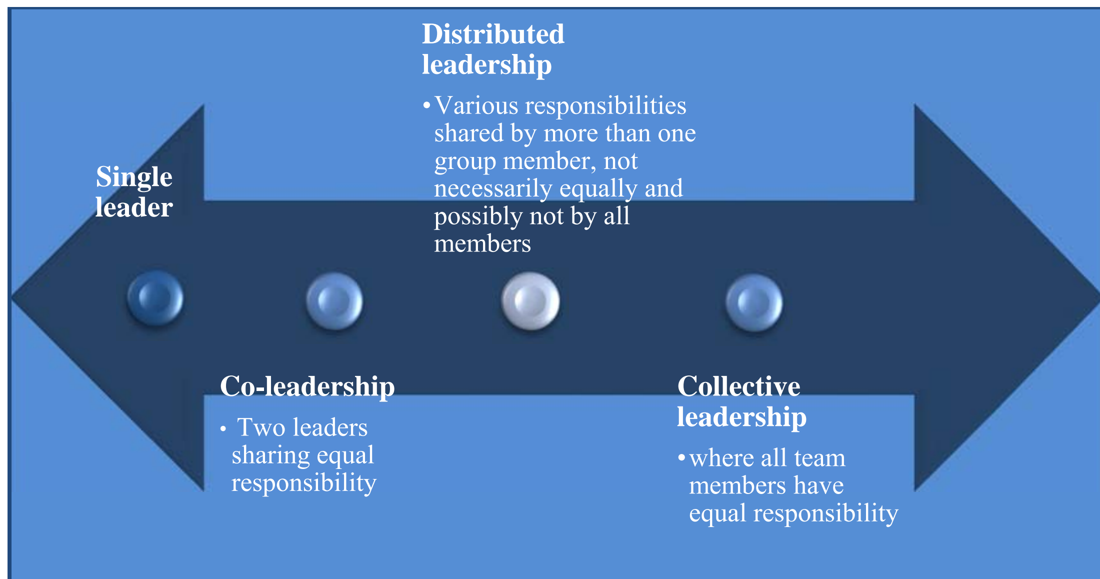
Using destructive methods of influence can lead to adverse effects on the recipients of the abuse (for example, depleted physical and psychological well-being: Krasikova et al. 2013). Thus, in recent years new approaches to relational leadership have been proposed.

1.2.3.2 The present: the current relational Discourse

More recently, Fairhurst and Uhl-Bien have described relational leadership as a "*phenomenon generated in the interactions among people acting in context"* (Fairhurst and Uhl-Bien 2012; p. 1043). Thus, leadership becomes available to all and the current relational leadership Discourse represents a shift away from traditional, hierarchical organisational structures toward possible shared or distributed leadership processes that occur out-with formal positions of leadership (Avolio et al. 2009; Yukl 2013). This shared or distributed type of leadership is defined as more than one person (who may not be in a formal position of leadership) undertaking the responsibilities of leadership either simultaneously or concurrently (Offermann and Scuderi 2007). This leadership process is recognised either formally or informally by a group or the organisation (Offermann and Scuderi 2007). Thus leadership becomes "the aggregated behaviour of some, many or all members of a team" (Gronn 2002, p. 428).

The key premise of this Discourse is that distributed (or shared) leadership within an organisational setting is inevitable as an organisation cannot be defined only through the choices and activities of individual leaders (Offermann and Scuderi 2007; Yukl 2013). Thus this viewpoint argues that the accumulative effect of the decisions of many (both formal and informal leaders) have more weight and importance than that of any individual (Day et al. 2014; Offermann and Scuderi 2007). This concept marks a departure from the traditional theoretical Discourses of leadership which for the most part focus on the actions of individuals (both leaders and followers). In the literature, the terms for leadership relating to this theoretical standpoint are: shared leadership; distributed leadership; collective leadership; team leadership; co-leadership; emergent leadership; and self-managed teams (Offerrnann & Scuderi 2007). Offermann and Scuderi (2007) use this premise to offer a continuum of leadership (see Figure 1.1).

Figure 1.1 Continuum of leadership (interpreted from Offermann and Scuderi 2007)



Focussing on distributed leadership, Gronn (2002) suggests it has three properties. First through changing technologies, he argues that knowledge is more dispersed

through an organisation and increased organisational complexity requires rethinking how tasks are organised. The second property is 'interdependence'. By this Gronn means mutual reliance between two or more members of an organisation thus resulting in joint requirements for information and support. Gronn (2002) argues that this encourages 'complementary role behaviour' (p. 432) enabling advantageous use of individual assets through: combining skills and abilities; the opportunity to learn from each other through shared discussion and observation; and building trust relationships through shared experience and emotions. The final property of distributed leadership is coordination (Gronn 2002). Therefore, through management of activities, work is coordinated both explicitly (through formal communication) and implicitly (through informal communication).

As a product of co-construction, leadership can be seen as something that is negotiated on an ongoing basis as part of a multi-faceted interaction between social beings (Fairhurst and Grant 2010). This social-constructionist theoretical approach to leadership therefore places emphasis on the capacity of leaders and followers to make sense of their organisational experiences and on the interactions they have with each other (Fairhurst and Grant 2010). Each interaction is seen to be socio-historically and culturally bound and operates through language (for example: use of terminology; metaphors; or habitual forms of argument: Fairhurst and Grant 2010).

In summary, relational leadership theorists argue that leadership can only be understood through exploring the underlying social systems in which leadership happens (Uhl-Bien 2006; Gronn 2002). As such, social processes and interactions between leaders and followers should be studied to understand how shared goals are achieved and how these relationships are continually adapted as the needs of a certain situation change (Gronn 2002; Uhl-Bien & Ospina 2012; Yukl 2013).

Hosking (1988) describes incidences in which the process of leadership occurs as an 'influential act of organising' (p. 147). These influential acts are seen as being the central activities of designated or emergent leaders where the main emphasis is on the 'turning point' within an interaction that organises a group to take action (Hosking 1988).

Until recently, the focus of scholarly activity in leadership has been on leaders with little consideration given to followers other than being seen as recipients of leader behaviours or agents of a leader's authority (Yukl 2013; Uhl-Bien et al. 2014). As such, the followership literature is largely absent. A recent review of the journal Leadership Quarterly found that between 1990 and 2008, only 14% of articles had the word 'follower' in the abstract or title (Bligh 2011). In fact, when the search was limited to the use of the word 'followership', only a handful of articles were returned (Bligh 2011).

A traditional follower-centric theory is The Romance of Leadership (Miendl 1995). Within this theory leaders become: the product of follower construction; the central focus of the group; and credited for group outcomes, both successful and unsuccessful (Miendl 1995). Another traditional way of thinking about followership are implicit followership theories in which followers develop an idea of how leaders should behave; with these ideas often being formed through previous experiences or as part of the process of professional socialisation (Schyns and Miendl 2005). This influences how followers perceive leader effectiveness. Leadership is seen as 'good' or 'bad' as followers link leader behaviours to pre-existing categories or leader 'prototypes' they have retained from previous experiences or conceptualisations (Lord et al. 2001; Uhl-Bien et al. 2014).

These traditional follower-centric theories lead to a potential lack of acknowledgement and understanding of how followership relates to and influences leadership as a process (Uhl-Bien et al. 2014). Uhl-Bien and Pillai (2007) state: "*if leadership involves actively influencing others then followership involves allowing oneself to be influenced*" (p. 196). Shamir (2007) argues that followership is so crucial to leadership that: "*leadership exists only when an individual (or sometimes a pair or small group) exerts disproportionate non-coercive influence over others*" (p. xviii). Thus, without followership there is no leadership process (Shamir 2007; Uhl-Bien & Pillai 2007).

As discussed in previous sections, the leadership process does not occur in a vacuum, it is embedded in context (Osborn et al. 2002). Grint (2005) argues that the context in which leadership occurs is also socially constructed. Thus, the leadership process can be seen to be socially constructed in and from a context that is historically located (Osborn et al. 2002). Grint (2005) characterises "*the environment … (not as) some objective variable that determines a response but rather an issue to be constituted into a whole variety of problems or irrelevances*" (p. 1470). Therefore, the wider environment in which the process of leadership occurs cannot be ignored. Osborn et al. (2002) argue that there is increasing recognition that organisations are diverse and as such concepts of leadership are becoming more complex as the contexts themselves grow in complexity.

1.2.4 The future 'at the edge of chaos'? A complexity Discourse

There is a growing body of opinion that traditional understandings of leadership based around the notion of goals being rationally created and realised through well-defined practices is no longer sufficient to explain how leadership can be successful (Marion and Uhl-Bien 2001; Plowman and Duchon 2008; Uhl-Bien and Ospina

2012). Although there is not a requirement in every context to innovate, relying only on known solutions can run the risk of creating a stagnant organisation that is unresponsive to changing circumstances (Lord 2008). Kernick (2006) suggests that prevailing organisational research methodologies seek to reduce and simplify the complex environments they study. Thus many theorists have turned to complexity theory as a possible new approach to the study of leadership.

There is debate as to how complexity theory is defined. Indeed, 45 definitions of complexity theory can be identified within the literature (Kernick 2006). This thesis draws on the definitions of complexity leadership theory put forward by leadership theorists Russ Marion, Mary Uhl-Bien and their colleagues.

The basic unit of analysis within a complexity leadership Discourse is the complex adaptive system (CAS: Uhl-Bien et al. 2008; Lichtenstein and Plowman 2009). A CAS can be seen as systems of ‘agents’ (which can be both human and non-human) which are joined in a collaborative dynamic by a common purpose (Uhl-Bien et al. 2008). Variation is the norm within and between CASs as these interactions occur between wide ranges of agents, thus the interaction within a CAS can be seen to be more crucial than the isolated actions of the individual parts (Pslek and Wilson 2001). These systems can be seen as unpredictable and “have multiple overlapping hierarchies that are linked in a dynamic interactive network” and change within a CAS can therefore be described as “non-linear” (Uhl-Bien et al. 2008; p. 187). Huge numbers of interactions within an organisation happen between peers rather than through formal leader-follower hierarchies. Therefore it can be suggested that much of the basic influence on a system will happen out-with traditional leader-follower roles, creating informal patterns of leadership (emergent leadership) and distributed leadership (Lichtenstein and Plowman 2009).

As such, role, leadership, identity construction, professional identity, conflict and team dynamics can all be seen as "emergent properties of a CAS constructed through activity rather than predetermined" (Bleakley et al. 2013; p. 35). Agents within a CAS will tend to form relationships and adjust to each other's preferences and ways of thinking; and how they do so will be defined in certain ways by their context (Marion and Uhl-Bien 2001; Osborn and Hunt 2007).

There are several premises for complexity leadership theory: first, at the heart of this approach is the assumption that leadership is co-constructed through interaction between individuals and groups working within complex systems and thus it becomes an emergent phenomenon that takes into account the unpredictable conditions of an organisation (Uhl-Bien and Marion 2009; Bleakley 2010; Lichtenstein and Plowman 2009). The focus of complexity leadership is on exploring ways to facilitate local and wider organisational creativity, learning and adaptability within the context of a traditionally hierarchical organisation that is historically bound (Cilliers 2010).

Second, a complexity leadership theoretical perspective necessitates a distinction between *leadership* and *leaders* (Uhl-Bien et al. 2008). A complexity view of leadership is that it can be seen as an emergent, interactive process that produces adaptive outcomes (Heifetz 1994, cited in Uhl-Bien et al. 2008). Within this leadership process, leaders can be seen as any individuals that work in a way to influence the dynamic process and its outcomes (Uhl-Bien et al. 2008; Lichtenstein and Plowman 2009). Complexity leadership theory therefore explores the complex systems and processes that encompass *leadership.*

Third, a complexity leadership theoretical perspective separates leadership from designated positions within an organisation (Uhl-Bien et al. 2008). In other words, leadership can be seen to be present out-with formal leadership positions. Therefore, it is argued that research that is undertaken with a focus only on hierarchical position within an organisation will not sufficiently address the leadership process (Rost 2001; Schneider 2002; Bedeian and Hunt 2006).

Finally, complexity leadership has evolved in response to a changing workplace environment in which new learning and new work patterns are often required (Uhl-Bien et al. 2008). This is dissimilar from technical issues that are resolved through current organisational knowledge and experiences often possessed by individuals (Parks 2005). “Adaptive challenges” are not conducive to “standard operating procedures” and instead demand a search for new ways of working (Uhl-Bien et al. 2008, p. 188). Thus leadership development can be denoted by circumstances in which teams have to “learn their way out of” unpredictable problems (p. 188). Uhl-Bien and colleagues (2008) suggest that doing this will shift an organisation from a traditional industrial-era bureaucratic set-up to a knowledge-era organisation capable of adapting within a rapidly changing world. This is done through the notion of distributed intelligence rather than reliance on the few that hold formal positions of leadership (McKelvey 2008).

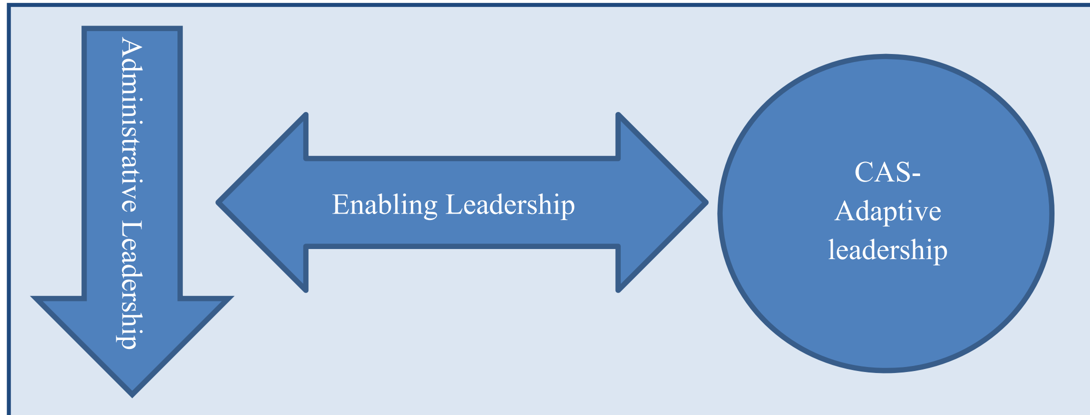
Uhl-Bien and colleagues (2008) have set out a proposed structure for complexity leadership theory in which they suggest that there are three broad functions of leadership (see Figure 1.2). First, there is *administrative leadership,* which is grounded in the traditional hierarchies within an organisation, focussing on task, function, order, regulation and prescribed organisational outcomes (Uhl-Bien et al. 2008).

Second, is *adaptive leadership,* which refers to the adaptive, innovative and learning activities that emerge from the interactions within a CAS in response to "tensions" (Uhl-Bien et al. 2008; p. 198). This emergence is informal and a result of interactions rather than an act of power and authority. Thus key to adaptive leadership is that it is a *complex process* rather than the acts of responsible individuals. This adaptive leadership process can be formed by a conflict of discordant ideas which evolves to create new ideas, learning or change. The process of "seeing beyond" original concepts is the product of these interactions. Uhl-Bien and colleagues (2008) describe this as the "space between" individuals (p. 202). Thus, emergence and creativity can happen at any level within an organisation, to varying degrees, but is most recognisable when it has impact (i.e. identifiable outcomes).

The third type of leadership within a complexity Discourse is *enabling leadership,* which works to facilitate emergence and adaptation through adaptive leadership but also manages the link between the emergent and the administrative functions of an organisation (Uhl-Bien et al. 2008). Managing this 'entanglement' between informal and formal systems involves a creation of an environment in which emergence can occur (through adaptive leadership) as well as ensuring that there is flow of new knowledge throughout an organisational structure to other CASs and administrative structures (Uhl-Bien et al. 2008). Thus, enabling leadership facilitates interaction and interdependency between systems and those within a CAS. Pslek and Wilson (2001) argue that the biggest stumbling block (when it comes to taking a complexity approach to leadership) is individual leaders who are in positions of authority, undertaking leadership based on traditional hierarchical forms of control. Another function of enabling leadership is to protect a CAS from top-down control whilst

ensuring that the work of the CAS is linked to the wider goals of an organisation. Key to this is the management of the flow of information in all directions (Uhl-Bien et al. 2008).

Figure 1.2 Complexity leadership theory (interpreted from Uhl-Bien et al. 2008)



In summary, a complexity leadership Discourse represents a new direction in leadership theory. Leadership is seen as too complex to be conceptualised solely as the actions of an individual or a group of individuals but instead, is seen as the complex interplay of many interactional components (both human and material[9]). Complexity leadership theory pays attention to the way in which leadership emerges across multiple levels of an organisation and in multiple timescales (Lichtenstein et al. 2006; Lichtenstein and Plowman 2009). For example, leadership can occur, (1) in the minute-by-minute interactions of agents working together in a focussed way (through their 'micro-level' interactions), (2) at a 'meso-level' through the daily and weekly minor changes in relationships and ways of working within an organisation; and (3) at a 'macro-level', with change occurring over weeks and months through major events and emergent learning that changes routines at individual and organisational levels (Dooley and Lichtenstein 2008; Lichtenstein and Plowman 2009).

[9] By material, I mean something that has 'substance'. For example, paperwork or medical artefacts.

Thus, it could be argued that complexity leadership theory explains leadership as a relational phenomenon that is dispersed across an organisation, moving beyond the current relational leadership Discourse and its corresponding conceptualisations of shared, collective, distributed and relational leadership (Dooley and Lichtenstein 2008). Thus research within a complexity leadership Discourse should examine the "*dynamic (changing, interactive and temporal) informal interactive patterns that exist in and among organisational systems"* (Uhl-Bien et al. 2008; p. 214). As such, there is a need to ask how leadership is articulated in the space between agents within their everyday interactions (Lichtenstein et al. 2006; Dooley and Lichtenstein 2008).

1.2.5 Leadership theory in healthcare

Souba (2004) argues that the way in which leadership is conceptualised in a context, affects how it is talked about and enacted. This section will explore what leadership Discourses are drawn upon within current healthcare literature.

1.2.5.1 Healthcare leadership: the shift to a relational Discourse

There is a noted recent shift in Discourse within the grey literature in healthcare away from an individualistic Discourse of leadership to arguments for shared and distributed leadership models that draw on a relational Discourse (The Kings Fund 2014). Reports such as Frances and Garling argued that leadership was no longer the province of those in formal leadership positions, but should be distributed across many levels of a healthcare organisation for a positive organisational impact (Souba 2004; Garling 2008; Martin and Learmonth 2012; Blumenthal et al. 2012; Frances 2013).

A series of publications commissioned by The Kings Fund (2011-2013) articulate this transition to a relational Discourse arguing that: heroic leadership was outdated and that shared leadership models were required (The Kings Fund 2011); engagement in the leadership process of employees at all levels of a healthcare organisation was important and that leaders played a crucial role in promoting such engagement (The Kings Fund 2012); and that leadership development at all levels was essential for fostering a patient-centred culture (The Kings Fund 2013). Other suggested benefits of distributed leadership practices included improved patient experience; reduced errors, infection and mortality; increased staff morale and reduced staff absenteeism and stress (The Kings Fund 2012). Most recently, the Kings Fund (2014) have suggested that development of a collective leadership culture requires frequent dialogue, debate and discussion in which ongoing improvements are achieved through learning, careful planning and through any member of the organisation leading at any given point. Other grey literature corroborates that leadership in healthcare is something that works best within a team environment in which groups emphasise shared, collective leadership (WHO 2009). However, others argue that despite the growing focus on staff engagement as a key determinant of healthcare organisational performance, the term ‘engagement’ can be seen as a poorly defined concept (Martin 2011). There is also growing interest in Grint’s (2005) contextual theorising about the differing types of problems healthcare organisations face.

1.2.5.2 Healthcare leadership and complexity

A developing argument in healthcare posits that leadership within healthcare organisations should be able to deal with the uncertainty associated with complex, non-linear contexts and problems, as well as the more easily defined problems that

are resolved through structured processes relying on previous knowledge or experience (Martin 2011; Fulop and Mark 2013). Many different contexts within healthcare may have aspects relevant to different organisational states and place emphasis on the importance of understanding the leadership processes within them (Osborn et al. 2002; Souba 2004; Fulop and Mark 2013).

Similar to Osborn et al.'s (2002) argument about organisations 'at the edge of chaos', leading a healthcare organisation becomes essentially about meeting issues head-on and learning to distribute leadership throughout the organisation in order to learn how to resolve them. This idea has the potential to be intuitively unpopular as it is the opposite of the widely held (individualistic) view that leaders are problem-solvers (Martin 2011).

An acknowledgement that healthcare organisations are in a continuous state of flux and inherently complex has led to the premise that leaders need to explore and understand the complexity of healthcare systems in order to find ways in which they can be improved (Weberg 2012). Within the healthcare literature, interest has recently developed in complexity theory and how leadership is enacted within what is perceived to be a complex organisation such as the healthcare system (Psleck and Greenhalgh 2001; Kernick 2002; McKimm and Swanwick 2014). As discussed in the previous section (1.2.4), the interconnectedness and non-linear change (i.e. an organisational environment at the edge of chaos) associated with complexity thinking are thought of as being normal operating conditions within healthcare organisations (Pslek and Wilson 2001; Kernick 2011; Weberg 2012). As such, leadership becomes an "emergent interactive dynamic" (Pslek and Wilson 2001; Souba 2004; Plowman and Duchon 2008; Uhl-Bien et al. 2008; p. 187).

In summary, within the context of healthcare, recent discussion about leadership would appear to reflect the current leadership Discourses found within the wider leadership literature (relational and complexity Discourses). However, it is argued that many of these theories, in particular the more recent theories remain fundamentally inaccessible to those undertaking the work of healthcare (Kernick 2011). The following section explores how the theories discussed above are operationalised as part of healthcare and medical education research.

1.3 Researching leadership in healthcare and medical education

Uhl-Bien et al. (2014) propose that within the leadership literature there are currently two approaches to leadership and followership research. First, is the *role-based* approach to leadership research in which leadership and followership is seen as a role that can be occupied by individuals either formally or informally. The focus of this approach is on behaviours, effectiveness and outcomes of these roles (Uhl-Bien et al. 2014). Second, is the *process-based* approach to leadership research which focuses on the leadership process through the interaction of leaders, followers and the wider context (Uhl-Bien et al. 2014). These two proposed approaches to leadership research are used to structure the following sections, which focus on the large body of research literature on leadership in healthcare and medical education.

1.3.1 'Role-based' leadership research

Despite the relational and complexity Discourses found in the grey literature about healthcare leadership (see section 1.2.5 above), exploration of empirical studies on leadership in healthcare and medical education found that researchers tend to focus on the 'role' of leaders, by concentrating on their behaviours, their effectiveness as leaders and the outcomes of leadership. Thus, an individualistic Discourse or early relational Discourse perpetuates. The following section focusses on this premise by

exploring the ‘role-based’ research. Split into subsections is a discussion of the research, pertaining to the following identified themes: leader behaviours and styles; leader-follower relationships; the role of followers; and leadership development.

1.3.1.1 Leader roles, behaviours and styles

Survey and questionnaire studies are a popular method used in the wider leadership research literature. For example, studies can be focussed on the influence of a leader’s actions (Agashae and Bratton 2001); or exploring leadership styles and behaviours (Bass et al. 1996; Avolio and Bass 1999). Within healthcare research, survey studies (summarised in Table 1.3) focussed on, for example, styles of leader decision-making (Flin et al. 2006); or identifying competencies and skills of nurse leaders (Zelembo and Monterosso 2008; Palarca et al. 2008). Survey methods are valued for studying perceptions and summarising judgements about leadership and followership of large groups of participants (Fairhirst and Uhl-Bien 2012). However, some of these studies had very small numbers; for example Zelembo and Monterosso (2008) only recruited 23 participants (21%), thus potentially limiting the generalisability of their findings. Plus, such small samples may have had insufficient statistical power to detect significant relationships within the data (i.e. a Type II error: Polgar and Thomas 2008).

Other research has focussed on single specialties, for example, surgery (Henricksson-Parker et al. 2011). The focus of this research is on the use and validation of measuring tools, for example, the Non-technical Skills for Surgeons Scale (NOTTS: Yule et al. 2006; 2008) or the Observational Teamwork Assessment for Surgery (OTAS) tool (Undre et al. 2006). Both these tools are designed to rate surgeons’ leadership behaviours. Similarly, interviews have also been used in the surgical specialty to rate surgeons’ leader behaviours (Yule et al. 2006; Henrickson-

Parker et al. 2012). Literature reviews like those of Henrickson-Parker et al. (2011) and Patel et al. (2010) have used study results to identify the characteristics for a good surgeon leader. This list was used by Henrickson-Parker et al. (as the Surgical Leadership Inventory, SLI: 2012; 2013) in observational studies to identify and rate leadership behaviours of surgeons within the operating theatre. Table 1.3 summarises the behaviours described.

Studies involving individual and group interviews have focussed on defining what makes a good leader in modern healthcare practice, what attributes belong to whom, or what a leader role entails (for example, Yule et al 2006; Taylor et al. 2008; Plotner and Trach 2010; Martin and Learmonth 2012). Often, the participants of interview studies are individuals who have already attained senior roles and thus views are gleened from those with traditional positions of leadership (for example, Blackler 2006; Ham et al. 2011; Newman 2011). Others have explored the experiences of higher stage medical trainees as they undertake transition into formal positions of leadership as trained doctors (currently in the UK this is around certificate of completion of training). This research suggests that higher-stage trainees can feel less prepared to undertake non-clinical responsibilities including leadership and management (Brown et al 2009; Morrow et al., 2009, 2012; Westerman et al 2013).

Similar interview studies in academic medicine (for example, Lieff and Albert 2010; 2012) have found common key areas of a leader's practice which include intrapersonal, interpersonal, organisational and systemic. These domains of practice reflect results from the healthcare based studies. Some authors also conclude that

these domains of practice can form the basis for leadership education (Rich et al. 2008; Mets and Galford 2009; Lieff and Albert 2010; 2012).

The impact of gender on leadership has been frequently studied using interviews, particularly in the field of academic medicine. Although it is outside the scope of this thesis to focus specifically on gender and leadership, it is noteworthy that women can experience leadership differently (Newman 2011). For example, Bartels et al. (2008) in an interview and survey study found that male trainees found giving orders and direction less stressful than female trainees.

These interview studies represent the beginnings of a departure from the prevailing individual Discourse that is typically maintained by studies focussing on leader behaviours. These interviews provided an opportunity to take into account and explore in detail wider contexts, relationships and systems that are part of the leadership process (Lieff and Albert 2010; 2012). However, many interview studies to date have focussed on the leader, rather than the process of leadership. It could be suggested that concentrating only on aspects of a leader's role, understands communication within the leadership process as an act of transmission of information as opposed to sense-making acts cognisant of relationships and context (Fairhurst and Uhl-Bien 2012). As such, relational leadership theorists question whether 'leadership' is really studied when the focus is only on a leader's role (Uhl-Bien et al. 2014).

Table 1.3 Studies exploring leadership behaviours and leader-follower relationships (discussed in Sections 1.3.1.1 and 1.3.1.2)

Authors (date)	Study	Leader characteristics identified
Flin et al. (2006)	Questionnaire to identify surgical decision-making styles (n=352)	Autocratic; consultation; joint; delegation
Undre et al. (2006)	Observation of 50 operations using OTAS	Adherence to best practice; time management; resource utilisation; giving feedback; authority and assertiveness
Yule et al. (2008)	Observation of surgeons using NOTTS (n=44)	Leading team; providing direction; high technical abilities; consideration team members' needs
Zelembo and Monterosso (2008)	Survey study to explore nursing students perception of required leadership qualities in nurse leaders (n=23)	Care and compassion; competence; and role modelling
Garber et al. (2009)	Use scale measuring attitudes to physician-nurse relationships and servant leadership. Questionnaire used with nurses; physicians and residents (n= 497 of 3278)	Weak positive correlation between collaboration and servant leadership in nursing group; no significant correlation between collaboration and servant leadership in physician and resident group.
Patel et al. (2010)	Literature review to determine the characteristics of surgeon leaders	Professionalism; technical competence; motivation; innovation; teamwork; communication skills; decision-making; business acumen; emotional competence; resilience; and effective teaching
Henrickson-Parker et al. (2011)	Literature review to determine the characteristics of surgeon leadership	Developed seven categories: Managing resources; managing tasks; decision-making; maintaining standards; directing and enabling; guiding and supporting; communicating and coordinating
Henrickson-Parker et al (2012)	Video-observation of leader behaviours in surgery (n=29)	Guiding and supporting; communication and coordination; task managment
Henrickson-Parker et al (2013)	Ten focus groups to validate Surgical Leadership Inventory (SLI)	As Henrickson-Parker et al 2011 above with the addition of training.
Henrickson-Parker et al (2014)	Observation of surgeon behaviours in theatre using SLI (n=29)	As Henrickson-Parker et al. 2013 above
Auer et al. (2014)	Survey data of hospital nurses (n=1633)	Indirect associations between management support for patient safety and perception of patient safety than direct associations.
McFadden et al. (2014)	Structural equation modelling based on questionnaires and patient safety data from 204 hospitals	Related safety climate to chief executive leadership style and continuous quality improvement initiatives. A safety climate was related to improved patient safety outcomes.

1.3.1.2 Leader-follower relationships

This subsection focusses on research that has explored how leader behaviours impact on others (see Table 1.3). Survey research in this domain, typically focusses on attitudes of followers towards collaboration and servant leadership (Garber et al. 2009) and to describe the relationship between leadership and patient safety (Auer et al. 2014; McFadden et al. 2014). As discussed previously in section 1.3.1.1, some of this survey research once again involved comparatively small participant numbers (for example Garber et al.'s (2009) response rate was 497 of 3278, only 15.2%).

An observational and interview study by Edmondson (2003) identified that behaviours of leaders (the surgeon) impacted on how well a surgical team adopted a new technology. A subset of interview and survey data focussing on professional identity, found that early career doctors and nurses perceived leadership differently (Barrow et al. 2011). While nurses saw leadership as a core attribute for both doctors and nurses, doctors were less likely to see leadership as an attribute for nurses. Similarly, this study found that doctors were less likely to say that nurses should contribute to and make decisions on behalf of the team; and have a leadership role in interprofessional team working (Barrow et al. 2011). These two studies highlight leadership relationships in healthcare teams. While Edmondson (2003) describes unambiguous traditional interprofessional leader-follower relationships, Barrow et al's (2011) more recent study suggests that this is less straightforward. Thus, it seems that leadership is influenced by relational and contextual factors, and any research should take this into consideration.

1.3.1.3 The role of followers

Similar to the wider leadership literature, very little research has explored the role of followers. Indeed only one interview study was found which considered

followership. Undertaken in nursing this study, aimed at identifying how leadership was perceived among community nurses, found that the role of "following" was complex (Kean et al. 2011). The authors suggested that followers contributed to the social construction of leadership and therefore followers played an active role in leadership (Kean et al. 2011). It is therefore suggested that any future research should consider *both* leadership and followership as an 'interdependent concept'.

1.3.1.4 Leadership development

Within the medical education literature, leadership is typically defined as a skill to be learned or a set of behaviours to develop. A priority for many organisations, for example, is human factors training for healthcare professionals to enhance patient safety: with team leadership identified as a core non-technical skill in this context (WHO 2009). The literature calls for educational programmes focussing on the development of personal and interpersonal competencies associated with a good leader, which is perhaps unsurprising due to the role-based focus of much leadership research in healthcare and healthcare education (as discussed above: Dow et al. 2013; NHS Leadership Academy 2013; Royal College of Physicians Canada 2013; Stoller 2013; Gabel 2014).

Literature pertaining to leadership development typically focusses on the development and evaluation of frameworks, training and competencies, focussing on individuals as leaders (Calhoun et al. 2008; Swanwick and McKimm 2012). For example, medical career progression has traditionally been based on technical and academic ability but now there is an increased recognition of the importance of the development of leadership traditionally taught as a "non-technical skill" within professionalism and communication training (The Kings Fund 2011; Gabel 2012). In response to these changing demands within the UK, the NHS Leadership Academy

has developed the Healthcare Leadership Model (NHS Leadership Academy 2013). The recently published GMC Document "Leadership and Management for all Doctors" identifies ways in which leadership competence can be attained by all doctors (GMC 2012).

Traditional approaches to leadership development in medicine have been the participation of doctors in courses in their final postgraduate training years, ignoring leadership development at earlier stages in medical training (Swanwick and McKimm 2012). There is currently a plethora of ways in which it is perceived that leadership 'competence' can be gained. Table 1.4 summarises these methods. Gabel (2012) argues for techniques that go beyond lecture format aiming instead for more interactive scenarios, group-based work and role-play, observation and mentorship. Other authors suggest that leadership is developed through a cycle of trial and error, learning from successes and failures. In other words, it is just about doing it (Patel et al. 2010; Souba 2011).

A recent systematic review of leadership training programmes described a 'modest' effect of leader development focussing on knowledge, skills, attitudes and behaviours (Straus et al. 2013). An earlier review in 2012 recommended that more robust research into leadership and leadership education was necessary and noted that there was a range of ways in which leadership was conceptualised within the medical education literature, calling for a more distinct articulation of definition (Steinart et al. 2012). This review also concluded that there was a need to explore leadership in context (Steinart et al. 2012).

Table 1.4 Examples of leadership development methods found in the literature

Authors (date)	Cohort	Training methods
Hill (2003)	Senior Nursing and senior administrative staff.	360 degree assessment used to develop leadership competencies
Gilfoyle et al. (2007)	Paediatric trainees	Workshop to train resuscitation leadership skills- including simulation. Demonstrated skills learned and retained at 6 month follow up
Crites et al. (2008)	Undergraduate medicine	Formal programme developed that integrated leadership development with medical education and business management education or public health
Foster et al. (2008)	Physicians	Leadership preventative medicine programme. Includes formal teaching and coaching in the workplace.
Hall et al. (2008)	Rural interprofessional palliative care teams	Needs assessment exercise which identified leadership qualities and designed educational interventions which were work and team-based.
Grout and Winson (2009)	Nursing	Mentorship
Victoroff et al. (2009)	Dental students	Voluntary leadership development programme focussed on knowledge, skills and role modelling.
Kuo et al. (2010)	Postgraduate medicine	Leadership development incorporated into standard clinical training. Focus on knowledge and skills tied to own clinical experiences.
Evans and Wyre. (2010)	Nursing	Health Foundation Leaders for Change Scheme: focussed on skills and knowledge.
Geist and Cohen (2010)	Senior employees in academic medicine	Executive coaching
Goldstein and Zuckerman (2010)	Paediatric trainees	360 degree assessment emphasising communication skills, interpersonal skills and professionalism.
Hendricks et al. (2010)	Undergraduate nursing	Extracurricular programme: focussed on leadership skills and self-reflection plus mentorship
Paterson et al. (2010)	Early stage nursing staff	Formal programme educating leadership practices
Spector et al. (2010)	Academic medicine	Facilitated peer group mentoring
Dyess and Sherman (2011)	New graduate nurses	Formal programme designed to support transition and leadership skills in first year of practice
NHS Leadership Academy (2014)	Postgraduate nursing and medicine	Formal training programmes. Experiential learning: specific leadership tasks
NHS Education for Scotland (2013)	Higher-stage trainees (medicine all specialties)	Online formal programme.

1.3.1.5 Summarising 'role-based' leadership research

In summary, much leadership research within healthcare and medical education to date has focussed on individual roles (of leaders and followers) and impact of leadership, thus perpetuating an individualistic Discourse or at best, an early relational Discourse. However studying leadership: *'requires…methods that go beyond individual based theorising and survey approaches to the interactional processes at the heart of leadership'* (Fairhurst and Uhl-Bien 2012; p1044). Much of the relational research discussed above was focussed on interpersonal relations and how leading and following relates to each other (Gronn 2002; Uhl-Bien 2006). Uhl-Bien (2006) notes that although new approaches to leadership emphasise relationships (for example distributed leadership; Gronn 2002), little is known about *how* these relationships are shaped. The current relational and complexity Discourses criticise leader-centric research for its emphasis on leaders, how effective their activities are and how others (followers) act in response to their influence (Alvesson & Svenningsson 2012).

Also, the research described above, although alluding to it, has not explored how context affects leadership. Willcocks (2004) identifies six factors that influence cultural context within different medical specialties. These include: historical background; nature of the work and use of technology; internal/external relationships; individualism and motivation; inter-specialty interaction and communication; and values and socialisation. The culture-focussed mode of leadership research is also ignored by the majority of the wider leadership literature as well as the healthcare and medical education literature (Alvesson & Sveningsson 2012). Thus, there is a need to explore how leadership is understood and experienced

in different contexts, for example, across clinical specialties, by different professional groups and within different clinical settings.

Criticism is similar for the literature on leadership development in healthcare, which again focuses on the role of the leader. This may explain the ‘modest’ effect of leadership development programmes found through systematic review as many may fail to take into account dynamic leadership relationships that occur in context (Straus et al. 2013). Little attention has been paid to direct workplace learning experiences and how the complexities of this environment might contribute to the emergence and development of leadership. Despite acknowledgement that much postgraduate learning happens in the workplace, medical and healthcare education as a whole lacks literature on the importance of work-based learning experiences (Swanwick 2005; Rees and Monrouxe 2010a). This warrants further exploration as it may impact on the development of ‘one-size-fits-all’ leadership education programmes. There is ongoing concern that a focus on standardisation of healthcare practices through competency frameworks and training programmes may be at the expense of in-depth attention to the local complexities of knowing and doing (Talbot 2004; Iedema et al. 2009).

The following section explores leadership research underpinned by more current relational and complexity Discourses, seeing leadership as a process rather than the undertakings of individual actors.

1.3.2 ‘Process-based’ leadership research

Key assumptions of both relational and complexity Discourses of leadership is that leadership is co-constructed within interaction and that communication in its various forms is a key component (Shamir 2007; Fairhurst and Uhl-Bien 2012). Interactions

are conceptualised as dynamic and something that can change over time (Uhl-Bien and Ospina 2012). Denis et al. (2012) state that current leadership research:

> "*represents a growing body of organisational research and theorizing that examines leadership not as a property of individuals and their behaviours, but as a collective phenomenon that is distributed or shared among different people, potentially fluid, and constructed in interaction"* (p. 2).

This subsection will discuss papers from healthcare leadership research literature that have used a leadership-process approach. Few studies in healthcare were identified that had this focus. Thus, this section will also critique examples from beyond the healthcare leadership literature. To make sense of the context of this research, this section is split into subsections according to contextual levels within an organisation (Lichtenstein et al. 2006; Lichtenstein and Plowman 2009). These are as follows: macro-level research (the ways of working within an organisation); meso-level (through the daily and weekly working and relationships); and micro-level research (focussing on the minute-by-minute interactions of agents working together in a focussed way: Dooley and Lichtenstein 2008; Lichtenstein and Plowman 2009).

1.3.2.1 Researching complexity at a macro level

A 'macro' approach to process research using complexity leadership theory was used as a basis for undertaking change of behaviours and services in public health nursing and dynamic network analysis of fifteen subunits of a hospital laboratory through interview and survey data (Rowe and Hogarth 2005; Hanson and Ford 2010). Each author explored leadership from the perspective that healthcare organisations consist of interlinking networks (and complex adaptive systems CASs) of people, resources, materials and knowledge. Although it could be argued that one study was describing

an approach (Rowe and Hogarth 2005) whilst the other study was explaining a system that was already in place (Hanson and Ford 2010) both authors discussed similar issues. Both argued that a CAS, either as a metaphor for change or a way to explain leadership within a system, depended on several factors including: the level of interaction and involvement of members in reflective practices, planning and decision-making; the number of relationships each CAS had with other CASs; the speed and ease at which a CAS could communicate throughout the wider organisation; development of simple 'rules' that pertained to that particular CAS; and the level of 'boundary spanning' in which group members link with others building relationships and providing 'bridges' for the flow of information (Rowe and Hogarth 2005; Hanson and Ford 2010). Although this macro-approach and the methods the authors chose lack the advantages of exploring leadership processes 'as they happen' they provide valuable insight into understanding the dynamics of how CASs interact with each other within a healthcare organisation.

Critics argue that a CAS should be seen as a form of explanation rather than an entity and thus it is not always apparent what is and what is not a CAS (Paley and Eva 2011). Rather than developing simple rules as Rowe and Hogarth (2005) did, Paley and Eva (2011) argue that simple rules already exist either consciously (through policy and protocol) or unconsciously (through routines, behaviours and customs) and that agents do not recognise that they are following these rules. Thus, they argue that researching leadership through a complexity lens should involve making these rules visible.

1.3.2.2 Researching complexity at a meso-level

Meso-level research within healthcare tends to concentrate on leadership processes focussed on individuals or groups over time. Denis et al. (2010) used data from three

case studies from a program of research within healthcare to describe the process of leadership. Fitzgerald et al. (2013) used interview data to describe the leadership process. Both authors argued that the processes of leadership are collective and dynamic. Denis et al (2010) also suggested that leadership is *situated* in that it is expressed in the actions of leaders in interaction with others in context and that leadership is *dialectic*, in that the strengths of leaders in one context can become weaknesses at another point in time. Fitzgerald et al. (2013) also discussed the notion of 'hybrid' leaders (those with both clinical and leadership responsibilities) who worked to drive change and link frontline staff with senior management (thus, I suggest, undertaking an enabling leadership role).

This meso-approach to leadership research opens up opportunity to explore leadership relationships within context and how these relationships link with the wider contexts across an organisation. Denis et al. (2010) argue for further research that studies micro-leadership practices, leadership enactment and emergence, the embodiment[10] of leadership and the materiality[11] of leadership. It could be argued that exploring leadership using a meso-perspective in combination with a micro-perspective could provide a detailed exploration of leadership in context (through both a wide-angled and close-up view).

1.3.2.3 Researching complexity at a micro-level

A micro-level approach found in the leadership research is organisational discourse analysis (ODA: Fairhurst and Uhl-Bien 2012). ODA focusses on language-in-interaction and what leadership means to those involved. ODA goes beyond

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[10] 'Embodiment' is defined as the expression of a concept in a physical way.
[11] 'Materiality' is defined as a physical state. For example, paperwork or medical artefacts.

individual leaders to see leadership as being a process that is co-created by people as they interact (Rost 2001; Fairhurst and Uhl-Bien 2012).

The use of 'how' research questions explore the *processes* of leadership over 'why' questions which help understand leader *role* and effectiveness. For example, exploring how language constructs multiple realities in terms of leadership relationships can be done through exploring the 'linguistic turn' (known as little'd' discourse analysis: Alvesson and Karreman 2000; Fairhurst and Uhl-Bien 2012). Thus, key to an ODA approach to leadership research is that researchers "*suspend the assumption of assigned leader roles to look for influential acts of organisation in the sequential flow of action* [in context] *by <u>any</u> leadership actor"* (Hosking 1988: Fairhurst and Uhl-Bien 2012; p. 1045, original emphasis).

One approach to ODA leadership research has been the analysis of interview data. Interview data contributes to the understanding of leadership processes as the leadership relationships and contexts are narrated by at least one person who has been involved in that experience (Fairhurst and Uhl-Bien 2012). Within interviews, ODA-focussed researchers will often move beyond thematic analysis to explore other feature such as narrative or the use of language and typical ways of talking that will indicate a broader Discourse (Fairhurst and Uhl-Bien 2012). Also through the view that leadership is a social construction it can be suggested that identities can be negotiated and renegotiated within an interview:

> "*just who leaders are and who followers are and how they relate to one another <u>must</u> be open to reinvention when their sensemaking is problematised in well crafted, in depth interviews"* (Fairhurst and Uhl-Bien 2012; p. 1053).

MacIntosh et al. (2012) combined interview methods with observational methods to explore the extent to which interactions between clinicians and managers were dialogical (in the Bakhtanian sense)[12]. The authors found that clinicians and managers positioned themselves differently through their language (for example talk about ‘targets’). Each group presented themselves as less powerful than the other group and lacking agency (for example, managers being invisible or clinicians not listening to managers: MacIntosh et al. 2012). Thus, rather than dialogical, MacIntosh et al. (2012) described clinical-manager relationships as dialectical. This study demonstrates the ways in leadership identity is conceptualised through talk. To date, no other healthcare interview studies were identified which focussed on the leadership process through narratives of leadership experience or the ways in which participants talked about leadership. This is arguably a gap in the healthcare leadership literature.

ODA can also be seen to be contextual as well as relational (and therefore complex) in that it has the ability to integrate context into leadership in several ways. Examples include: an ODA approach that focuses on leadership entrenched in power and organisational culture (Foucault 1980); an ODA approach that reveals how actors affect context as much as they are affected by it (Fairhurst 2011); or an ODA approach that gives the opportunity for individuals involved in leadership to define characteristics of a context that are most pertinent in explaining their current situation (Goffman 1959). Out with healthcare leadership research, an ODA approach to leadership research is growing in popularity.

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[12] Dialogue in the Bakhtanian sense means ‘*allowing the position of another to enter one’s own understanding so that meanings and oneself are potentially changed’* (MacIntosh et al. 2012, p. 334).

Wang (2006) argues that power (and thus arguably leadership and leader-follower relationships) is an inherent feature of all conversation both in formal and informal contexts. Studies (not directly related to healthcare leadership) have found power structures being constructed in talk in various ways: through the strategic use of questioning in audio-recorded doctor-student interactions (Van der Zwet et al. 2014) and during audio-recorded multiprofessional palliative care team meetings (Arber 2008); through the use of directives (Takano 2005); through pronominal use in student-patient interactions (Rees and Monrouxe 2008); and the use of laughter in bedside teaching encounters (Rees and Monrouxe 2010a).

Focussing on leadership research (outwith healthcare), Wilson (2013) audio-recorded interactions between two rugby coaches and a rugby team. Using Goffman's (1959) concept of 'frontstage' and 'backstage' talk as an analytical lens[13], Wilson (2013) was able to identify that these two types of verbal interaction can be occurring simultaneously, with each coach alternating between the two. This enabled leader identity construction of both coaches in relation to the rugby players (front stage) and each other (backstage). Using this type of analysis enabled in depth exploration of a context in which there were perceived to be multiple leadership structures, such as distributed leadership.

Clifton (2014) recently published a study underpinned by positioning theory in which the author analysed narratives and wider institutional Discourses that occurred naturally during video-recorded interactions within a business meeting. The study set out to identify the 'small stories' that participants used to construct their leader

[13] According to Goffman's (1959) dramaturgical perspective of social interactions, 'Frontstage' and 'backstage', means that people will behave in different ways at a given moment. By front stage, Goffman means the 'public' behaviours that are open to judgement by those that observe them. By backstage, Goffman means the place where people can practice, polish and discuss their behaviours. It provides opportunity for individuals to express behaviours and opinions that may not be deemed publicly acceptable.

identities. Clifton (2014) argued that participants used narrative as 'acts of identity' to position themselves as leaders by using the stories to manage the meaning of a situation. Thus the leaders emerged as "*those who achieve the most influence in the course of negotiation, who also most consistently and who come to be expected and perceived to do so*" (Hosking 1988: p. 153).

Both studies focussed on verbal interaction (despite Clifton 2014 using video-recording). Although this provided opportunity to explore institutional discourse, it lacked analysis of movement and physical positioning as part of interaction. A large amount of studies look at verbal interactions but this approach to research can often be at the expense of non-verbal interaction (Alvesson and Svenningsson 2012). Thus, it can be suggested that collecting interactional data through direct observation (with or without video) may provide opportunity to explore context and the interactional processes that are 'simultaneously organisational' (Boden 1994; p. 206; cited in Fairhurst and Uhl-Bien 2012).

Recent healthcare research by Lingard et al. (2012) and Chriem et al. (2013) have focussed on these micro-leadership processes. Both authors collected observational and interview data from interprofessional healthcare teams in Canada, seeking to understand: the role of physician leadership within collaborative healthcare practices (Lingard et al. 2012), and how leadership practices are undertaken across boundaries in interprofessional teams (Chriem et al. 2013). Lingard et al. (2012) found that despite an articulated desire for a shared approach to leadership within interprofessional teams, when observed, behaviours and systems perpetuated traditional leadership hierarchies within the healthcare workplace. Chriem et al.

(2013) found that central to leadership practices was boundary work[14] in various forms internally and externally and that practices are embedded in a wider macro-environment. Both studies concluded that there is ongoing need to discuss these tensions and the nature of leadership and interprofessional collaboration in the healthcare workplace (Lingard et al. 2012).

Prior to this study, Long et al. (2006) used video-ethnography to explore teamworking within an Australian interprofessional team that ran an interprofessional clinic. The authors explored formal, informal and non-formal modes of communication and discussed what had been videoed through regular feedback sessions with participants in which participants had the opportunity to view themselves in practice. Similar to Lingard et al. (2012), the authors found that despite a desire for shared leadership, a number of internal and external factors prevented this. For example, in formal communication meeting settings, the doctor was found to (unconsciously) dominate discussion and decision-making. The authors also found that there was a 'waiting hierarchy' within the clinic[15].

These three studies provide a micro-view of the processes of leadership in healthcare and indicate that there are deeply entrenched values, beliefs and practices toward healthcare leadership that are perpetuated by traditional medical and interprofessional hierarchies and relationships. Through this, they provide a solid basis for further research into the interactional processes of leadership in context.

[14] By boundary work, Chriem et al. (2013) mean managing boundaries between leadership roles and other leaders within the organisation, between an individual's leadership and clinical roles, between the leader and other interprofessional team members, between different professional groups, between personal experiences and professional work and between the team and the wider environment.
[15] This meant that certain medical specialties would wait for no-one while other healthcare professionals would have to wait until other professionals had finished before they could see the patient (Long et al. 2006).

What is of particular interest is that both Lingard et al. (2012) and Long et al. (2006) purposefully sampled interprofessional teams that had a reputation for high-quality team working. Similarly, the case studies described by Denis et al. (2010) could also be seen as atypical (for example, a chief executive tasked with the closure of hospitals). There is, therefore, a lack of literature in which the 'everyday' healthcare workplace environment is explored. In addition, although these studies came from Western healthcare systems (Canada and Australia) they differ in many ways from the UK healthcare system.

Similar to Wilson (2013) and Clifton (2014), these studies also missed opportunities to explore in detail the interactional processes occurring between leadership actors, in particular Lingard et al. (2012) and Chriem et al. (2013) who neither audio- or video-recorded the interactions they observed. The value of detailed interactional analysis is demonstrated in work by Rees et al. (2013b) who conducted a video and audio-recorded observation of seven bedside teaching encounters. Unlike Clifton's (2014) study, this study took full advantage of the use of video through analysis that moved beyond verbal interaction. They found that power (and therefore arguably leader-follower relationships) was constructed by medical students, patients and clinical teachers through a range of linguistic, para-linguistic and non-verbal communication strategies. Verbal strategies included the use of questions, directives, advice, pronouns and medical talk. Paralanguage included the use of interruptions and laughter. Finally, non-verbal communication included physical positioning and control of material artefacts.

This study highlights a further gap in the leadership literature. Through moving beyond mere analysis of verbal interaction (i.e. little 'd' discourse analysis) Rees et al. (2013b) provided opportunity for analysis of non-verbal human-human and

human-material interactions, and were thus able to explore in novel ways the complexities and micro-processes of the healthcare workplace.

1.4 Conclusion

In summary, this chapter has provided a historical overview of leadership theory and how this relates to the current healthcare workplace. It has also explored leadership research with a particular focus on healthcare and medical education.

While the theoretical literature has moved on significantly over the years, there is a mismatch between theoretical progress and the realities of leadership research. Similar to the wider leadership literature, much research in healthcare and healthcare education has focussed on the role of leaders rather than leadership as a process (Parry et al. 2014). Thus, the outcome of this is that leadership educational practices within medical education remain focussed on leaders (and their development) rather than the processes and practices of leadership.

Research focussed on leadership processes is still in its infancy but these approaches would appear to match modern leadership Discourses and address some of the questions they ask. There is a need therefore to explore leadership in the complex interprofessional healthcare workplace from a process-perspective. As such, the overall aim of this research is to explore the emergence of leadership within the interprofessional healthcare workplace.

Research focussed on leadership processes is a relatively novel and several specific gaps were noted during review of the literature. First, there is a lack of understanding of how leadership is conceptualised by those outside formal positions of leadership. Second, the potential of narratives to reveal leadership identities and experiences as identified by Clifton (2014) remains an unexplored area within healthcare leadership

research. Finally, there is a lack of literature which explores how the processes of leadership are enacted in the interprofessional healthcare workplace. I propose that addressing these gaps through research I present in this thesis, there are implications for future approaches to leadership development in medical education.

Thus, using the methodologies and methods described in the following chapters (Chapters 2 and 3), the following overarching research questions are addressed in this thesis:

1. How do participants conceptualise leadership and followership?
2. How do participants narrate their experiences as leaders and followers?
3. How is leadership and followership enacted within the context of interprofessional healthcare workplaces?

CHAPTER 2: METHODOLOGY

2.1 Introduction

This chapter begins by providing an historical account of my research within a personal context (Silverman 2010). This personal context underpins the theoretical and methodological approaches I applied to my research that explored the emergence of leadership in the interprofessional healthcare workplace. As introduced in Chapter 1, central to my thesis is the theoretical standpoint that leadership is a complex process that involves individuals, relationships, contexts and systems (Marion and Uhl-Bien 2001).

This chapter is split into four sections. First, I provide an analysis of how my own experiences and worldview support the theoretical and methodological approaches to my research. Second, I outline the theoretical perspectives that informed my research approach. Third, I detail the methodological approaches I applied to my research, returning regularly to my own position as researcher within this work. Finally, I discuss the ethical considerations particular to this research and detail efforts made to ensure research quality. This chapter precedes my methods chapter (Chapter 3) in which I will detail how the theories and methodological choices were operationalised.

2.2 Introducing the researcher

The development of knowledge through research is grounded in human interest. Therefore, I subscribe to the notion that seeing research as neutral and objective is problematic (Alvesson, 2002). The intention of this section is to make explicit how my professional experiences have impacted on the choices I made as a researcher at the beginning of and during my research journey. I sought to remain cognisant of my

experiences as a clinician and an educator throughout my research using a reflexive approach to avoid predetermining my study findings. However, I also embraced the notion that my part in this research process has created unique outcomes. I will explore this concept later in this chapter.

During my early career, working as a practicing physiotherapist (1993-2002), I was drawn to working with people with acute and chronic neurological conditions[16]. I was tutored in a conceptual approach to neurological physiotherapy which was grounded in therapeutic handling of the individual patient to "facilitate" normal movement patterns (Bobath 1990). At any given point, this approach was situated in the patients' needs at the time of treatment (these needs could fluctuate for a wide variety of reasons). As a clinician, I felt comfortable with this complexity and uncertainty of working with a person with an acute or chronic neurological condition often relying on "intuition" to make clinical decisions. Thus my physiotherapeutic approach could be described as "emergent". I found working as a neurological physiotherapist professionally liberating, perceiving other specialties such as the treatment of orthopaedic and musculoskeletal outpatient conditions as too structured and prescriptive. Working in a variety of healthcare settings and neurological specialties in the UK[17], I developed an appreciation of the diversity of relationships I had with patients and interprofessional colleagues, as well as the context in which we worked.

At this time, my developing interest in the processes of education superseded my interest in physiotherapy processes and the dominant positivist discourse I had

[16] Examples of the types of conditions patients had that I worked with included: stroke; head injury; multiple sclerosis; motor neurone disease etc.
[17] This included large inner-city acute hospital settings to small rural community hospitals and home-rehabilitation.

experienced and felt some discomfort with within the physiotherapy research community. My readings, whilst undertaking an MSc in Professional and Higher Education, allowed me to explore other research approaches and introduced me to some of the theories I subsequently engaged with as part of this thesis.

At a more practical level, I bring to the research table my clinical experiences affording me 'insider' status in the research process (Carroll 2009). I openly disclose that my own healthcare experiences influenced my relationships with participants and my position within the research, and I will reflect on this throughout my thesis. My ability to converse in the 'language of healthcare' has offered understandings and interpretations of the data from a certain perspective that may be invisible to the non-clinician researcher. In fact, as a healthcare educator I have become "bi-lingual" in the languages of healthcare *and* education. However, I also appreciate this 'insider' status could limit as some aspects were taken for granted where others, those with 'outsider' status may have asked "why does that happen" (Burns et al. 2012).

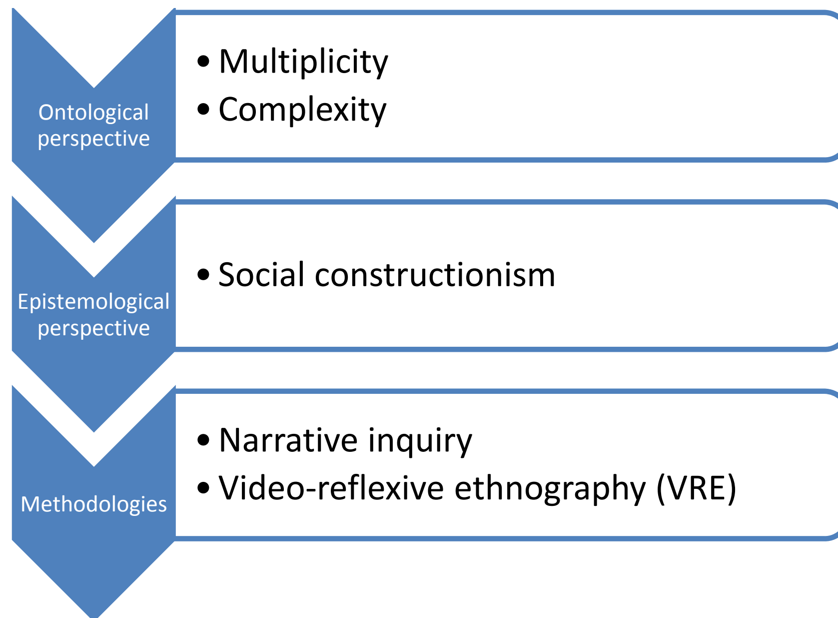
Essentially, my professional experiences provided fundamental grounding to my research approach. I draw on the view that there are multiple, emergent possibilities for reality and thus my research approach, my position within the research and my research journey reflect that. Within the following section, I will discuss in detail the theoretical perspectives that underpin this world view.

2.3 Theoretical perspectives

As identified in the previous section, this thesis embraces complexity and uncertainty. Within this section I draw on several authors to articulate the theoretical underpinning of this research. My intention is not to provide an in-depth account of

the work of any particular individual but to draw together and connect the theoretical principles that inspired and grounded this thesis. Figure 2.1 provides a summary of the association of the theoretical underpinnings and methodological approaches applied to this research.

Figure 2.1: Theoretical underpinnings and associated methodologies



2.3.1 Ontological perspective: Multiple realities

John Law (2004) refers to the term "multiplicity" as the notion of the simultaneous representation of an object in different practices, when those objects are said to be the same. In other words, Law is referring to multiple realities in which the same thing (such as leadership) can be represented and enacted in many different ways[18]. This occurs in response to varying practices that differ, but also overlap and interfere with each other (Law 2004; Mann et al. 2011). Mol and Law (2002) suggest that rather than presenting single theories, we pose questions that are multiple. Thus,

[18] Multiplicity differs from pluralism in that pluralism refers to multiple realities that exist independently from each other.

rather than depicting a single representation of leadership within healthcare, this thesis offers an account of representations of multiple "leaderships".

Paying attention to multiplicity brings with it the requirement for new thinking about what it might be to hold things together (Law and Mol 2002). I draw on Mol's concept of the "body multiple" here and apply this to the argument for my thesis, meaning that leadership can mean and be enacted as different things at the same time[19]. Thus my role within this thesis becomes "coordinator", using various strategies to "reassemble" these multiple versions of reality and "hold" them together (Mol and Law 2002). Deleuze and Guattari use the term "assemblage"[20] to portray the processes of the coming together of multiple objects and realities (MacGregor Wise 2011). Using "assemblage", I do not produce neat, defined and well-tailored accounts. Instead, I argue that the realities this thesis presents are many and fluid (Law 2004). Using the concept of assemblage, I worked within both multiplicity and complexity, allowing me to consider and bring together multiple dimensions of leadership in healthcare simultaneously. Rather than striving for "unity" within this, I acknowledge that myself and the research participants were an assemblage of "partially connected figures" (Mann et al. 2011, p. 224). As such, within this thesis, I used assemblage to identify and magnify particular patterns of multiple realities that were and are constructed within my research. I also accept that the methods I used

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[19] In her book "The Body Multiple" Mol presents an ethnographic account of arteriosclerosis in relation to the body and various medical specialties. There is a traditional idea that each specialty reveals an aspect of a single coherent body. She argues that these specialties' *"different knowledge's (clashing at some points ignoring each other at others) all know their own 'body'*" (p. 10). These different bodies are held together by coordination of paperwork, routines, conversations etc. Thus, she argues it is not the knowledge generated that holds a 'body' together but the various strategies of coordination participating in reassembling multiple versions of reality (Mol 2002; Law and Mol 2002).

[20] Deleuze and Guattari's definition of assemblage comes from the French term 'agencement' usually translated for example as 'putting together', 'arrangement' or 'laying out'. It is not a static term but relates to the *process* of organising, arranging or putting together. It is important to note that assemblage does not relate to putting together pre-set parts or a random collection of things (MacGregor Wise 2005; p. 77). Mann et al. (2011) use the metaphor of a cooked dish in which the ingredients can no longer be separated out to describe assemblage.

within this research only exist within the time and place in which they were enacted and as such the time and place will have shaped them (Carter 2010). I draw on Deleuze and Guattari's metaphor of the "rhizome"[21] to explain that this thesis is partial, it "*has no beginning or end; it is always in the middle"* (Deleuze and Guattari: translated by Massumi, 1987, p. 25). What I elect to represent (or detect and identify) within this thesis is grounded in my theoretical understandings and the methodological choices I made at the time of undertaking the research. As "rhizomatic" thinking might suggest, the work of my thesis continues to develop through ongoing development of ideas through discussion, dissemination and the formation of new collaborations.

2.3.2 Complexity principles and complexity thinking

Whilst I present multiple realities within this thesis, I recognise that many more (an infinite number) could have been presented (Law 2004). In my role as "coordinator of multiplicity", I turned to complexity theory and the principles of complexity thinking to influence my research questions and my methodological choices. As indicated in the previous chapter, complexity leadership is not based on the convention that leadership is centred on individuals and their relationships with others but is seen as an emergent process affected by a combination of individuals, relationships, contexts and systems across time (Marion and Uhl-Bien 2001). As established in Chapter 1 (section 1.2.5), a complexity leadership approach is a process that occurs in interaction (Uhl-Bien 2006). Within the following paragraphs I

[21] From 'rhizoma' in ancient Greek meaning a 'mass of roots' In botany, a rhizome is a modified subterranean portion of a plant that is usually found underground, often sending out roots and shoots in different directions. If a rhizome is separated into pieces, each piece may be able to give rise to a new plant (Jang et al. 2006). Deleuze and Guattari use "rhizome" and "rhizomatic" to metaphorically describe theory and research methodologies that allow for multiple, data representations and interpretations which have numerous access and departure points (Deleuze and Guattari, 1987).

analyse some of the fundamental principles of complexity theory and complexity thinking introduced in the previous chapter that helped to shape my research.

Byrne (2005) states that complexity theory is:

> "[the]…*interdisciplinary understanding of reality as composed of complex open systems with emergent properties and transformational potential….complexity science is inherently dynamic. It is concerned with the description and explanation of change"* (p. 97)

Complexity engages with change, connectedness, uncertainty and emergence (Cohen et al. 2007). A complex system such as the healthcare workplace can involve an array of things, material and virtual, human and technical, seen or unseen, which are organised and connect with one another in order to form groups or "learning collectives" (Fenwick et al. 2011). These "*complex open systems"* emerge in a continuously dynamic process, creating *"unpredictable patterns"* (McKelvey 2008; Fenwick et al. 2011). This unpredictability is intensified by the dynamic nature of healthcare clinicians' roles (Iedema et al. 2013). To summarise, complexity theory recognises that reality is not unchanging; instead, reality is seen as dynamic and responsive to internal and external influences, both human and non-human (Prigogine and Stengers 1984; Iedema et al. 2013). Using complexity theory as a basis for research requires researchers to undertake studies that are 'multileveled and multi-faceted', thus collecting rich data that capture the 'subtlety of the patterns of the system' that reflect the dynamic nature of leadership as it is enacted everyday within the healthcare workplace (Dooley and Lichtenstein 2008; p. 287). Thus, using complexity principles necessitated me to ask multiple questions, choose

methodologies and methods that took into account the range of phenomena that could affect the leadership process and the system in which leadership emerged.

Complex systems operate under three guiding principles; firstly they involve interaction; second they are dynamic; and third they are adaptive (Marion 2008). Interactions change as the relationships between agents change and new groups are formed that are co-dependant with one another ie they are *complex adaptive systems* (Langton 1986; Rowe and Hogarth 2005). Complexity theory proposes that all things are formed through a dynamic dialogue between order and disorder (Fenwick 2011). In healthcare, clinicians work together to negotiate the complexity and uncertainty of their working practices, however, it is argued that complex environments and what is experienced within them can mean different things to different people (Iedema et al. 2013). Each exchange and every relationship provides opportunity for leading as a team individually and collectively learns and takes part in the process of organisation and reorganisation (Uhl-Bien 2006). Aligned with multiplicity, complexity thinking ascribes to the concept that uncertainty and multiple approaches and understandings are inherent in everyday practice (Dekker 2011). Therefore within this research, using complexity thinking, it was fundamental that my approach enabled multiple perspectives and focussed on how participants negotiated and made sense of this complexity in terms of leadership in the interprofessional healthcare workplace (Carroll 2009; Iedema 2011).

Change, even when it is arbitrary, is a central feature of a complex system and gives rise to creativity, learning and flexibility (Marion 2008, Fenwick et al. 2011). A complex system has the capacity to adapt at both an individual and systemic level to external influence (Marion 2008). Within this context, I argue that the chosen methodologies (detailed in section 2.4) had the potential to make this adaptability

possible and visible through the interactions between myself, the research participants and the research data that I collected.

Marion (2008) states that although complexity theory does involve networks, researching using a complexity approach is not about describing these social networks, rather it "*examines the patterns of dynamic mechanisms that emerge from the adaptive interactions of many agents*" (p. 5). Mechanisms can be described as the influences or causes for emergence and/or adaptation within a complex adaptive system and as such, built into my research was the opportunity to explore and identify some of the mechanisms that facilitate and inhibit leadership emergence (Marion 2008). The structures that emerge as a result of these mechanisms cannot be recognised as linear combinations of the original actors involved (Marion 2008). Therefore, a complex system cannot be separated into its original components as their interactions have changed them. Complexity thinking postulates that the future is unpredictable because of the nature of these interactions and their interdependency; in particular, when this is related to social interaction (Marion 2008). Using a complexity approach to leadership research pays attention to the mechanisms and contexts in which change occurs and how systems expand and learn (Uhl-Bien et al. 2006). To understand these mechanisms demands methodologies that are able to analyse the interactions of multiple agents over time (Uhl-Bien et al. 2006). Thus, using a complexity approach within the context of this thesis means the articulated "assemblages" of leadership presented within my results chapters can be seen as dynamic and situated within the context, time and space in which they were formed.

In summary, using complexity thinking emphasised the need to explore the workplace learning environment as a dynamic system. Complexity theory and

complexity thinking as the grounding for my thesis allows me to explore multiple new ways to know, learn about and practice leadership. Researching using a complexity approach complements multiplicity by exploring and assembling multiple emergent perspectives on leadership through the use of a multi-methodological approach (Cohen et al. 2007).

2.3.3 Engaging with the research: social constructionism

In the previous sections, I have explained my understanding of reality as being multiple and complex and have outlined the overarching theoretical underpinnings for this research. Within this section I move closer to the practicalities of my research by articulating how it is that I see these multiple, complex realities being revealed and known within my research.

For this, I draw on social constructionism, the view that "*all knowledge and therefore all meaningful reality as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world…"* (Crotty 1998; p. 42). Thus, meanings are constructed by people as they interact with the world around them. Social constructionism is about how those "meanings" are created through interactive relationships between people (Gergen and Wortham 2001). A social constructionist viewpoint is that participants within a research process actively produce realities and objects through the meanings they attribute to certain events and practices (Flick 2009). Thus, within the context of this thesis I ascribe to the understanding that multiple, complex realities about leadership are constructed through social interactions, in both language and non-verbal interactions and the methodologies and methods I chose reflect this (Gergen 1999). Social constructionism also takes into account that all participants in an interaction bring to the table their own histories and previous relationships and aligned with complexity

thinking, social constructionism recognises that all interactions are dynamic and thus meanings are not fixed (Gergen and Wortham 2001). It is also recognised that these social interactions take place within a certain context and that participants bring forth their own knowledge about those contexts as part of the interaction (Gergen and Wortham 2001). Within this thesis I undertook to explore how leadership emerges within the interprofessional healthcare workplace through the use of methodologies that searched for the multiple and complex meanings that are socially constructed between people (Ellingson 2009). That is, for example, the planned, unplanned and observed interactions between the researcher, the participants, the wider research team and, I suggest, between this thesis and its readers.

2.4 Methodologies

Within the previous sections in this chapter I began by outlining my own historical context and how this influenced my thesis. I followed this by detailing the theoretical perspectives that underpin the methodological choices made within my research. The methodological approaches that informed the methods for this research are narrative inquiry and video-reflexive ethnography (VRE).

2.4.1 Narrative inquiry

Narrative accounts of the healthcare workplace offer abundant sources for research (Bleakley 2005). The word "narrative" is derived from the Latin "narrare" which means "to know" thus narrative (or storytelling) becomes more than simply the description of events (Bleakley 2005). Narrative can take many forms (for example oral or written narratives), which can, for example, be solicited through the interview process or could be heard unsolicited during fieldwork, or within the process of conversation (Chase 2005; Riessman 2008). Broad narratives can be seen as life stories or autobiographical accounts. However, within my thesis the "narratives" I

refer to are short, about discrete events and recounted in interactions in various contexts as sense-making tools (Riessman 2008; Clifton 2014). A narrative in this form makes the "self" the central character (or protagonist), either playing an active part within the story or as Chase (2005) describes as an "*interested observer of others' actions*" (p. 657).

Narrative within the context of my thesis is seen as a relational process in which a narrative is the shared construction of narrator and audience at whatever point the narrative occurs (Riessman 2001; Chase, 2005; Smith and Sparkes 2008). Bound to this is the context in which the narrative is shared; the specific setting, the specific audience and the reason the story is told (Chase, 2005; Smith and Sparkes 2008). Current thinking in narrative research pays attention to the narrator's "voice" and embraces the notion that *how* individuals narrate their experiences and the context in which the story is told, is as integral to the story as *what* has been said (Gubrium and Holstein 2002; Chase 2005). Pivotal to this thesis is the concept of the "narrative turn" in that narrators "construct" events through their story, expressing their feelings, beliefs and understandings about leadership and followership (Chase 2005). As such, the narrative becomes a construction of who a narrator is and how they wish to be known (Riessman 2008). In other words, when a story is told, the narrator constructs and presents identities, events and realities in interaction with others (Chase, 2005; Smith and Sparkes 2008). Thus narrative is a distinct form of discourse; narrating a story is a way to make sense of one's own and others' conduct, structure occurrences and objects into a meaningful whole and of visualising and relating to the temporal consequences of actions (Chase 2005; Riessman 2008). As Bruner (1997) states, "[a] *narrative is not simply a form of text but a mode of thought*" (p. 64).

Narrative inquiry is not novel in the fields of education (e.g. Atkinson 2004; Butcher 2006) and healthcare research (e.g. Riessman, 2003; Hurwitz et al. 2004; Lomas et al. 2013) particularly when the intention is to gain the viewpoints of marginalised groups (Urquhart et al. 2014). More specific to medical education, narrative inquiry has previously been utilised to analyse professionalism dilemmas and feedback experiences at both an undergraduate and postgraduate level (Monrouxe and Rees 2011; Rees et al. 2013b; Monrouxe et al. 2014; Urquhart et al. 2014). In leadership research, however, narrative inquiry has tended to be limited to the broader narratives of an organisation or the life story of a leader (e.g. Boje 2008; Cuno 2005). Clifton (2014) argues that a narrative approach to leadership research helps open up the "black-box" of leadership and contributes to the notion of leadership as an emergent process (p. 113).

Within the context of my thesis, paying attention to and asking questions not only about what participants experience but also about how participants narrate their experiences of leadership afforded insight into the multiple realities and identities that participants construct as leaders and followers (Chase 2005). Thus, I used narrative inquiry to explore the multiple ways in which leadership and followership was conceptualised and experienced in the interprofessional healthcare workplace. In addition, I investigated how participants constructed multiple leader and follower identities for themselves and others through their narratives. In practical terms, this meant collecting narratives in a range of forms, from a variety of contexts at multiple points within the research (this process will be described in detail in the following chapter).

As a researcher, I remained cognisant of the social, cultural and historical circumstances in which the narratives within my research were shared, and while

recognising that every narrative is distinct, I used this premise to consider similarities and differences across the narratives (Chase 2005). Thus the results chapters within this thesis (see Chapter 5 in particular) will offer not only a close-up analysis of individual experiences but also a broad overview of the range of narratives across all participants.

In my role as researcher, as I "interpret" and present the research within my thesis, I also recognise my own role as "narrator" (Denzin and Lincoln 2005). Just as my participants told stories within this research, I also constructed my own narrative from the research process and the methodologies I used and as such I am mindful that my own "realities" influence how the research is represented within my thesis (Denzin and Lincoln 2005; Chase 2005; Riessman 2008). However, through the lens of complexity, the influence I have on the interpretation of the narratives collected will be integrated with the theoretical perspective that knowledge and realities are multiple and shifting. As such, bringing together multiple perspectives of these stories (including my own) contributes to the assemblage of leadership in the healthcare workplace.

2.4.2 Video-reflexive ethnography

Ethnography has grounding in the traditions of social anthropology (Atkinson and Pugsley 2005). Ethnography is undertaken as a methodology to live, understand and embody culture and society through an ethnographer's own experiences (Pink 2007). Culture can be whatever connects a group of individuals together and ethnography is about understanding how people give meaning to everyday life within these cultures (Nicholls 2009). Ethnography lets us appreciate the messiness of everyday practices and the realities that are constructed within them (Law 2004).

Ethnography has been utilised to study aspects of medical education for several decades (Atkinson and Pugsley 2005). Traditional ethnographic practices involve becoming part (on a temporary basis) of the environment of study (Atkinson and Pugsley 2005; Fielding 2008). Ethnographers will utilise a range of methods which can include formal and informal interviews, observation of daily practices and analysis of documents in order to immerse themselves in the daily experiences of their participants (Fielding 2008).

Images cannot be separated from our identities, narratives and socio-cultural existence (Pink 2007). Pink (2007) argues that ethnographic research is in fact inextricably linked to visual images and visual metaphors. Within the context of my study, I combined these traditional ethnographic methods with the use of video, a methodology termed "video-reflexive ethnography", here-in known as 'VRE' (Iedema et al. 2006; Carrol et al. 2008). VRE refers to a methodology that uses video, is 'ethnographic' in that the video captures participants in their 'natural' working environments and it is 'reflexive'[22] in that it involves participants who were captured in the analysis of the video footage (Iedema et al. 2013).

Historically, utilising video and film as a means for ethnographic study was used if the central aim of the research was the capture of cultures in their entirety (Pink, 2007; Harrison, 2002). More recently, postmodernist views of research have moved away from this view of providing objective accounts of whole cultures to an approach which takes into account the subjective experiences of the researchers and the researched (Pink 2007; Rees, 2010). VRE within the context of my research is grounded in this post-modernist ethnographic methodological viewpoint (Iedema et

[22] "Reflexivity" being the capacity of those involved in a practice to see that practice from a different position and explore changes and/or improvements in practices (Iedema et al. 2013).

al. 2006; Carroll et al. 2008). Video-based field studies, drawing on ethnographic methodology, place at the centre context, actions and social interactions; they make visible how participants respond to each other's behaviours and actions; and provide opportunity for repeated scrutiny of those actions and interactions (Heath et al. 2007). Thus VRE has the potential to make everyday practices visible to researchers and participants as it captures the delicate relationships between verbal and non-verbal actions (Iedema et al. 2013).

Visual methodologies are gaining in recognition at the boundaries between social sciences and health services research through their ability to capture the complexities of healthcare practice at the level of workplace interaction (Iedema et al. 2007; Rees 2010). Increasingly within healthcare and healthcare education video is being utilised by interprofessional teams in collaboration with patients and researchers as a tool for inquiry, learning and service development (Carroll 2009). Examples include: neonatal handover practices (Mesman 2008); intensive care unit communication (Carroll et al. 2008); teamworking (Long et al. 2006); laboratory procedures and processes (Iedema et al. 2006); bedside teaching encounters (Rees et al. 2013a; Rizan et al. 2014); and in simulation settings (Ker et al. 2003). To summarise, there is a growing use of the visual within medical education research as it highlights the complexities of healthcare practices. Aligned with complexity theory, VRE responds to the need to reflect the complexities and fluidity of relationships and interactions; and can reveal the "unseen" habits of everyday work (Iedema et al. 2013).

Thus my rationale for using VRE within this research was threefold. First, VRE provided a way to depict leadership complexity and interactions as they happened and were experienced within the healthcare workplace through the capture of in-situ practices (Carroll et al. 2008; Iedema et al. 2013). VRE added a further dimension to

traditional ethnographic methodology in that it provided visual access to the spaces in which leadership interactions occurred (Fele 2012).

Second, it allowed a more close-up exploration of how the leadership process emerged through the social interactions between clinicians than traditional ethnographic practices may have offered (Lomax and Casey 1998; Knoblaugh and Schnettler 2012). The advantage of using video meant that as well as providing opportunity for big-picture analysis (similar to traditional ethnographic field notes) there was additional opportunity for more detailed and focussed analysis of interactions that enabled access to the intricacies of healthcare work in real time (Heath et al. 2007; Knoblauch and Schnettler 2012). Thus, the video-recordings became a rich source from which I could study leadership within the healthcare workplace (Heath et al. 2010).

Finally, and possibly most importantly, working in partnership with participants, VRE offered a means to convey and negotiate the multiple and complex dimensions of the leadership process and to explore how participants made sense of their experiences of leadership as they watched the footage back (Carroll et al. 2008; Iedema et al. 2013). I found the use of video-reflexivity as part of the VRE approach to be a potent method for developing awareness of the processes of leadership within the interprofessional workplace (Carroll, 2009). Through viewing both their own practice and the practices of the interprofessional team, participants would be able to explore and construct the meanings and feelings that surrounded their practices; drawing out different viewpoints and positions in relation to leadership (Iedema et al. 2006; Long et al. 2006; Carroll et al. 2008). As a researcher, engaging the participants with the research process and the video-recordings served to enhance my understandings of the emergence of leadership in the healthcare workplace and

deepen my grasp of situated leadership practices (Lomax and Casey, 1998; Iedema, 2007). As Iedema et al. (2007) state:

> "*Video rearranges and reframes situated practice for researchers and researched alike enabling each to re-apprehend the substantive dimensions through the lens of the normative-affective significances that define situated work"* (p. 18)

Using this methodology, it was essential for me to remain cognisant of the multiple functions that using video-based research has for my own reflexivity (Carroll 2009). While undertaking the methods associated with VRE, as the researcher, I essentially "controlled" the camera, made decisions about what was captured and decided what should be played back to clinicians (Carroll 2009). This highlighted the potential for video to be either empowering or disempowering subject to the way in which it was used (Pink 2007; Carroll 2009). Thus it was vital that attention was paid to power relations between the researcher and the researched. A reflexive approach ensured that this was continuously reviewed (Harrison 2002; Carroll 2009). Through this I was able to account for my role within the research process and ensured I remained ethical in my approach (Harrison, 2002; Pink, 2007; Carroll, 2009). What follows in the next session is a more detailed discussion about my position as researcher within this study.

2.4.3 Researcher position: "boundary riding"

Horsfall and Higgs (2011) use the metaphor "boundary riding" to describe research methodologies that cross traditional research boundaries. My research involved "boundary riding" across traditional researcher roles and relationships between the researcher and the researched and challenged expectations I had of my research and

my position within it (Carroll et al. 2008; Horsfall and Higgs 2011). Throughout the course of the research, my position within it shifted, back and forth between the "traditional" interpretivist role in which I undertook my own analysis and presented my own interpretations of the data, and that in which I worked "alongside" the research participants to interpret the data (Crotty 1998; Carroll 2009). Through this, my own subjectivity and interpretations were evident (Carroll 2009). Use of video within this research did, in fact, serve to literally 'make visible' my participation in the research process, the relationships I had with my participants and any unexplored influences I may have had (Harrison 2002; Carroll 2009). An example of where this was particularly evident was through sharing edited footage with participants in reflexivity sessions. Within these sessions, I was able to view and talk about the video footage I had collected and edited 'alongside' my participants rather than only looking 'at' my participants (Carroll 2009).

My argument to support this shifting researcher position is two-fold. First, from the theoretical perspectives of multiplicity and complexity, I suggest that this "fluid" researcher position allowed me to work within the complex environments or "research fields" I was studying. As such, complex, emergent leadership processes were revealed in collaboration with my participants and these multiple perspectives served to contribute and enrich the leadership assemblage I present within the results chapters of my thesis.

Second, I propose that this flexible position helped attend to potential power differentials between the researcher and the researched as discussed in the previous section. By working "alongside" participants as "experts" when using video-reflexivity, the contributions they made to the interpretation of the video footage

served to empower the researched and “expose” me as researcher, making my “researcher’s gaze” more explicit (Carroll 2009; p. 248).

2.5 Ethical considerations

At this point, I turn to the ethical considerations of my research. In practical terms, all appropriate ethical approvals and permissions were obtained from the University Research Ethics Committee and participating healthcare organisations (see Appendix A). Throughout the methods section in the following chapter, I also refer regularly to the documents that were approved by the appropriate ethics committees. However, this section will discuss more broadly ethical considerations specific to this research.

2.5.1 Informed consent

Informed consent, the voluntary agreement of participants to take part in research based on the information provided, was of particular concern to my research (Flick 2006; Clancy 2007; Bulmer 2008). Information provided to participants was of paramount importance to obtaining and maintaining consent. As part of this, reflexivity as a researcher was essential in recognising and negotiating any ethical tensions that arose (Lingard and Kennedy 2007; Pink 2007). For this, I looked to my own clinical background and my experiences of consenting patients for treatment in which it was important to revisit where possible consent for ongoing treatment. Thus, as a researcher, I did not rely on one-off considerations of consent at the start of each phase of my research (Mulhall 2003). Throughout all stages of my study I revisited consent with my participants. For example, at the beginning of interviews I asked permission to switch on the audio-recorder and whilst videoing in the workplace, I was always overt about videoing and sought verbal consent before switching on the video. Using a collaborative approach to VRE (in that I co-constructed with participants the visual images I captured through discussion with

them what was to be videoed whilst in the field and during the reflexivity sessions) contributed to an ethical approach to informed consent (Pink 2007). It was important to be available as a researcher to answer questions and provide information over and above the standardised information provided within the information sheets, thus I also made myself available through email, telephone and face-to-face to answer questions and discuss consent throughout the research.

2.5.2 Anonymity

Anonymity means that anyone engaging with the research through dissemination should not be able to identify the participants (Flick 2006; Bulmer 2008). This was easily achieved in the initial stages of my research as the data I was working with (interview transcripts) were easily anonymised and de-identified. As part of addressing this issue, it was made clear to participants at the beginning of group discussions that when referring to others, they should maintain anonymity for that person.

However, using video changes the parameters of ethical research in that video footage makes it impossible to completely maintain the anonymity of people and places (Flick 2006; Pink 2007; Tenny and MacGubbin 2008). To address this, I spent time considering how visual images (both stills and video footage) would be used in the final publication of my data (Pink 2007). As part of multi-level consent I asked participants to specifically consent to the use of visual images for publication and dissemination. Within this thesis, photographic images are used but are anonymised as much as possible and any video footage is only available to the research team and examiners of this thesis. Although I have consent to use visual images from the majority of my participants, prior to any dissemination through presentation, I sought specific permission to use any edited video from the participants involved.

2.5.3 Doing no harm

Ethical research practices meant that I should avoid doing harm to participants either physically or emotionally (Flick 2006; Bulmer 2008; Tenny and MacCubbin 2008). Full information provision, a reflexive collaborative approach, and the right to withdraw at any time within the context of this research helped minimise harm to participants.

Asking troubling questions during the interviews, the experience of being videoed and viewing that video all could have triggered negative experiences. If participants found anything distressing, as the researcher, it was my responsibility to ensure appropriate support was sought (depending on the specifics of the situation). Within my research there was always the potential that participants would feel uncomfortable emotionally regarding what was discussed during group sessions or what the video footage may have revealed. However, Tenny and MacCubbin (2008) argue that one can never predict how any information is going to affect a person. Provision of the chance to stop, review information revealed, delete or withdraw may be sufficient and this premise was maintained throughout my research. As a researcher, the principle that the research was being conducted without judgement of someone's behaviour was upheld.

In researching leadership, there was always the potential that a participant could reveal information or display behaviours on video that others considered to be bullying behaviour, either given or received. As such, there was potential that participants, being privy to these opinions or behaviours, would feel that they had to keep a secret or may have felt the need to take action. There was also potential that illegal practices (for example physical abuse or sexual harassment) or activities that were harmful to others (for example wrongful prescribing on a ward round) would

be captured on film or revealed within group interviews and reflexivity sessions. If this had occurred then the appropriate authorities (for example the General Medical Council or appropriate NES Deanery channels) would have been contacted dependent on the situation.

Participants had the right to withdraw from my research at any time. However, it was made clear to participants that any video footage and observational data could only be withdrawn prior to the video-reflexivity session. If the reflexivity session had occurred and a participant withdrew, all video footage of that participant would be de-identified as far as was reasonably practicable for any future dissemination.

2.6 Research quality

Using complexity and multiplicity as a research approach means that I did not search for a singular "valid truth" within my research. As I previously discussed within this chapter I look to present within my thesis the multiple, socially constructed realities that were offered at the time and within the context of my study. Thus, my research is bound by my own values as a researcher, my choice of research approach, my theoretical perspectives and the context within which the research was undertaken (Lincoln and Guba 2007).

What follows in this section is a discussion about the efforts I undertook to ensure that quality was maintained within my research. Lincoln and Guba (1985) proposed criteria for qualitative research "trustworthiness", which included credibility, transferability, dependability and confirmability. These criteria were easily linked to criteria for research quality within a positivist research paradigm: credibility= internal validity; transferability= external validity; dependability=reliability; and confirmability=objectivity (Tuckett 2005). However, Lincoln and Guba (2007)

themselves have recently criticised the use of these criteria as they argue that they reflect what is important in a positivist discourse and ignore the importance of context. They propose that as well as “trustworthiness”, qualitative researchers should be seeking research “authenticity” (Lincoln and Guba 2007). They suggest that this is achieved in five ways. First, through “fairness”, the presentation of a balanced view of the multiple constructions of reality the research unearths; second through “ontological authentication”, the notion that through the research process new understandings and ways of knowing are presented; third, through “educative authenticity”, the notion that not only do I emerge as a researcher with “findings” and recommendations from this research but I also demonstrate my own more complex understandings that are both personal and professional; fourth, “catalytic authentication”, the notion that these new constructions can be used to stimulate and facilitate action; and finally, through “tactical authenticity” the sense that the research has served to empower rather than impoverish participants (Lincoln and Guba 2007). Within the context of my research, I argue that measures have been taken to ensure research “trustworthiness” and “authenticity” through researcher reflexivity, crystallisation and internal coherence.

2.6.1 Researcher reflexivity

Reflexivity as a researcher served to emphasise my own presence within the research process with the ultimate aim of improving the quality of my research (Barry et al. 1999). Throughout this research process, I actively engaged in reflexivity. In practical terms, this meant: keeping and maintaining a research diary; jotting down personal reflections; regular meetings with my supervisory team; and regular presentation and discussion of my work with peers in both formal and informal settings. This reflexive process, as well as influencing the ongoing research design,

served to expose any training, supervision or mentorship requirements I had as a researcher.

In addition, using VRE as a methodology, served to enhance my reflexivity as a researcher. During the process, I recognised that the visual images that I had produced were shaped by my own theoretical approach and I was already “editing” the footage whilst filming (Pink 2006; Carroll 2009). This emphasised for me the “power” I exercised as a researcher, which was further underlined as I went through the editing process (Carroll 2009). Video-reflexivity offered me a different method to the traditional “objectifying” use of video (Carroll 2009). As mentioned previously in this chapter, I allowed myself to ‘boundary ride’ within this research and shift position from looking ‘at’ participants to working ‘alongside’ them. Thus, the emphasis at this stage of my research shifted from the researcher to the researched. Viewing the edited video with my participants exposed my “researcher’s frame” and the choices I had made about what to video within their practices and how to edit, therefore, enhancing my reflexivity as a researcher (Carroll 2009; p. 258).

2.6.2 Crystallisation

Within the context of complexity and multiplicity, I ascribe to the notion that the socially constructed meanings elicited within this research are not static or predetermined nor are they necessary comparable between people. As such I propose that my thesis and my research findings described within it are read through the lens of crystallisation.

Laurel Richardson outlines the notion of writing as a method of inquiry and crystallisation (Richardson and St Pierre 2005). She describes crystallisation as a

shift away from the traditional concept of "triangulation" in which different methodologies and methods are employed to "validate" findings (Richardson and St Pierre 2005). She argues that triangulation assumes that there is a "fixed point" that can be triangulated but the notion of the crystal:

> *"…combines symmetry and substance with an infinite variety of shapes, substances, transmutations, multi-dimentionalities and angles of approach. Crystals grow, change and are altered…[they] are prisms that reflect externalities and refract within themselves, and arrays casting off in different directions. What we see depends on our angle of repose…"* (p. 963).

Laura Ellingson (2009) describes crystallisation as an emergent framework for qualitative research. Engaging with crystallisation involves amalgamating multiple representations into a coherent form and "*building a rich and openly partial*" account of my research that highlights my own positioning (Ellingson 2009, p. 4). I enact crystallisation within this thesis through engagement with several principles.

First, use of multiple methodologies and methods enabled me to provide both a "wide-angled" overarching view of leadership, as well as the "close-up" stories, emotions and interactions involved in the leadership process. As such, I was able to explore different positions, points of view, patterns and exceptions. Second, I acknowledged and engaged with complexity and multiple ways of 'knowing' leadership through exploring its enactment in different contexts and involving diverse participants, taking into account the individuals, relationships, contexts, materials and systems involved. Third, within the results chapters in my thesis I used several different but interrelated ways to express the data (for example: excerpts from transcripts and video footage). Fourth, as discussed above, I place myself

within this research and engage in reflexivity throughout. Finally, I recognise and embrace the notion that this thesis is inevitably situated, partial and constructed. I accept that although bringing together multiple methodologies and methods serves to enhance findings and each part complements the others, I present "*pieces of the meaning puzzle, but never complete it, marking the absence of the completed image*" (Ellingson 2009; p. 13).

2.6.3 Internal coherence

Throughout my research, the choices I have made and the directions I took were not 'plucked from thin air'. Carter (2010) argues that ensuring internal coherence between epistemology, methodology and methods is a challenging but vital and substantial route to research quality. This, she states, has implications for the way in which we write about research, in particular qualitative studies. As I have discussed above, embracing the messiness of my research was part of my identity as a qualitative researcher (Law 2004). However as Carter (2010; p. 144) states:

> "*…it's amusing to notice what happens when we articulate our methodologies. The fertile complexity that we are happy to claim at a general level disappears when we make specific justifications for our actual projects. Like children, whose allowance depends on the state of the bedroom floor we push the evidence of what we have really been up to in the cupboard, and stand nervously against the door.*"

Carter argues for researchers to 'enact' their methodology rather than making claims about it. Thus, enacting internal coherence within my research is the product of my own reflexivity. However, what I write in this thesis is not intended to be a "self-indulgent catharsis" that bears no relation to the research (Carter 2010; p. 147).

Researcher reflexivity within my thesis allows me to enact internal coherence by taking responsibility for the research process and my role within it. Thus, laid bare is the "thoughtful mess" of the process of this research, one in which methodologies were continuously revised and new leads were pursued (Carter 2010; p. 150). I seek to be "clear and open about what actually happened" (Silverman 2010; p. 331). As such, within the upcoming methods chapter (Chapter 3), I will make explicit the decisions I made about research choices that accord with my original research questions and the questions that evolved during my research.

2.7 Conclusion

To conclude, this chapter has explored the theoretical perspectives that realities are multiple and complex and discussed that my role within this research is to present an 'assemblage' of these multiple, complex realities of leadership in the interprofessional healthcare workplace. I also explored the notion that these realities are constructed through social interaction and discussed how this premise influenced my methodological choices of narrative enquiry and VRE. Finally, this chapter explored the ethical considerations specific to my research and argued how I addressed research quality.

The following chapter within this thesis will specify how the theoretical perspectives and methodological approaches discussed within this chapter were operationalised by detailing my research design and methods used.

CHAPTER 3: METHODS

3.1 Introduction

This chapter focusses on the technical and practical approaches undertaken in order to address my overarching research questions (and the supplementary research questions which emerged as the research progressed). In light of the theoretical perspectives outlined in the previous chapter and the gaps in the literature identified in Chapter 1, I begin by reiterating that the aim of this research was to explore the emergence of leadership in the interprofessional healthcare workplace by asking the following overarching research questions:

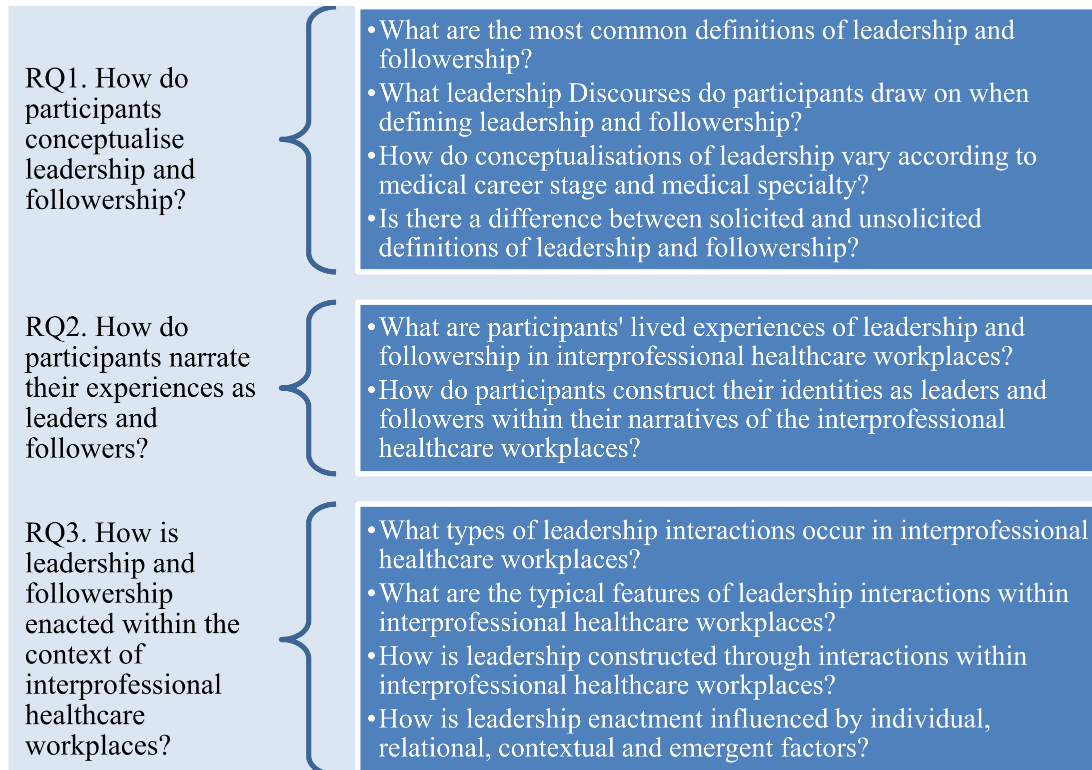
1. How do participants conceptualise leadership and followership?
2. How do participants narrate their experiences as leaders and followers?
3. How is leadership and followership enacted within the context of interprofessional healthcare workplaces?

In addition, as the research process evolved, a number of supplementary questions were developed to enable more in-depth exploration of the data collected and to inform decisions about data analysis methods (Reeves et al. 2008; Rees and Monrouxe 2010a). These are set out in figure 3.1.

Section 3.2 provides a general overview of the research detailing the research design and discussing the shift from a preliminary study that focussed on medical trainees to a second study that involved the whole interprofessional team. Section 3.3 details recruitment and sampling and section 3.4 specifies the data collection methods used. In section 3.5, I describe and discuss how I managed large quantities of qualitative data collected and section 3.6 details the multiple complementary forms of analysis I

undertook. To conclude this chapter, I outline what results chapters (Chapters 4-7) are coming up within this thesis that answer the three sets of research questions.

Figure 3.1: Research Questions and their corresponding supplementary questions



3.2 Research design

In order to address the multiple research questions, I undertook a multi-phase design between July 2012 and July 2014. Decisions about the design of each part of the research process were informed by two factors; first, the research questions and their associated supplementary questions; and second, (for phase 2) the data that had been collected in the previous phase. In addition, at this point I will explain that as the research progressed the research focus shifted from a study centring on medical trainees to one exploring the whole interprofessional healthcare team (involving medical trainees). As an NHS Education for Scotland (NES) funded SMERC

researcher[23], the initial expectation was that my research would focus on medical trainees only, and my initial data collection method reflected this. However, preliminary analysis of the medical trainee interviews made it apparent that in order to explore my research questions more fully, it was imperative that any further research design should take into account the whole interprofessional team. For example, through group and individual interviews with trainees in phase 1, I identified that many trainees conceptualised leadership as an interprofessional process (see Chapters 4 and 5 later).

Figure 3.2 provides an overview of the various methods used for data collection and analysis. In the following sections, I will provide more detail about the conduct of each these research methods within the context of my study.

3.3 Participant recruitment methods

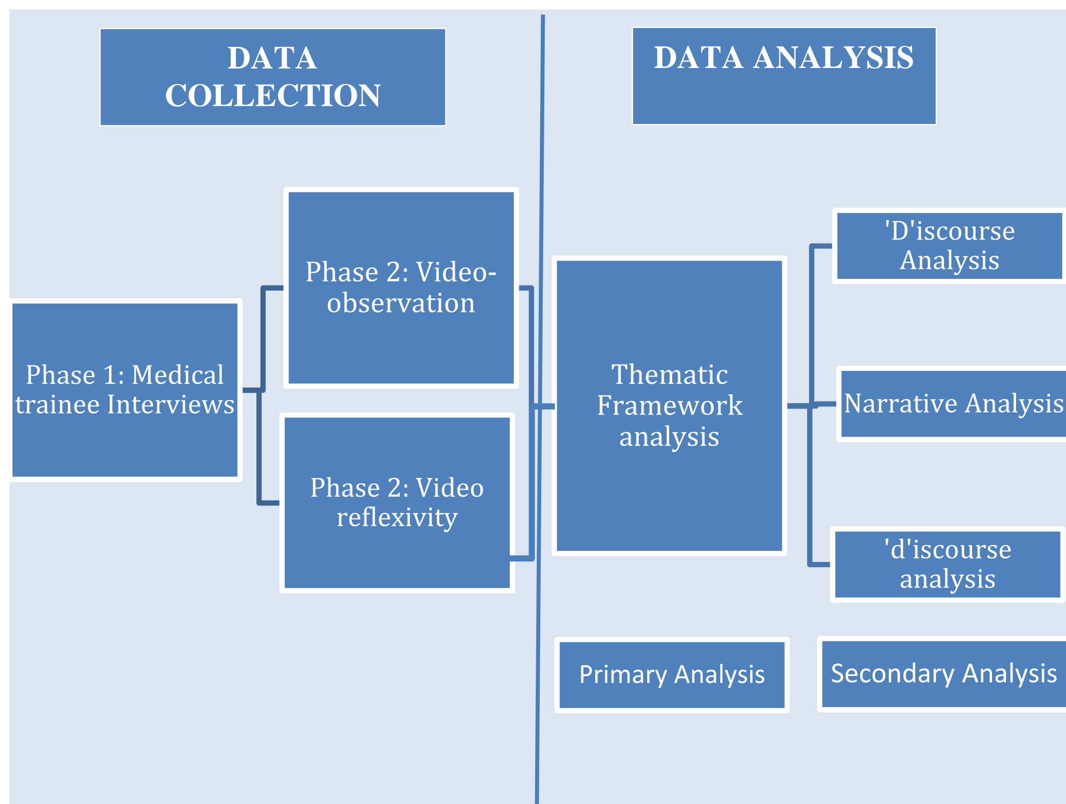
The following section details participant recruitment and sampling for each phase of the study and includes details of participant characteristics in each stage.

3.3.1 Phase 1: Recruitment of participants

Upon receiving ethical approval and appropriate institutional consents (see Appendix A), I utilised maximum-variation sampling to ensure a diversity of medical trainees in terms of gender, ethnicity, stage of training, specialty and location. This allowed me to explore similarities and differences within and between medical trainee groups.

[23] SMERC is the Scottish Medical Education Research Consortium: it is a consortium between NHS Education for Scotland and the five Scottish Medical Schools with the aim to produce internationally excellent medical education research.

Figure 3.2 Methods Overview



Initially I recruited by email, having been provided with the details of relevant gatekeepers within the NHS Education for Scotland (NES) Deaneries (this included training programme directors, postgraduate deans and deanery administrative managers)[24]. Introductory emails requested that a general email be sent out to trainees inviting them to take part in an interview study about leadership (see Appendix B for an example of these emails). Following this initial recruitment drive, I recruited further participants using flyers (see Appendix C) at trainee teaching sessions held within the Deaneries and through snowballing (Cohen et al. 2007). All interested trainees responded to me by email and I then replied to them individually providing them with an information sheet (see Appendix D) and consent form (see Appendix E, which also includes participant details questionnaire), inviting them to

[24] At the time of my studies, NES was split into four Deaneries: North, South-east, East and West Deaneries. Now there is one Scottish Deanery with four regions (North, South-east, East and West).

take part (with a choice of either group or individual interview). Trainees were then provided with the opportunity to ask questions and withdraw their interest. Finally, if they wished to take part, a suitable date and time for their group or individual interview was arranged was arranged.

A total of 67 medical trainees from two Deaneries within Scotland consented to take part in 11 group and 19 individual interviews. Table 3.1 below outlines participant characteristics.

Table 3.1 Participant characteristics: medical trainee interviews

Participant Characteristics		Frequency
Gender	Male	25
	Female	42
Ethnicity	White	53
	Non-white	14
Training Stage*	Early	34
	Higher	31
	Certificate of completion of training (CCT)	2
Training Programme**	Foundation	8
	General Practitioner (GP)	23
	Medical	13
	Surgical	11
	Service	10

* To clarify, within the context of this study, early stage specialty trainees within the context of UK medical training included foundation trainees, core trainees and trainees who were up to and including the half-way point of higher specialty training. Higher-stage trainees included trainees who were beyond the half-way point of their higher specialty training programme up to certificate of completion of training. NOTE: within one focus group, 2 CCT GPs attended as part of the snowballing process.
** To clarify, surgical specialties included trauma and orthopaedics, general surgery, ear nose and throat, obstetrics and gynaecology and ophthalmology; medical specialties included general medicine, emergency medicine, psychiatry, cardiology, renal medicine, acute medicine, paediatrics and core medical training; those placed in the “service” category included anaesthetics, radiology and histopathology.

3.3.2 Phase 2: Site recruitment

This phase involved using a methodology (VRE) which was relatively new within the UK healthcare workplace. Thus I decided to ‘sound out’ the concept with a couple of workplaces to explore the feasibility of undertaking such a study in an NHS Scotland workplace. Key contacts from two workplaces (one GP practice and one hospital ward: sites A and B respectively) were identified and provided by one

of the NES Deaneries through the Deanery representation on the SMERC Medical Education Research Executive (MERE)[25]. These key contacts were approached by email and face-to-face meetings were arranged.

In July 2013, I was invited to provide a short presentation about my study at a multidisciplinary education meeting in site A which several practice members were present. Also in July 2013, I met face-to-face with one of the two hospital consultants from site B. The purpose of these meetings was to outline the proposed study and to discuss whether it was realistic to undertake the study within their workplace. I presented them with an initial site information sheet in these meetings (see Appendix G). Practicalities were discussed and this influenced the final design of the research protocol. Those that participated in the initial discussions agreed that they had a potential interest in taking part in my research and it was arranged that I could make further contact with these sites once full ethical approval was obtained.

Consequently, when ethical approval was obtained, I undertook purposeful sampling of sites A and B based on their initial expressions of interest in taking part in my research. I chose to undertake my study on two different sites because the literature, my theoretical perspectives and phase 1 of my research all suggested that leadership varied by context.

Further meetings were arranged, in site A with the GP practice manager; and in site B, I met one-to-one with both the other ward consultant and the senior charge nurse and introduced my research at a multidisciplinary ward management meeting.

Both sites A and B agreed in principal that the research could be undertaken in their setting, and an initial entry date to their workplaces was agreed in order for me to

[25] See Appendix F for details about the structure of SMERC; Phase 1 (2011-2014)

begin the recruitment phase of my research. Table 3.2 below provides outline details of each site, although a more thorough description of each site is presented as part of Chapter 6.

Table 3.2 Outline details of each Phase 2 site

Site	Context	Service area	Facilities	Initial Key Informants
Site A	GP Practice	Small town and rural surrounds	GP practice and community hospital (16 beds)	GP partner and Practice manager
Site B	Elderly rehabilitation ward in a district general hospital	Small city and surrounds	30 rehabilitation beds	Consultant and Senior charge nurse

3.3.3 Phase 2: Individual participant recruitment and consent

Potential participants that were invited to consent included all members of the interdisciplinary teams working in sites A and B at the time of data collection. Recruitment occurred face-to-face and I approached all potential participants on an individual basis. I introduced myself and explained the purposes and outline of the study, and also provided each with information sheets (see Appendix H). Participants were given time to consider whether they wished to participate (during the cooling-off period they were also able to contact me by phone or email if they had any further questions).

During the latter part of this recruitment phase and following the opportunity for the cooling-off period, I started to obtain individual written consents. The multi-level consent form (see Appendix I which also includes the participant details questionnaire) gave participants the opportunity to consent to certain things but potentially not to others. For example, a participant could consent to being observed but not videoed. Thus, using this form, multi-level written consent was sought for: observation in the workplace; observation in the workplace using video; use of video

in the reflexivity sessions; participation in the video-recorded reflexivity sessions; and use of video-recordings for educational and dissemination purposes. At all times when a consent form was returned to me, I would discuss consent with that individual and clarify exactly the level of written consent they had given.

The majority of consents were obtained during this stage. However some consents were obtained during later stages as other staff members became serendipitously involved in the study (e.g. staff at the community hospital in site A). This was always done in the same way through initial information-giving and then provision of a cooling-off period before obtaining written consent.

Due, in particular to shift and unpredictable working patterns, this stage within Site B took longer than site A. In site A, staff numbers were smaller and work patterns more predictable.

Later in this study, in consultation with the key informant from each site, I arranged two initial reflexivity sessions to which all participants were invited by email, posters within the clinical sites or through word of mouth. Following these sessions, I arranged by email and/or telephone with specific participants to attend further reflexivity sessions. These latter invitations to participate in the reflexivity sessions were guided by who was in the videos and the need for breadth of participants in terms of profession and medical training stage. A total of 39 participants consented to take part in site A and 42 in Site B. Table 3.3 below details participant characteristics for stage 2.

Table 3.3 Participant characteristics: VRE study

Site A (n=39)		
Gender	Male	8
	Female	31
Ethnicity	White	39
	Non-white	0
Professional role	General Practitioner	9
	Specialty Trainee (GP)	2
	Medical Student	2
	Pharmacist	1
	Senior Nurse	5
	Specialist Nurse (MacMillan)	1
	Staff Nurse	7
	Administrative staff	10
	Physiotherapist	1
	Occupational Therapist	1
Consent Level	Full	31
	Partial- all except use of video footage for dissemination	3
	Partial- observation without video only	4
	Partial- observation and video observation without video-reflexivity	0
	Partial- observation without video but allowing audio only	1
Site B (n=42)		
Gender	Male	7
	Female	35
Ethnicity	White	40
	Non-white	1
	Not answered	1
Professional Role	Medical Consultant	2
	Specialty Trainee (medicine)	1
	Foundation Trainee	2
	Medical Student	3
	Senior nurse	4
	Staff nurse	11
	Health Care Assistant (HCA)	2
	Nurse student	4
	Pharmacist	2
	Physiotherapist	2
	Physiotherapy support worker	2
	Occupational therapist	2
	Social worker	2
	Social worker assistant	1
	Non-clinical Administrative staff	2
Consent level	Full	36
	Partial- all except use of video footage for dissemination	0
	Partial- observation without video only	4
	Partial- observation and video observation without video-reflexivity	2
	Partial- observation without video but allowing audio only	0

3.4 Data collection

Data collection occurred between July 2012 and April 2014. As described above data collection occurred in two distinct phases, first the medical trainee interviews (July

to October 2012) and second a VRE study within two healthcare contexts (June 2013 to April 2014). This section describes these two phases.

3.4.1 Phase 1: Medical trainee interviews

Group interviewing is a popular method within medical education research (Wilkinson 1998). The advantage of undertaking group interviews within the context of my study was that I could consult a diverse range of medical trainees from different stages (Wilkinson 1998; Barbour 2005; Fontana and Frey 2005). A forum such as a group interview provides participants with the opportunity to construct ideas through interaction, they are rich in data as they stimulate participants and support them in remembering events (Fontana and Frey 2005; Flick 2009). Participants interact with each other rather than the interviewer which supports emergence of participants' agendas rather than that of the interviewer and a group situation has the potential to give confidence to discuss sensitive issues (Wilkinson 1998; Cohen et al. 2007).

The initial phase of my study involved undertaking both group and individual interviews with medical trainees. These interviews were used to provide me with an insight into medical trainees' conceptualisations of and stories about leadership and followership. Although my preference was for group interviews for the reasons discussed above, practicalities made it necessary for me to offer the opportunity for individual interviews in order to fit in with medical trainees' busy work schedule (Rees et al. 2014).

3.4.1.1 Phase 1: The interview process

As previously stated I undertook eleven group and nineteen individual interviews between July 2012 and October 2012. The individual interviews lasted between 29

minutes and 52 minutes (average 37.9 minutes) and group interviews lasted between 37 and 80 minutes (average 52.5 minutes), totalling nearly 22.5 hours of interview data. At the beginning of each group or individual interview I provided participants once more with the information sheet and participants were once again given the opportunity to ask questions and withdraw from the study. Following this, if participants hadn't already done so, participants were asked to complete and sign the consent form and the individual written data sheets which included demographic questions plus space to provide free text answers to the questions "What is leadership?" and "What is followership?" (See Appendix E).

I designed an interview schedule based on my research questions. This provided guidance to me as the interviewer to ensure some consistency in approach across interviews (Appendix J). The semi-structured nature of the interviews allowed for a certain level of flexibility so that ideas could be pursued and expanded upon. The interviews were broadly split into two sections: first, I asked participants orienting questions in which they were encouraged to articulate their understandings of leadership and followership. Following this, I used narrative interviewing techniques to collect narratives pertaining to participants' experiences of leadership and followership (Riessman 2008). All narratives within interviews are arbitrated by social interaction (Gubrium and Holstein 2002). Often, participants in an interview situation will generalise rather than recount specific narratives because there is an assumption that general views of reality rather than what is specific about an experience is of more interest to the researcher (Weiss 1994). Thus, in the context of these interviews where participants were seen as storytellers, I had to work hard to elicit specific narratives from participants (Chase 2005). Eliciting narratives from my participants, afforded me the opportunity to explore and analyse how participants

constructed themselves and their multiple realities in relation to their leadership and followership experiences.

The interviews were audio-recorded (with permission) and these recordings and the written answers to the free text questions were transcribed verbatim by an independent transcribing company. In order to contribute to research rigour, my primary supervisor (Professor Charlotte Rees) undertook one of the early group interviews and listened back to the audio-recordings of several initial interviews. This provided me with feedback on my interview technique and triggered very initial discussions about data analysis. At the end of every interview, consent and “right to withdraw” was revisited and I provided participants with details about data storage and management.

3.4.2 Phase 2: Video-observation and video-reflexivity

Tight timelines for healthcare and healthcare educational research have challenged traditional ethnographic practices of prolonged engagement in the field and have resulted in exploration of alternative methods of data collection than traditional ethnographic field notes (Pink 2007; Carroll and Mesman 2011). Thus, within healthcare research, video-observation is considered to be a powerful method for ethnographic data collection (Lomax and Casey 1998; Pink 2007; Forsyth et al. 2009). Using video-reflexivity as a method offered a means to discuss and negotiate with participants the multiple and complex dimensions of the leadership process within the context of the interprofessional healthcare environment and to explore how participants made sense of their experiences of leadership as they watched the footage back (Carroll et al., 2008; Iedema et al., 2013).

The process of VRE that I undertook in my research is based on the work of Rick Iedema and his colleagues who have undertaken and developed VRE as a methodology over a ten year programme of healthcare research (Iedema et al., 2013)[26]. The method I used occurred in four stages: (1) site recruitment stage (detailed above); (2) a period of familiarisation and observation within the workplace; (3) video-footage was recorded of real workplace practice (video-observation stage); and (4) this footage was then compiled and edited and the edited footage was played back to the interprofessional team, providing them with the opportunity to reflect on and discuss their practices (video-reflexivity stage). These stages (with the exception of the recruitment stage) will be described in detail below. Table 3.4 below depicts a timeline detailing the different stages of the Phase 2 study at each site (which includes the site recruitment stage).

Table 3.4: Timelines for Phase 2**

Site	Stage 1	Stage 2	Stage 3	Stage 4
Site A	July to September 2013	October 2013	November 2013	November 2013 to January 2014
Site B	July to November 2013	November 2013 to January 2014	January 2014	February to April 2014
**Key to stage numbers Stage 1= site recruitment stage (this also included obtaining ethical approvals) Stage 2= familiarisation and observational stage Stage 3= video-observational stage Stage 4= video-reflexivity stage				

The formation, editing and watching of visual footage requires careful planning and consideration of what is being and has been captured (Carroll and Mesman 2011). What follows in the next sections is a detailed description of the processes of data collection I undertook within Phase 2 of my research.

[26] In February 2014, funded by a travel scholarship awarded to me by the Scottish Clinical Skills Network, I travelled to Sydney to spend two weeks at the University of Technology, Sydney with Professor Iedema and his colleagues as a Visiting Fellow to learn more about VRE.

3.4.2.1 Phase 2, Stage 2: Familiarisation and observation

Initially, I attended each site for short periods (between ½ hour and 3 hours) during normal working hours (8-6pm) in site A on five different occasions and in site B on seven different occasions. This amounted to a total of 10 hours 50 minutes in site A and 9 hours in site B. The aim of this stage was to introduce the project to staff within each site, provide information about the study and to familiarise myself with the working practices of each healthcare workplace, as well as allowing participants to become familiar with my presence as the researcher.

Familiarisation with each site was achieved through informal discussion at various points during the working day. At this point, key informants within each site were identified (in site A the practice manager and in site B the ward's senior charge nurse). These key informants acted as facilitators, providing initial introductions as well as the provision of information about systems and staff working patterns and potential points in the working week where observation and (latterly video observation) could take place. Other potential participants also offered information about their working environment and their perceptions of constraints or enablers with respect to good interprofessional working and leadership.

The observation stage involved watching practices that had been identified by the participants within the familiarisation stage as points of interprofessional interaction (with non-patient contact[27]). In site A, I was onsite for periods of between two and five hours on four occasions (a total of 15 hours 25 minutes observation time); in site B I was onsite for periods of one to four hours on four occasions (a total of 7 hours 55 minutes observation time).

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[27] It is important to note at this point (and in accordance with my ethical approvals) that all interactions I observed took place when participants were not in direct contact with patients (although patient care was often the central subject of discussion within any given interaction).

I observed team meetings, educational sessions and spent time in the GP reception area and at the hospital ward's nurses' station. During this time, I took basic field notes which provided outline details pertaining to working practices, notes from discussions I had had with various participants and more detailed descriptions of the format of more formal settings, for example, multidisciplinary team meetings. I also made notes within my research diaries about my own changing role within the environment.

The purpose of this observational period (without video) was four-fold. First, to continue to make my presence familiar to participants in preparation for the filming stage of the research second, to make myself familiar with the types of leadership interactions that occurred within these workplaces; third, to identify specific formal points in the working week that I might undertake video-observation (for example, educational meetings in site A or ward rounds in Site B); and finally, to identify specific contexts (out with the formal settings) where I might be able to video leadership interactions (for example, the GP reception area in Site A or the nurses station in site B). Thus, my field notes and diary reflections from Stage 2 were used to plan stage 3, the video-observation stage.

3.4.2.2 Phase 2, Stage 3: Video-observation

The focus of this video-observation stage was to capture leadership interactions as they occurred within the context of the interprofessional workplace. Again, as with the observational stage, the purpose of the video-observation stage was to capture interactions that did not involve patients. If at any point a patient was inadvertently filmed (or for that matter a healthcare worker who had not consented), then this footage was immediately deleted.

The equipment I used was a small Sony handi-cam with a wide-angled lens (see still 3.1). I chose to use this because this type of equipment is generally familiar to people and its size made it discreet. Despite the desire to use familiar, discreet equipment, at all times I was overt about my intention to video and let participants know verbally what I was planning to record that day (Carroll 2009). At first, during more formal settings (for example, multidisciplinary team meetings), I tried using a static tripod but found I preferred to hold the camera and 'rove' with it, which enabled me to 'home-in' on specific interactions and capture the dynamic nature of leadership in the interprofessional healthcare workplace. When videoing, I held the camera at chest height and viewed the activities through the side-view. This allowed me to maintain eye contact with participants and thus maintain the familiarity I had built with the participant in the early stages of this research phase.

Still 3.1: The video equipment used

My initial intention was to video using a 'fly-on-the-wall' style throughout and the majority of footage captured was done in this way. However with some footage, in particular when a participant was alone with me, he/she would interact with me and discuss their thoughts and actions while I was videoing thus the style of videoing became 'expert-apprentice' (Carroll 2009). My theoretical standpoint that meaning is

constructed through social interaction (discussed in Chapter 2) meant that I did not discourage this type of interaction. I continued to make notes in my field diary throughout which I used for reference at a later date when it came to editing the video (see section 3.4.2.3).

3.4.2.3 Phase 2, Stage 4: Video-reflexivity

The final stage in my VRE study was video-reflexivity, the purpose of which was to provide participants with the opportunity to view their interactions in practice and discuss leadership and followership as they saw it happening. In total, I ran five reflexivity sessions in site A and seven sessions in site B.

The first step in this process was to edit the video-observational footage I had collected into short clips that could be discussed within the reflexivity sessions. In order to undertake this task, I uploaded my raw video footage and used the basic video-editing software available with my Windows PC (Windows movie-maker). This reduced the video footage down to approximately 20 minutes of footage for each site. I used several premises to guide this editing process and facilitate decision-making about which clips to choose.

My first premise was to ensure that a range of activities and participants (taking into account their job roles) were depicted in the edits; second, I was informed by my field notes both from the observational sessions (without the camera) and the informal discussions I had with participants about their daily work and any particular issues related to leadership enactment; and third, I was informed by my knowledge of the literature in terms of my own theoretical understandings of leadership (see Chapter 1). Thus, I edited the video-observational footage to include what I perceived to be examples of 'influential acts of organising' (Hosking 1988).

Furthermore, my ongoing analysis of phase 1 data and my initial analysis of the observational data informed me of the different ‘types’ of leadership occurring within the workplace and I was conscious of including this range (e.g. clinical leadership, educational leadership and/or administrative leadership).

Finally, through my discussions with participants during the first 3 stages of this VRE study, I had also identified a particular issue of concern within each site. In site A (the GP practice) there were concerns expressed by participants, in particular the community hospital senior charge nurse (SCN), about the medical input into the hospital. She described this as a “clinical risk issue” in that medical input was inconsistent and there was often a gap between requests for medical input and GP attendance at the hospital due to GPs other clinical commitments. GPs kept their own patients rather than there being a single GP responsible for all inpatients; the SCN saw this as a leadership issue in that change in systems was required. In site B, several participants including the SCN, a consultant and several nursing staff raised the issue of what was perceived to be inconsistent and at times unacceptable behaviour on the part of one of the consultants. This was seen to be a leadership issue that affected interprofessional relationships. Thus, included in my edits were clips which had the potential to ‘make visible’ these specific issues in order to provide opportunity for participants to discuss and analyse them within the reflexivity sessions.

Each reflexivity session began with an introduction to the session and explanation of the layout. Following this, I would show an edited clip. Then I would provide participants with the opportunity to discuss the clip generally, in terms of leadership and followership and any other aspects they particularly wanted to discuss in relation to the clips. My role within this was to facilitate the discussion through prompt

questions, to ensure the discussion stayed on topic and probe some issues in more depth. At the end of each session I thanked them for participating and reminded them that they could be in contact with me at any time if they wished to discuss any of the issues further.

Each session was videoed using the Sony hand-held camera, with wide-angled lens. Unlike the video observation footage, the camera remained static (on a tripod) throughout each session and I was visible within the footage.

3.5 Data management

The following section pays attention to the types of data I collected across the research study and how that data were managed in terms of transcription, storage and preparation for analysis.

3.5.1 Interview data

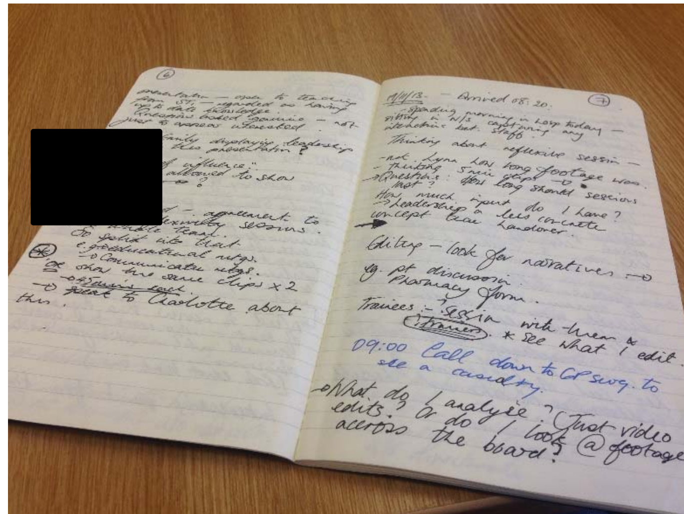
As previously stated all interviews were audio-recorded and these recordings were uploaded and sent as an audio-file to be transcribed by an independent transcribing company. This company was experienced in this type of work and had a confidentiality clause in their agreement. At this point, the transcripts were anonymised and interview participants were assigned a number and names and places were removed. Data pertaining to trainees' definitions of leadership and followership from the participant questionnaires were also transcribed into word documents by me. Thus, all interview data were available as a set of word documents and audio-files.

3.5.2 Field notes

My field notes were written in notebooks and because their purpose was to inform further stages of the VRE study rather than act as data as some qualitative

researchers do, no transcription took place. I referred to them directly throughout my data analysis and during the process of writing this thesis (see still 3.2 for example of my field notes).

Still 3.2: Example of field notes



3.5.3 Video data

Video data came in three forms: the raw video footage data from the observational phase; the edited video clips; and the video recordings of the reflexivity sessions. As previously mentioned the raw video footage was initially uploaded to my PC for editing purposes (for which I used Windows movie-maker). Due to file size an external hard-drive was used for file storage. At this point no transcription took place of any video files.

3.5.4 Data storage

All data in the various forms described above were kept in a secure manner. The paper-based data, including consent forms, participant questionnaires and field notebooks were kept in a locked filing cabinet on university premises. Participant questionnaires and consent forms were kept separately in order to maintain anonymity. All electronic data, which included audio-files from the interviews, word

documents of interview transcripts and all video-files (due to their size) were kept on an encrypted external hard-drive which was also kept securely in a locked cabinet when not in use. There was also a back-up external hard-drive which was also encrypted and kept in a locked filing cabinet on university premises. Data as a whole were only available to myself as principal researcher and my research supervisors.

3.5.5 Data management software

Computer assistance in qualitative data analysis (CAQDAS) has become a universally acceptable way in which to manage qualitative data (Lewins 2008). The main purpose of my use of CAQDAS as part of my research was that it assisted me in managing the large volumes of data each phase of my study produced (Lewins 2008). For these purposes, I chose to use Atlas.ti (Version 7, GmbH: Berlin) and received a 2-day training course in its use. This package had the functionality to allow me to code directly onto transcripts, audio-files and video-files; to link audio-files with their associated transcripts, thus allowing me to listen to recordings whilst reading transcriptions and make associated timestamps; and to organise, interrogate and retrieve segments of the data to assist with my data analysis. Thus, in preparation for coding and analysis, all data were uploaded to a single hermeneutic unit in Atlas.ti (Version 7.2).

Prior to doing this, all unedited video footage had to be converted from MPG files to WMV files (this had already occurred with the edited videos). To do this, I used the conversion software AVS Video Converter (Version 8; Online Media Technologies Ltd).

3.6 Data analysis

As with any qualitative research, data analysis occurred on an ongoing basis throughout my research study. As discussed in the previous chapter, using crystallisation as a framework for my research meant using multiple data analysis strategies to provide both a "wide-angled view" of leadership plus the "close-up" stories and interactions involved in the leadership process. Thus, I undertook multiple complementary forms of data analysis in order to address my research questions.

3.6.1 Thematic framework analysis

In order to get an overarching view of all data, I used thematic framework analysis (Ritchie and Spencer 1994). This allowed me to look at the data as a whole and identify patterns within the data. This type of analysis occurs in five stages: familiarisation; identification of a thematic framework; indexing; charting and interpretation. Within my research, these stages of analysis occurred throughout each phase of my study and I would move back and forward between these stages as new data were collected and the thematic framework was reviewed and evolved.

On an ongoing basis, I familiarised myself with the data through repeated reading of transcripts, listening to audio-recordings and viewing of video footage. In December 2012, December 2013 and May 2014 team data analysis sessions were held. This included myself, my three research supervisors and in the two December meetings Professor Timothy Dornan from Maastricht University who was a visiting professor for SMERC. The purpose of these sessions was to explore in detail a subset of my data and provided opportunity to discuss and negotiate possible themes to be included in the thematic framework. In preparation for these meetings I provided each team member with a subset of data (each member had a different set of data),

for example, a transcript and audio from a focus group. Each excerpt of data were analysed separately by each team member who made notes to bring to each meeting and as the principal researcher, I analysed all data excerpts.

During our meetings we discussed and negotiated initial key themes for the coding framework, with a focus on my research questions. Each meeting involved a discussion concentrating on different types of data: in December 2012, the focus was on the interview data; in December 2013, the raw video footage; and in May 2014, the edited clips and the reflexivity sessions. Following each meeting, I would draft and re-draft the coding framework. Through as iterative process of discussion, feedback and agreement with my research supervisors, my coding framework was developed (see Appendix K).

The next stage in the process was to 'index' my data using the developed coding framework. This involved coding all the data within Atlas.ti (Version 7.2). New codes were added and agreed through further discussion as part of the ongoing analytical process. The functions of Atlas.ti allowed me to chart and organise my data around my overarching research questions.

To begin to address RQ1, I coded all data pertaining to interview participants' explicit definitions of leadership and followership as dimensions of leadership and followership. New dimensions were added as and when I identified them. To add further depth to my thematic analysis, the definitions were also coded as a *solicited conceptualisation* (when participants were specifically asked to define leadership and followership in the interviews and within the participant questionnaires) or an *unsolicited conceptualisation* (when participants volunteered a definition of leadership or followership within the context of a narrative or as part of the general

discussion). Because all group interviews involving specialty trainees were homogeneous in terms of specialty, I was also able to group the interview data together and interrogate it according to broad specialties (surgical, medical, GP, service). It was also possible for me to attribute each definition to a specific trainee or trainees. I was also able to interrogate the data according to training stage (early and higher stage).

To address RQ2, I identified and time-stamped within Atlas.ti all personal incident narratives (PINs) within both the narrative interview data and the reflexivity session data. To identify the PINs, I drew on Labov's (1997) construction that a narrative is a structured account of incidents that have become part of the biography of the storyteller[28]. Once the coding framework was agreed I then coded these narratives. The initial thematic analysis identified three different sets (or groupings) of themes.

The first grouping, the contextual themes, provided me with orientation to the timing of the events; where the events took place; how the narrators positioned themselves in the story (for example as leader or follower); the type of activity that was being undertaken when the event occurred; and how the narrator evaluated their experience[29]. When coding, these themes were coded to the whole PIN.

The second group of themes focussed on the content of the story and signposted the gist of the story; in other words what could be described as the main plotline of the story. As with the contextual themes, these themes were coded to the whole narrative.

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[28] I discuss narrative structures in more detail later in this chapter, in section 3.6.3

[29] Within narratives a narrator will evaluate and experience (for example, positively or negatively) through their commentary on the events within the story.

Finally, a group of themes were identified that focussed on *how* the stories were narrated (process-orientated themes). This set of themes highlighted, for example, linguistic features that were used by narrators within their stories. These themes were coded to partial sections of the narrative which included a line or two prior to or following the specific section in order to contextualise the codes.

To initially address RQ3 I identified within the raw video footage points at which the process of "leadership" occurred in context. I termed this an "influential act of organising" (IAO) based on the premise that leadership is a complex relational process that is co-created by leaders and followers in context (Hosking 1988; Fairhurst and Uhl-Bien 2012). As part of this, I also identified and coded the different types of IAO (to be presented in Chapter 6). Similar to coding the narratives, I coded the IAOs to a wider piece of video which took in the moments leading up to the IAO and the moment following it. Also coded to the full IAO were more detailed themes which identified the context, who was involved and what activity was being undertaken. To add depth to this initial thematic analysis I also identified and coded the various leadership processes I identified as typically occurring within each IAO.

In addition, I thematically coded the reflexivity data. First it was necessary for me to identify when the discussion within the reflexivity sessions was related to the edited video footage viewed within the sessions. For this I used phasal codes which pay attention to the rhythm of the discussion (O'Halloran, 2011). Within the reflexivity sessions talk moved through different phases in two different ways: (1) discussion related to the video and discussion not related to the video; and (2) discussion related to leadership and discussion unrelated to leadership. Coding the different phases

within the discussion allowed me to identify which 'phases' of the complex reflexivity sessions related directly to my research questions.

When I identified phases of talk that were directly related to both the viewed clips *and* to leadership, I coded these entire 'phases' to the IAO and leadership process codes discussed above. This allowed me to identify and link the reflexive discussion (and thus the participants' analysis) to my own detailed analysis of the edited clips (see Chapters 6 and 7). Also coded within the reflexivity data was reflexive talk: both about leadership (on leadership) and about other matters (off leadership). Factors that were discussed as facilitators or inhibitors to the leadership process were also coded.

3.6.2 Big 'D' Discourse analysis

Discourse research is the study of language in use and human meaning-making (Wetherall et al. 2001). The notion that discourse is a social action challenges the notion that language is a transparent medium that is representational and separate from the world and people (Wetherall et al. 2001). Discourse researchers argue that language is constructive and constitutive of social life, in other words, language builds it does not just reflect (Wetherall et al. 2001).

To briefly recap, discourse research can take many forms. Different but complementary definitions of discourse can be split into two forms: little "d" discourse which focusses on the minutiae of language and its use in context; while big "D" Discourse focusses on the Discourse as systems of thought that are historically situated (Alvesson and Karreman, 2000). To explore further how leadership is conceptualised, and extend my analysis related to RQ1, I undertook the latter, big "D" Discourse analysis in which I explored how leadership and

followership definitions were situated within the wider leadership literature (both academic and popular) and societal Discourses about leadership (presented in Chapter 1).

In Chapter 1 (section 1.2) I identified and described four broad discourses of leadership within the leadership literature which could be described historically and in increasing levels of complexity, these being: *individual*; *contextual*; *relational*; and *complexity*. Thus, in order to undertake this type of Discourse analysis, the explicit definitions of leadership I identified across the data were mapped according to these four discourses.

3.6.3 Structural narrative analysis

To add a further layer of analysis to the PINs and further explore RQ2, I used a form of structural narrative analysis. Structural narrative analysis pays attention to the ways in which narratives are organised (Riessman, 2008). Labov (1997) states that a fully formed narrative includes seven elements: (1) an abstract (summary and/or point of the story); (2) orientation (to time, place, characters, and situation); (3) complicating action (the event sequence: usually with a crisis or turning point); (4) evaluation (where the narrator steps back to comment on the meaning of a situation); (5) most reportable event (which is the event that narrators will evaluate most within a PIN) (6) the resolution (the outcome of the most reportable event in which action is taken); and (7) a coda (ending the story and bringing the action back to the present). Not all stories will contain all elements and often the elements will occur in different sequences with narrators moving back and forth, providing further complicating actions and evaluations as they make sense of the story for themselves and their audience (Riessman 2008; Monrouxe et al. 2014).

Through this structure and using the premise that identities are formed through talk and interaction I investigated not only *what* participants said within their narratives but also the interplay with *how* participants narrated their stories (Smith and Sparkes 2008). Thus I was able to explore how participants constructed their identities as leaders and followers within their narrative, what parts of the story they constructed as important, and how the narrator used their language to evaluate the event (Urquhart et al. 2014).

3.6.4 Little 'd' discourse and beyond

To add a further layer of analysis to the enactment data and my exploration of RQ3 in more depth, I undertook a form of little 'd' discourse analysis. This meant paying close attention to the language-in-use in social interaction between the interprofessional healthcare teams within the edited video footage (Alvesson and Karreman 2000; Fairhurst and Uhl-Bien 2012). Detailed transcription of the edited clips, as well as repeated viewing of the video footage, allowed me to identify how language in interaction was used to negotiate the leadership processes, for example, through the use of pronouns, questions and answers, name use, directives, pauses and hedges within talk.

To augment this, and take this analysis beyond the mere analysis of talk, I undertook visual analysis of non-verbal human-human interactions (for example, body language, physical positioning and eye contact) and human-material interactions (for example use and/or control of artefacts or background noise). I also linked to this analysis the interactions (verbal and non-verbal) which occurred within the videoed-reflexivity interviews in direct response to these clips.

3.7 Conclusion

To conclude, this chapter has described in detail the methods used to operationalise the theoretical perspectives and methodologies discussed in Chapter 2. Within this chapter I have described: my multi-phase research design; participant recruitment for each phase; data collection for each phase; how the large quantity of qualitative data were managed; and finally the different but complementary forms of data analysis I undertook.

To summarise, Table 3.5 below describes the different types of data and data analysis in relation to the research questions (both overarching and supplementary). The table also indicates in which if the three results chapter that follow this chapter (Chapters 4 to 7) these data analyses will be presented.

Table 3.5 Matrix of research questions, their corresponding data sources and forms of data analysis

RQ1: How do participants conceptualise leadership and followership?			
Supplementary RQs	**Data source**	**Forms of data analysis**	**Corresponding results chapter**
What are the most common definitions of leadership and followership?	Medical Trainee narrative interviews	Thematic framework analysis	Chapter 4
What leadership Discourses do participants draw on when defining leadership and followership?	Medical trainee narrative interviews	Big 'D' Discourse analysis	
How do conceptualisations of leadership vary according to medical career stage and medical specialty?	Medical trainee narrative interviews	Thematic framework analysis; Big 'D' discourse analysis	
Is there a difference between solicited and unsolicited definitions of leadership and followership?	Medical trainee narrative interviews	Thematic framework analysis	
RQ2. How do participants narrate their experiences as leaders and followers?			
Supplementary RQs	**Data source**	**Forms of data Analysis**	**Corresponding Results Chapter**
What are participants' lived experiences of leadership and followership in interprofessional healthcare workplaces?	Narratives within interviews and video-reflexivity sessions	Thematic framework analysis	Chapter 5
How do participants construct their identities as leaders and followers within their narratives of interprofessional healthcare workplaces?	Narratives within interviews and video-reflexivity sessions	Structural Narrative analysis	
RQ3. How is leadership and followership enacted within the context of interprofessional healthcare workplaces?			
Supplementary RQs	**Data source**	**Forms of data Analysis**	**Corresponding Results Chapter**
What types of leadership interactions occur in interprofessional healthcare workplaces?	Workplace video-footage	Thematic Framework Analysis	Chapter 6
What are the typical features of leadership interactions within interprofessional healthcare workplaces?	Workplace video-footage	Thematic framework analysis	
How is leadership constructed through interactions within interprofessional healthcare workplaces?	Edited video footage and video-reflexivity sessions	Thematic framework analysis and Little 'd' discourse analysis(and beyond)	Chapter 7
How is leadership enactment influenced by individual, relational, contextual and emergent factors?	Edited footage and video-reflexivity sessions	Thematic framework analysis and Little 'd' discourse analysis (and beyond)	

CHAPTER 4: RESULTS- CONCEPTUALISING LEADERSHIP

4.1 Introduction

The following four chapters (Chapters 4 to 7) make up the results section of this thesis. In the previous two chapters (Chapters 2 and 3), I outlined the theoretical and methodological perspectives that underpin this work and described in detail the methods I used within this research. Each of the four results chapters are aligned with one of the overarching research questions (see Table 3.5 in Chapter 3). Thus, within this first results chapter I will explore the ways in which leadership and followership was conceptualised by participants (RQ 1).

This chapter focusses on the specific definitions of leadership and followership offered within the medical trainee narrative interviews. The chapter begins by providing an overview of the different and most common ways in which medical trainees defined leadership and followership. I then consider whether there is a difference in these conceptualisations between solicited and unsolicited talk. Following this, I explore the data more closely, considering the different Discourses trainees used when talking about leadership and followership. Finally within this chapter, I consider whether medical career stage and medical specialty group affected how leadership was conceptualised by exploring the similarities and differences between groups. Examples from the data are presented throughout this chapter in the form of direct quotes.

To recap, this chapter focusses on overarching RQ1 by addressing in turn the supplementary research questions (see Box 4.1).

Box 4.1 Chapter 4: research questions and supplementary research questions

RQ1: How do participants conceptualise leadership and followership?

Supplementary questions:

- What are the most common definitions of leadership and followership?
- Is there a difference between solicited and unsolicited definitions of leadership and followership?
- What leadership Discourses do participants draw on when defining leadership and followership?
- How do conceptualisations of leadership vary according to medical career stage and medical specialty?

4.2 Defining the terms “leadership” and “followership”

Within this section I explore the multiple explicit definitions of leadership and followership that medical trainees offered during the interviews in Phase 1. This section is concerned with two supplementary research questions: what are the most common definitions of leadership and followership? And, is there a difference between solicited and unsolicited definitions of leadership and followership?

When medical trainees defined leadership and followership within the interviews, their talk revolved around the clinical environment. Leadership and/or followership for them, was focussed on patient care or how the clinical environment that they worked in was led and managed. Leadership of the wider NHS was only occasionally touched on. This is perhaps unsurprising given the point at which participants were in their careers. As medical trainees, the key focus of their work was developing competence in patient care, working within the clinical environment (GMC 2011). Even in the final years of their training, prior to certificate of completion of training (CCT), this remains the focus (GMC 2011).

Across the dataset, I identified 347 explanations of leadership and 131 explanations[30] of followership. Within these broad explanations, I identified multiple, distinct definitions of leadership and followership and so each explanation was multiple-coded for definitions. In total, I coded 757 definitions of leadership (414 solicited and 343 unsolicited) and 317 definitions of followership (302 solicited and 15 unsolicited); a total of 1077 coded definitions overall.

4.2.1 Definitions of leadership

Trainees had clearly heard of the term leadership and were able to define their understanding of it. Through my analysis of what trainees said, I identified fifteen key themes (or dimensions) related to leadership definitions. These were (in order of most commonly defined to least) leadership as: behaviour; role; hierarchy; group process; personality; principles and values; responsibility; skills; emergent; management; knowledge; gender; exclusive; and not management.

Table 4.1 depicts each dimension; its frequency (percentage of total number of definitions); its frequency in terms of solicited and unsolicited talk; a definition of each dimension and an illustrative quote from the interview data. What follows is a description and discussion about the five most commonly used leadership dimensions and an analysis of the differences between solicited and unsolicited talk.

4.2.1.1 Leadership as behaviour

Trainees most commonly described leadership as a set of behaviours enacted by individuals within the healthcare workplace. Within their solicited definitions, trainees described how these behaviours were conducive to good leadership. Examples of behavioural descriptors included coordinating; delegating; supporting;

[30] By 'explanations', I mean sections of talk that were specifically linked to defining leadership and followership, this could either be solicited through direct questioning by myself as researcher or unsolicited through general discussion within the group and individual interviews.

facilitating; clear decision-making; directing; setting an example; optimising performance and efficiency (see Table 4.1; Quote 1). Within solicited discussions, leadership as behaviour was most commonly coded alongside leadership as group process and was something that occurred in team environments. Trainees talked about how good leadership behaviours affected those that were being led and how good leaders were those that had an overall view of what needed to be done (see Table 4.1; Quote 4).

4.2.1.2 Leadership as role

Popular amongst trainee interviews was to define leadership as linked to role within the healthcare workplace. This could be seen to come through job designation, for example, being a consultant or a GP would mean automatic leadership status (see Table 4.1; Quote 2). Some trainees also talked about how being a "doctor" meant automatic "leader-status" as part of the interprofessional hierarchy. Trainees responded to the idea of leadership coming through their clinical role in different ways. This will be discussed later in this chapter when I present similarities and differences between training stage and specialties. Alternatively, trainees also talked about leadership in itself being a designated "role", often linked to "good leader" behaviours (described above) and relationships with other members of the team. Trainees also identified that different contexts demanded different requirements of the leadership role and thus different individuals would be designated.

4.2.1.3 Leadership as hierarchy

"Role" and "hierarchy" were seen to be closely linked. Throughout the interviews, trainees talked about the clear-cut hierarchies present within the medical profession and within interprofessional relationships. This was perceived as particularly evident within the hospital workplace environment, where clinical leadership in any given

situation was seen to be the automatic responsibility of the most senior medical professional present. This included medical trainees, particularly during out-of-hours care when more senior clinicians may not be present in the clinical environment (see Table 4.1; Quote 3).

4.2.1.4 Leadership as group process

Within this dimension, trainees' discussions focused on team-working, both uni- and interprofessional. Trainees talked about leadership as a process that was part of team-working, was closely related to team performance and a sense of belonging. Focus of leadership as a group process was an emphasis on team goals rather than the individual goals of the leader (Table 4.1; Quote 4). Thus leaders within a group process were seen to be facilitative and supportive, and took a coordinating rather than directive role.

4.2.1.5 Leadership as personality

As well as relating leadership to hierarchy and role, trainees also popularly defined leadership as being part of an individual's personality (see Table 4.1; Quote 5). Trainees talked about certain individuals being "naturally" drawn to leadership roles, possessing personality characteristics such as charisma or dominance. Some trainees expressed anxiety that they may not possess these qualities and therefore may not be the "right person" to undertake leadership. At times, there was also discussion about whether leaders were "born" or "made".

Table 4.1: Dimensions of Leadership (in order of frequency- most to least common)

Leadership Dimension (n=15) **Leadership as:**	**Overall** **F (%)**	**Solicited** **F(%)**	**Unsolicited** **F(%)**	**Definition**	**Illustrative quote (Quotes 1-15)***
Behaviour	176 (23.2%)	114 (27.5%)	62 (18.1%)	Leadership is described as a set of behaviours.	Quote 1: *"I think communication probably is a huge part, erm, in* ***being able to ask or tell*** *people to do things, erm, but also maybe just sort of* ***show by example*** *or, erm,* ***gently sort of move people*** *or, you know,* ***cajole them*** *to give information or do things, erm, that kind of thing…"* R33 (F-surgical-higher)** [Solicited conceptualisation][Individual Discourse]
Role	106 (14.0%)	54 (13.0%)	52 (15.2%)	Leadership is described as being part of the role of a doctor i.e. "doctor as leader"	Quote 2: "*General practice is… a funny beast compared to… the hospital you can see where the leadership comes, they* ***[the consultants]… go on the ward rounds, they have a the lead****, their junior doctors with them… In* ***general practice it's a team of one*** *(.) so I'll, I'll see 20-odd people in here during the course of a day, and I'm* ***I am the, the single lead*** *for recognising and investigating, and passing out to other individuals for further information…"* R4(M-GP-higher) [Unsolicited conceptualisation][Contextual Discourse]
Hierarchy	94 (12.4%)	42 (10.1%)	52 (15.2%)	Leadership was talked about as something that is part of the medical or interprofessional hierarchy.	Quote 3: *"When I do on call out of hours,* ***I am the leader****, I guess, of the medical team running [specialty name] ward. So* ***I have a junior trainee who might be looking to me for advice*** *and guidance"* R5(F-surgical-higher) [Unsolicited conceptualisation][Individual Discourse]
Group process	82	66	16	This dimension is focussed around team	Quote 4: *"…if you're working within a group, then, I think, you have to, to*

	(10.8%)	(15.9%)	(4.7%)	working both uni- and interprofessional.	*make the right decisions,* ***you have to be aware of what the overall opinion of the group is****…you've* ***got to be very attuned to people's feelings*** *within it, I think, for it* ***to work effectively****, but sometimes take the harder decisions too, as to what should be done, delegating, and things like that"* R056(F-service-higher) [Solicited conceptualisation][Relational Discourse]
Personality	80 (10.6%)	28 (6.8%)	52 (15.2%)	Examples of this are trainees' talk about dominant personalities or individuals being "natural" leaders.	Quote 5: "R53 (F-medical-higher): *it (a leadership course) makes you understand the theory…but even a even a day's course they say, 'You know, you realise that you need to be more assertive,' that's all very well* R55 (F-medical-higher): *Uh-huh, yeah.* R53: *but* ***if you're not that by nature****, how do you go and put that into practice?* R55: *Yeah.* R53: *You can't suddenly stand up to somebody.* R51 (F-medical-early): *Um,* ***you can't change your personality."*** [Unsolicited conceptualisation][Individual Discourse]
Principles and values	59 (7.8%)	31 (7.5%)	28 (8.2%)	Trainees talked about a leader being fair, approachable, coaching and supportive, and allowing followers to develop and learn.	Quote 6: "*You have to be seen to* ***be fair****, the leader as well, I think...* ***You can't be seen to be putting your friends and yourself above the other people***" R37 (F-GP-early) [Unsolicited conceptualisation] [Relational Discourse]
Responsibility	56 (7.4%)	29 (7.0%)	27 (7.9%)	The person who has ultimate clinical responsibility within a given situation was perceived to be the leader.	Quote 7: "*…because it's as* ***in medicine leadership is a, or superiority is with responsibilities so if somebody is responsible then there the buck stops.*** *It's buck stops at the leader so whoever is the, so I've had a consultant who just jokingly saying, he said, "Why I get more paid* ***because if this patient dies I'm the one who gets to go to coroner,*** *not you so [that's] why I'm a consultant and you are a*

					trainee." R50 (M-service-higher) [Unsolicited conceptualisation] [Contextual Discourse]
Skills	35 (4.6%)	15 (3.6%)	20 (5.8%)	Trainees describe specific skills that a leader or leadership requires e.g. negotiation skills, delegation skills. This differs from behaviours in that there is explicit mention of skills.	Quote 8: "*…on a surgical point of view is, is* ***your operating skill*** *and the things that you do that are different from others that you (.) think are better."* R3 (M-surgical-higher): [Solicited conceptualisation] [Individual Discourse]
Emergent	20 (2.6%)	11 (2.7%)	8 (2.6%)	The focus is the dynamic nature of leadership as a process; trainees talk about "stepping forward" or "stepping back" as a leader according to the context and team present.	Quote 9: "*…sometimes nurses are very good, erm, they know the patients well, erm,* ***if they're managing the, the situation well, you know, it makes sense to step back*** *and I think it's a good quality to, to recognise, erm, you know,* ***you don't always need to be at the front of the scene,*** *…****there is times when, erm, you should step back*** *and, erm, teamwork is good and the ability to work in a team is a very good quality as well to have and leaders should be able to do both I think."* R29 (F-FY) [Unsolicited conceptualisation] [Complexity Discourse]
Management	16 (2.1%)	10 (2.4%)	6 (1.8%)	Often trainees talked about management roles being part of leadership. The two terms were sometimes conflated.	Quote 10: "*I think just speaking to other people that is similar…I'm not at all feeling ready to be a consultant …I mean in some respects…we are kind of forced to take a leadership role, um, and be in charge of the department and make fairly senior decisions quite early, and I suppose without realising it, you do develop leadership skills that way…so that's kind of clinical leadership, and* ***for a managerial leadership side I don't feel at all ready…we're not involved in any managerial stuff****…That's left to, like, the last six months before you finish…it's too late then*." R53 (F-medical-higher) [Unsolicited conceptualisation][Individual Discourse]
Knowledge	10	7 (1.7%)	3 (0.9%)	Trainees describe a leader or leadership as being in the possession of specific	Quote 11: "*I think yes, it's, it's people who've got (.) 'cos it doesn't need going*

	(1.3%)			knowledge, often clinical knowledge.	*to be the consultant, it could be obviously if you're more junior and somebody's a few years more senior and seen this before and* ***knows what to do****, I think there could be that element, um, for more junior people,* ***it could be people that have been on a, you know, an ALS [advanced life support] course or something therefore you know, what people know what they're doing, so I think people have the tendency to defer to the ones who they think know more about it, so I think there's a clear knowledge element****"* R40 (M-medical-higher) [Solicited conceptualisation] [Complexity Discourse]
Gender	10 (1.3%)	6 (1.4%)	4(1.2%)	In the data trainees talked about issues such as workplace culture and gender or talked about gender issues or used he when talking about leadership in the abstract. In these situations leadership was seen as male.	Quote12: "*I mean, the person, I can define leadership as the person who working within a group and* **he can direct them** *in which direction they can go and communicate with them and be able to manage every person and know the exact way of dealing with these people or knowing the problems they are discussing."* R25(F-GP-higher) [Solicited conceptualisation] [Relational Discourse]
Exclusive	8 (1.1%)	0	8 (2.4%)	Trainees describe leadership as something that is not for everybody.	Quote 13: "***I don't think it's possible for everyone to lead a project*** *like that, because you know because it just you know, I don't think that's possible."* R2 (M-medical-early) [Unsolicited conceptualisation][Individual Discourse]
Not management	3 (0.4%)	1 (0.2%)	2 (0.6%)	Trainees specifically identify that leadership and management are not necessarily the same but are separate entities.	Quote 14: R47 (F-service-higher): "***So you're making, making a difference between management and leadership****?* R45(M-service-early)*:Yes.* *R47:***They being two very separate things***.* *R45: Which is what you did as* ***well because you said there are very, they are managers who are pretty poor leaders***. *R47:[Laughs]* ***yes you can be one without being the other***.*"*

					[Unsolicited conceptualisation] [Contextual Discourse]
Followership	2 (0.3%)	0	2 (0.6 %)	Trainees talked about those they perceived to be leaders in name taking a followership role.	Quote 15: "*so they retain their, retain their ability to be a leader within a clinical setting i.e. this is how we're going to do, address this problem. Whereas I do take what you mean, that they're now having to, you know, having to follow managerial dictats"* R9 (M-surgical-early) [Unsolicited conceptualisation] [Contextual Discourse]
Totals	757 (100%)	414 (100%)	343 (100%)		*Please note that although the intention of these quotes is to illustrate the associated dimension of leadership within the table, these quotes were multi-coded and thus it is possible the reader will be able to associate the quotes with more than one dimension. **Key to Identifiers: 'Rxx' is the respondent number I allocated each participant when I anonymised the data. In brackets is gender-specialty-training stage. Note, in the case of foundation trainees as they are all early stage, they are identified with 'FY' only.

4.2.1.6 Solicited versus unsolicited definitions of leadership

Exploring the data further revealed differences in definitions of leadership between solicited and unsolicited talk (see table 4.1, third and fourth columns). In solicited talk, trainees were more likely to talk about leadership as a group process. In unsolicited talk however, trainees were more likely to focus on leadership being an inherent personality trait. Also more dominant in unsolicited discussion was talk of hierarchical leadership relationships (see Table 4.1; Quotes 3 and 5). The differences between solicited and unsolicited talk will be explored further later in this chapter.

4.2.2 Definitions of followership

Trainees found it more challenging to define followership, often explicitly stating that they had not heard of the term. Paralinguistic features such as pauses, hesitations and laughter were evident as trainees tried to articulate their definitions (See Table 4.2; Quote 19). Unlike their definitions of leadership which trainees were able to relate to the context of the healthcare workplace, talk about followership was more "hypothetical" in nature.

Through discussion, trainees began to define the term and I identified thirteen dimensions of followership from their talk. These were (in order most to least commonly defined) followership as: behaviours; active participant; group process; an unknown term; passive; hierarchy; personality; role; non-leadership; negative; emergent; responsibility; responsibility-free. Across the dataset, trainees commonly referred to followers as a group of people rather than an individual. As with Table 4.1, Table 4.2 depicts each dimension; its frequency (in terms of percentage of total number of definitions); the dimension's frequency in terms of solicited and unsolicited talk; a definition of each dimension and an illustrative quote from the interview data.

4.2.2.1 Followership as behaviours

Unlike the specific definitions of leadership behaviours which all had positive connotations, trainees described followership behaviours in both positive and negative lights. Definitions of positive follower behaviour included working constructively, listening and engaging with leadership (see Table 4.2; Quote 16). Others thought the word followership had more negative connotations, perceiving it to be related to more “cult-like” behaviour than team-working in the healthcare workplace (see Table 4.2; Quote 25). Followers were understood through their behaviours to be able to facilitate or inhibit the move toward a goal according to whether they agreed or disagreed with the leader’s vision.

4.2.2.2 Followership as active participant

Trainees perceived followership to be an active process in which followers were described as team-players who took an active, engaged and influential role within the leadership process (see Table 4.2; Quote 17). Trainees saw that key to this was a follower’s relationship with a leader. In order to actively follow, they perceived that followers should agree with the leader’s vision and goals. Thus, when describing followers as active participants, trainees described leadership as something that was granted to leaders by followers.

4.2.2.3 Followership as group process

Many trainees used “follower” and team player interchangeably (see Table 4.2; Quote 18). Linked closely to active participant, trainees saw followership as part of a group process. They understood that everyone in a team could not be a leader and it was often the role of other team members to follow and function within a group.

4.2.2.4 Followership as an unknown term

The fourth most commonly coded dimension of followership was followership as an unknown term. Within this dimension, trainees specifically stated that they had never heard of the term "followership" before (see Table 4.2; Quote 19). Some trainees even questioned whether the term had been conceived for the purposes of my study alone. Despite this, trainees were willing to try and define the term and often stated that they were guessing what they perceived it to mean.

4.2.2.5 Followership as passive

Within this dimension, in contrast to followers being seen as active participants in the leadership process, some trainees described followership as a passive process. This had more negative connotations associated with it and trainees described followers in this context as following instructions "blindly" (see Table 4.2; Quote 25). Others saw this passive followership as something that was necessary in some situations such as an emergency (see Table 4.2; Quote 20).

4.2.2.6 Solicited versus unsolicited definitions of followership

Much talk about followership was "hypothetical" in nature, in fact, as discussion moved on and trainees were not responding to direct questioning about followership, explanations of followership became scarce. In total, I identified only eight specific explanations of followership within unsolicited discussion, coding a total of 15 definitions (see Table 4.2; fourth column). Focus of these unsolicited conceptualisations revolved around how an individual's personality or the medical hierarchy could define a person as a follower (see Table 4.2; Quote 22). This could be explained by the shift in focus within unsolicited discussion to an individualistic Discourse, which focussed on leaders.

Table 4.2: Dimensions of followership

Followership Dimension (n=13) Followership as:	Overall F(%)	Solicited F(%)	Unsolicited F(%)	Definition	Illustrative Quote (Quotes 16-28)
Behaviour	76 (24.0%)	73 (24.2%)	3 (20%)	This dimension is focussed on followership being a set of behaviours of an individual which trainees perceive to be typical of a follower.	Quote 16: *"…**working constructively** under somebody but if you're something that you were completely thought was wrong then you **don't necessarily have to do it** even though you're not the leader of the team. Like, as long as you've you gone about it appropriately."* R51(F-medical-early) [Solicited conceptualisation] [Relational Discourse]
Active participant	44 (13.9%)	43 (14.2%)	1 (6.7%)	This is concerned with followers being active participants in the leadership process.	Quote 17: *"…**you [as a follower] can have a huge influence** and come up with lots of ideas and, you know, by **providing quality control, you actually have a lot of influence on the leader**…in a group setting, **you're contributing** to the overall vision…**ensuring that that particular all the goals, or aims are are achieved**.*" R57(M-service-early) [Solicited conceptualisation][Relational Discourse]
Group process	43 (13.6%)	42 (13.9%)	1 (6.7%)	This dimension describes trainees' understanding of the role that followers have to play within a team.	Quote 18: "***forming part of a team** are, have bought into whatever the vision is that the leader has set, and, er, are **going to work as a team with the same end goal in mind as to how they get there**. They may be taking on different roles, but the goal is the same. That's what I see them, that's if the term followership really even exists."* R48(M-service-late) [Solicited conceptualisation] [Relational Discourse]
Unknown term	35 (11.0%)	35 (11.6%)	0	Here, trainees explicitly state that "followership" is an unknown term or a new term. Some trainees questioned	Quote 19: *"Likes of some people,(3.0) yes see followership,[smiles whilst talking] **I don't know, I was filling that*** **(the form)** ***out and it is like***

				whether the term had been made up for the purpose of this study.	***what does that mean****, I'm* ***like I don't really know like.*** *I suppose just (1.0) more people who like (2.0) just (1.0) like perform tasks, like who things that have been delegated to them. But (1.0) I don't know followership kind of makes it seem as if like they were just blindly following on but without any (2.0) thought yourself.*" R42(F-FY) [Solicited conceptualisation] [Individual Discourse]
Passive	24 (7.6%)	24 (7.9%)	0	Here, in contrast to followership as active participant, trainees see followership as passive.	Quote 20: " *…it's the implicit assumption that you would, I suppose, well, so if my boss in theatre says, 'do this' and he has a certain (.)* ***tone in his voice, I know it needs to be done immediately and I'm not to discuss that. This is not, this is not an open invitation, it's you must do this now and, you know, that's the message given. So is that followership that in certain situations I am going to just do what I'm told basically****."* R65-M-surg-early [Solicited conceptualisation] [Individual Discourse]
Hierarchy	22 (6.9%)	19 (6.3%)	3 (20%)	Within this dimension, trainees link followership to the medical hierarchy.	Quote 21: "*the nature of our job is that* ***there's always an F- a junior who's just qualified, and there's always someone that's about to retire, and you're somewhere in the middle of that and the further on you go, the more, sort of, people there are below you to ask you to look to you for advice***" R2 (M-medical-early) [Unsolicited conceptualisation] [Relational Discourse]
Personality	17 (5.4%)	14 (4.6%)	3 (20%)	Within this dimension trainees talk about followership as something relating to someone's personality, often seen to be lacking leadership traits and therefore by default a follower.	Quote 22: "*…if you've not had any training in leadership then* ***it's easier just to be a follower if that's your personality*** *but, erm, in the workplace, like, in the hospital, it does differ from day to day because the staff, whoever's on differs*" R59 (F-FY) [Unsolicited conceptualisation][Individual discourse]
Role	16 (5.5%)	14 (4.6%)	2 (13.3%)	Trainees describe, as a junior doctor,	Quote 23:

				being expected to be the follower in the interprofessional healthcare workplace. This dimension is also relevant when trainees are talking about interprofessional roles and expectations of who should lead and who should follow, e.g. doctors as leaders and nurses as followers.	*"Well there are situations where you just don't have the,* ***you know, ability or expertise to actually take on a leadership role at, you think surgery, for example, you know, the scrub nurse to the surgeon, you know, he knows what he's doing, they are all working for his one goal, so she's going to follow his instruction****…"* R46: (M-service-higher) [Unsolicited conceptualisation] [Individual Discourse] **Note: also coded to leadership as gender**
Non-leadership	12 (3.8%)	12 (4.0%)	0	This dimension is concerned with trainees describing followership as the default position when someone is not a leader, also described as the "opposite" of leadership. This definition seemed to be most often used when trainees had not heard of (and therefore not thought about) the term followership and they were guessing what it meant.	Quote 24: *"**not being a leader.** Able to take guidance/instruction"* Text R27(F-GP-late) [Solicited conceptualisation] [Individual Discourse]
Negative	10 (3.2%)	10 (3.3%)	0	Trainees described followership and being a follower as having negative connotations.	Quote 25: "*Yeah, it's aha it suggests, it sounds like (.) I don't know to me it suggests that somebody's just like blindly following on from what they're told …"* R42 (F-Foundation) [Solicited conceptualisations] [Individual Discourse]
Emergent	10 (3.2%)	8 (2.6%)	2 (13.3%)	This dimension is concerned with the dynamic nature of followership. Within this trainees describe "stepping back" into a followership role in a context or situation where it is more appropriate for someone else within the team to take the lead.	Quote 26: "*Maybe you have to do something and then ask for it, when there's less chaos… so there's tactics and a practical approach to it, I guess, so that you can maintain healthy leader/follower relationship.* ***And it can change; the leader of today might be the follow- follower of tomorrow and vice versa***." R52 (F-medical-early) [Solicited conceptualisation][Complexity Discourse]
Responsibility	6 (1,9%)	6 (2.0%)	0	Within this dimension, trainees talked	Quote 27:

				about the responsibilities of the follower.	*"Being a member of a group who takes direction from a leader though having actively participated in discussions and offering opinions which help formulate activities/plan.* ***Obliged to ongoing "quality control" within group*** *and express opinions if thought to be in best interest of group.*" Text R56 (F-service-higher) [Solicited conceptualisation] [Relational Discourse]
Responsibility free	2 (0.6%)	2 (0.7%)	0	Within this dimension trainees describe followers as people who have no responsibility.	Quote 28: "*And I suppose, um, responsibility as well. So, so I suppose* ***as a leader you take responsibility for the outcomes and, for the group. Whereas as a follower, you're you don't***" R60 (M-medical-early): [Solicited conceptualisation] [Relational discourse]
Totals	317 100%	302 100%	15 100%		

4.3 Discourses of leadership and followership

This section will focus on the broad Discourses trainees used when talking about leadership and followership in both solicited and unsolicited discussion. Across the data, I found that trainees drew on all four leadership Discourses identified within the literature in Chapter 1 (i.e. individual, contextual, relational and complexity). Within this section I discuss each Discourse in turn and contextualise these with examples from my data. The question this section focusses on is: What leadership discourses do participants draw on when defining leadership and followership?

Table 4.3 depicts each Discourse (of both leadership and followership) and the percentage of total solicited talk and the unsolicited talk attributed to each Discourse.

4.3.1 Individual Discourse

As the most commonly drawn upon Discourse across the dataset (see Table 4.3; first column), trainees would single out who they thought was “the leader” and “the followers” within their workplace. Individualistic ideas about how to define leadership were articulated through descriptions of leaders’ behaviours, personalities and style. Trainees described leaders from an individual perspective with designation and role, defining an individual as the unquestionable leader in a given situation (both interprofessional and within medicine: see Table 4.2; Quote 23).

4.3.2 Contextual Discourse

Drawing upon a contextual Discourse- all rarely drawn on Discourse, trainees described that they might approach certain leaders for certain aspects of leadership (e.g. to resolve conflict) but may approach someone else for a different issue. Trainees also described how in certain contexts (e.g. surgical theatre), different individuals would take on leadership as it was appropriate to their position and

responsibilities within that context (see Table 4.1; Quote 7). Leaders were also seen to adapt their leadership style according to a situation (for example. as they moved from routine clinical care to an acute cardiac arrest).

4.3.3 Relational Discourse

Similar to the current relational Discourse found in the healthcare literature, (for example: The Kings Fund 2011-2014), many medical trainees identified that the aim of leadership was to coordinate or influence a team to move in a particular direction. Effective team working (both interprofessional and within the medical profession) was the focus of much of trainees' explanations of leadership and followership, particularly within the solicited discussion (see Table 4.3; second column).

Trainees saw team members (or followers) as key to influencing a leader's decisions; and who the leaders and followers were in their workplaces remained static (see Table 4.2; Quote 17). For trainees, this was enacted through a process of multidirectional feedback and shared decision-making. Trainees could also identify the medical hierarchy as relational, in particular from the perspective of defining their own position within this hierarchy (see Table 4.2; Quote 21).

4.3.4 Complexity Discourse

Within the least used of the Discourses, trainees talked about leadership and followership being a process rather than something that was attributed to an individual. "Leadership" was seen as a dynamic entity that moved around the healthcare team and emerged or was negotiated according to a situation. Trainees talked about the complex interplay between individuals, relationships and context and, described "stepping forward" or "stepping back" into leadership or followership

roles according to the needs of the immediate situation in hand (see Table 4.1; Quote 9).

Table 4.3: Discourses of leadership and followership*

*This table describes the distribution of the Discourses of leadership and followership that trainees drew on within their definitions. I coded Discourses to each broad explanation rather than each distinct definition thus the total numbers within this table are lower than previous tables (5.1 & 5.2).

Discourses of leadership	**Solicited f(%)**	**Unsolicited F(%)**
Individual Discourse	81 (42.0%)	88 (57.1%)
Contextual Discourse	20 (10.4%)	23 (14.9%)
Relational Discourse	79 (41.0%)	32 (20.8%)
Complexity Discourse	13 (6.7%)	11 (7.1%)
Totals	193 (100%)	154 (100%)
Discourses of followership	**Solicited f(%)**	**Unsolicited f(%)**
Individual Discourse	51 (41.5 %)	4 (50%)
Contextual Discourse	5 (4.1%)	0
Relational Discourse	59 (48%)	2 (25%)
Complexity Discourse	8 (6.5%)	2 (25%)
Totals	123 (100%)	8 (100%)

4.3.5 Solicited and unsolicited Discourses of leadership and followership

I noted differences between solicited and unsolicited discussion. As interviews progressed to talk about workplace experiences of leadership, I found trainees' definitions aligned more closely with traditional, historical conceptualisations in which personality, role and traditional hierarchies defined who a leader was (or was not: Haslam et al. 2011). Thus, in unsolicited discussion, there was an increase in individualistic Discourse across the interviews with a relative reduction in use of a relational Discourse (see Table 4.3).

4.4 Differences and similarities in conceptualisation

This section explores the data in greater depth by looking at the differences and similarities between different trainee groups. As previously discussed because the

group interviews were homogeneous in terms of broad medical specialty it was possible to interrogate the data in terms of broad medical specialty and training stage (early of higher stages). The research question this section seeks address is: How do conceptualisations of leadership vary according to medical career stage and medical specialty?

Tables 4.4 and 4.5 depict the different groups in terms of dimensions of leadership and followership identified and the discourses used by the different trainees groups.

4.4.1 Conceptualisations of leadership and followership by training stage

Foundation doctors offered the most limited range of definitions of leadership, defining only nine of the fifteen dimensions (see Table 4.4). Overall, when directly asked to define leadership, early stage trainees as a group described leadership as behaviours, personality, linked to role and the medical hierarchy and were more likely to draw on an individual discourse (see Tables 4.4 and 4.5). In contrast, higher stage trainees, were more likely to draw on a relational Discourse when describing leadership (see Table 4.5). This may reflect the current approach to leadership development of medical trainees in Scotland; this focusses on higher stage trainees and thus early stage trainees are perhaps drawing on early clinical experience to articulate their definitions (NHS Education for Scotland 2013).

As part of the early stage trainee group, foundation doctors drew on a relational discourse and they talked about using the leader-follower relationship for feedback on their own leadership and clinical care. Foundation doctors often defined leadership in terms of interprofessional working relationships. They talked about looking to more experienced members of the nursing profession for clinical

leadership. Some foundation doctors saw this as a dilemma stating that in their role as "doctor" they should be taking the lead.

For higher stage trainees leadership was seen to come with increasing clinical responsibility, experience and time served. Some higher stage trainees expressed concerns about preparation for the transition to consultant. Despite feeling ready clinically to take on the "leadership role" they did not feel prepared for the non-clinical responsibilities they would have moving into a consultant role (see Table 4.1; Quote 10). In unsolicited talk, higher stage trainees talk drew more often on an individual Discourse (see Table 4.5). Similar to early stage trainees, talk turned to personality and an individual's "ability" to lead, or position within the medical hierarchy.

Some early stage trainees defined leadership in general discussion as something one could "step into" or "step down" from according to what was right for patient care at the time. Often this definition was in the context of interprofessional working and leadership could come from a different (and perceived as non-traditional) professional, for example, nursing (Table 4.1; Quote 9). Thus, in unsolicited discussion, some early stage trainees talked about leadership being emergent (and therefore drew on a complexity Discourse).

Both early and late stage trainees defined followership as a set of behaviours and followers as active participants drawing on both an individual and relational Discourse (see Tables 4.4 and 4.5). Early stage trainees were more likely to state that they hadn't heard of the term followership although through discussion they did identify all thirteen dimensions (see Table 4.4). Foundation doctors talked about the role of a follower within the leader-follower relationship as being a passive one.

They differentiated “follower” from “team member” and used words like “blindly following” and “doing as instructed” to articulate their definitions (see Table 4.2; Quote 25).

4.4.2 Conceptualisations of leadership and followership by specialty group

Specialty groups identified varying total numbers of leadership dimensions. Only service trainees (including anaesthetics, radiology and histopathology) defined all fifteen (see Table 4.4). All groups most often defined “leadership as behaviour”. However, differences were noted in the types of behaviours typically described by the different specialty trainees.

For example, GPs linked leader behaviours with group processes and principles and values and most commonly drew on a relational discourse to define leadership behaviours, describing coordination, supporting and listening to group members as important leader behaviours (see Table 4.1; Quote 6). Similarly, medical trainees described leadership as a process that involved teams working towards common goals and objectives, drawing on a relational Discourse.

For both medical and service trainees, leadership was understood as revolving around the task in hand; leaders were seen as individuals who had the vision to decide how a task should be undertaken, and perceived ability to undertake leadership was often linked to clinical experience. Trainees within the service specialties used a relational Discourse to acknowledge the importance of the team in achieving these goals (see Table 4.1; Quote 5).

In contrast to GP, medical and service colleagues, surgical trainees saw decision making, providing direction, setting an example, optimising performance and efficiency as important leader behaviours. The surgical specialty group did talk about

the leader-follower relationship in the context of "providing support and guidance" but this talk was focussed on an individual's influence on another with the aim of persuading them to do something (see Table 4.1; Quote 1). Drawing most popularly on an individual Discourse (see Table 4.5), few of the surgical trainees talked about listening to followers or garnering opinion from others.

Of all trainee specialty groups, service trainees were most likely to talk about leaders as those whose role, clinical skills and abilities best matched the task. This was also related to hierarchical position and the responsibilities that came with position drawing on a contextual Discourse (see Table 4.1; Quote 7 and Table 4.5).

In unsolicited talk, GP trainees perceived more opportunity for clinical leadership in practice than as part of a hierarchical team within a hospital (Table 4.1; Quote 2). Some GP trainees were more likely to draw on context to describe how their role as independent practitioners defined them as a leader. Also, drawing on a contextual Discourse, particularly within the unsolicited discussion, surgical trainees stated that there was a clear-cut hierarchy within surgery with the consultant at the top as the "ultimate leader".

GP trainees were less likely to draw on a relational Discourse in unsolicited talk (see Table 4.5); although much of their focus did remain on the relationship between leader and follower, talk became more leader-centric or context-specific. As well as the contextual discussion about hierarchy, in unsolicited definitions, surgical trainees were also more likely to draw on an individual Discourse and define leadership as personality. (see Tables 4.4 and 4.5).

The medical and service trainee groups, similar to surgical trainees, leadership was linked to personality traits, position in the medical hierarchy and an ability to behave

“like” a leader within unsolicited talk. An essential leadership trait identified was to be able to appear confident. One service trainee group interview talked in depth about how effective group leadership was linked to ethical leader behaviours as well as the “possession” of a charismatic personality. Thus within medical and service trainee groups, discussion shifted from a relational Discourse to an individual Discourse in unsolicited talk (see Table 4.5).

Trainees from the different specialty groups identified between eleven and thirteen dimensions of followership (see table 4.4). As previously discussed, GPs, medical and service trainees in particular, described a follower as an active member of the group who contributes to team goals and the direction of the group. Medical trainees saw that although the decision-making would often come from the leader, it was up to a follower to participate in the process and often decide how to “implement” those decisions. A follower was seen to be responsible for their actions, but ultimately needed to undertake the leader’s instructions. Similar to their definitions of leadership, service trainees understood skill, job role and experience as dependent on how active a follower could be (see Table 4.2; Quote 23). It was common for these trainee groups to draw on a relational Discourse when defining followership.

Surgical trainees used the medical hierarchy and roles within that to define who the followers were; very few saw the leader-follower relationship as a two-way process. Types of behaviours attributed to followers by surgical trainees included deference, compliance, taking instruction or asking for help (see Table 4.2; Quote 20). For some surgical trainees, the word follower indicated inaction rather than active team member.

Table 4.4: Leadership and followership dimensions by training stage and specialty*

*It is important to note that within this table, foundation trainees are included within the count for early stage trainees but I also decided to provide a separate column for foundation trainees within this table as we refer specifically to foundation trainees within our results.

Leadership Dimensions	Foundation F (%)	Early stage F (%)	Higher stage F (%)	GP F (%)	Surgical F (%)	Medical F (%)	Service F (%)
Behaviour	21 (23.6%)	77(22.2%)	103 (24.1%)	65 (26.0%)	48 (23.4%)	22 (19.8%)	20 (18.7%)
Role	14 (15.7%)	44 (12.7%)	64 (15.0%)	35 (14.0%)	30 (14.6%)	11 (9.9%)	16 (15.0%)
Hierarchy	13 (14.9%)	44 (12.7%)	53 (12.4%)	20 (8.0%)	36 (17.6%)	12 (10.8%)	13 (12.1%)
Group process	6 (6.9%)	38 (11.0%)	44 (10.3%)	34 (13.6%)	12 (5.9%)	17 (15.3%)	13 (12.1%)
Personality	15 (17.2%)	47 (13.5%)	36 (8.4%)	19 (7.6%)	25 (12.2%)	14 (12.6%)	7 (6.5%)
Principles and values	6 (6.9%)	28 (8.1%)	32 (7.5%)	23 (9.2%)	13 (6.3%)	9 (8.1%)	13 (12.1%)
Responsibility	3 (3.4%)	22 (6.3%)	36 (8.4%)	24 (9.6%)	17 (8.3%)	9 (8.1%)	3 (2.8%)
Skills	8 (9.2%)	17 (4.9%)	18 (4.2%)	6 (2.4%)	9 (4.4%)	4 (3.6%)	8 (7.5%)
Emergent	3 (3.4%)	9 (2.6%)	11 (2.6%)	10 (4.0%)	3 (1.5%)	1 (0.9%)	3 (2.8%)
Management	0 (0%)	6 (1.7%)	11 (2.6%)	8 (3.2%)	5 (2.4%)	2 (1.8%)	1 (0.9%)
Gender	0 (0%)	2 (0.6%)	7 (1.6%)	4 (1.6%)	1 (0.5%)	2 (1.8%)	3 (2.8%)
Knowledge	0 (0%)	5 (1.4%)	6 (1.4%)	0 (0%)	3 (1.5%)	6 (5.4%)	1 (0.9%)
Exclusive	0 (0%)	4 (1.2%)	4 (0.9%)	2 (0.8%)	2 (1.0%)	2 (1.8%)	2 (1.9%)
Not management	0 (0%)	2 (0.6%)	2 (0.5%)	0 (0%)	0 (0%)	0 (0%)	3 (2.8%)
Followership	0 (0%)	2 (0.6%)	0 (0%)	0 (0%)	1 (0.5%)	0 (0%)	1 (0.9%)
Total (F)	**89 (100%)**	**347 (100%)**	**427 (100%)**	**250 (100%)**	**205 (100%)**	**111 (100%)**	**107 (100%)**

Table 4.4 (contd) Followership dimensions	Foundation F (%)	Early stage F (%)	Higher stage F (%)	GP F (%)	Surgical F (%)	Medical F (%)	Service F (%)
Behaviour	7 (20.0%)	29 (18.8%)	47 (25.4%)	29 (30.9%)	16 (23.2%)	13 (23.6%)	11 (17.2%)
Active participant	6 (17.1%)	21 (13.6%)	23 (12.4%)	18 (19.1%)	3 (4.3%)	13 (14.5%)	9 (14.1%)
Group process	4 (11.4%)	19 (12.3%)	24 (13.0%)	18 (19.1%)	5 (7.2%)	8 (14.5%)	8 (12.5%)
Unknown	2 (5.7%)	35 (22.7%)	18 (9.7%)	4 (4.3%)	14 (20.3%)	8 (14.5%)	7 (10.9%)
Passive	4 (11.4%)	15 (9.7%)	11 (5.9%)	3 (3.2%)	5 (7.2%)	5 (9.1%)	7 (10.9%)
Hierarchy	2 (5.7%)	9 (5.8%)	14 (7.6%)	4 (4.3%)	9 (13.0%)	3 (5.5%)	4 (6.3%)
Personality	2 (5.7%)	6 (3.9%)	11 (5.9%)	6 (6.4%)	3 (4.3%)	1 (1.8%)	5 (7.8%)
Role	2 (5.7%)	3 (1.9%)	13 (7.0%)	2 (2.1%)	4 (5.8%)	3 (5.5%)	5 (7.8%)
Non-leadership	1 (2.9%)	3 (1.9%)	9 (4.9%)	5 (5.3%)	3 (4.3%)	3 (5.5%)	0 (0%)
Negative	2 (5.7%)	5 (3.2%)	6 (3.2%)	0 (0%)	5 (7.2%)	1 (1.8%)	2 (3.1%)
Emergent	3 (8.6%)	6 (3.9%)	4 (2.2%)	4 (4.3%)	1 (1.4%)	0 (0%)	2 (3.1%)
Responsibility	0 (0%)	2 (1.3%)	4 (2.2%)	0 (0%)	1 (1.4%)	1 (1.8%)	4 (6.3%)
Responsibility-free	0 (0%)	1 (0.6%)	1 (0.5%)	1 (1.1%)	0 (0%)	1 (1.8%)	0 (0%)
Total (F)	**35 (100%)**	**154 (100%)**	**185 (100%)**	**94 (100%)**	**69 (100%)**	**55 (100%)**	**64 (100%)**

Table 4.5: Discourses of Leadership and followership by training stage and specialty *

*It is useful to note that the numbers within the early/late and specialty columns do not add up to the totals presented in Table 5.3. This is for 2 reasons: (1) due to the nature of focus groups, an explanation of leadership could be attributed to more than one participant and therefore an explanation that is the result of discussion between an early and a late stage trainee would have been coded to both groups (2) Within the specialty groups, foundation trainees account for the discrepancy between total numbers and specialty groups.

Discourses of leadership	Early stage F (%)	Higher stage F (%)	GP F (%)	Surgical F (%)	Medical F (%)	Service F (%)
Individual Solicited/unsolicited	40/42 (48.8%/53.2%)	42/51 (37.2%/63.8%)	36/18 (45.6/48.6%)	16/39 (53.3/66.1%)	10/13 (28.6/61.9%)	9/7 (28.1%/53.8%)
Contextual Solicited/unsolicited	7/12 (8.5/15.2%)	14/11 (12.4/13.8%)	5/4 (6.3/10.8%)	1/12 (3.3/20.3%)	5/2 (14.3/9.5%)	8/3 (25.0/23.1%)
Relational Solicited/unsolicited	30/49 (36.6/24.5%)	49/13 (43.4/16.3%)	32/12 (40.5/32.4%)	18/6 (36.7/10.2%)	18/5 (51.4/23.8%)	12/2 (37.5/15.4%)
Complexity Solicited/unsolicited	5/6 (6.1/7.6%)	8/5 (7.1/6.3%)	6/3 (7.6/8.1%)	2/1 (6.7/3.4%)	2/1 (5.7/4.8%)	3/1 (9.4/7.7%)
Totals	**82/79**	**113/80**	**79/37**	**30/59**	**35/21**	**32/13**
Discourses of followership	**Early Stage**	**Higher Stage**	**GP**	**Surgical**	**Medical**	**Service**
Individual Solicited/unsolicited	24/2 (42.1/40%)	31/2 (43.1/66.7%)	14/1 (35/100%)	12/2 (54.6/66.7%)	10/0 (45.5%/0%)	10/0 (40/0%)
Contextual Solicited/unsolicited	1/0 (1.8/0%)	4/0 (5.6/0%)	1/0 (2.5/0%)	2/0 (9.1/0%)	0/0 (0%/0%)	2/0 (8/0%)
Relational Solicited/unsolicited	27/1 (47.4/20%)	33/1 (45.8.33.3%)	22/0 (55/0%)	7/1 (31.8/33.3%)	12/0 (54.5%)	11/0 (44/0%)
Complexity Solicited/unsolicited	6/2 (10.5/40%)	4/0 (5.5/0%)	3/0 (7.5/0%)	1/0 (4.5/0%)	0/0 (0%/0%)	2/1 (8/100%)
Totals	**57/5**	**72/3**	**40/1**	**22/3**	**22/0**	**25/1**

4.5 Conclusion

This chapter, the first of four results chapters within my thesis, focussed on how medical trainees conceptualise leadership and followership in the interprofessional workplace. This analysis revealed the multiple ways in which trainees conceptualise leadership and followership, identifying numerous dimensions. Although trainees drew on all four Discourses within their definitions of leadership and followership, analysis revealed that trainees were most likely to draw on an individualistic Discourse, in particular in unsolicited discussion. Initial difficulties in defining followership gave way to descriptions that for some trainees echo contemporary definitions of the leader-follower relationship in the literature, with followers constructed as key, active participants in the leadership process (Shamir 2007).

Finally, this chapter revealed that different medical trainees groups conceptualise leadership and followership in different ways, revealing how context affects how leadership is understood. What follows in the next chapter (Chapter 5) is an analysis of the narratives that participants shared about leadership and followership in the interprofessional healthcare workplace.

CHAPTER 5: RESULTS- NARRATING LEADERSHIP

5.1 Introduction

This is the second of four results chapters within this thesis. Within the previous chapter, I explored the broad range of definitions of leadership and followership that participants offered within the narrative interviews in Phase 1 of my research. Chapter 4 revealed firstly participants' multiple understandings of leadership and followership. Secondly, I explored the overarching Discourses participants drew upon when defining leadership and followership. Although offering a multidimensional picture of leadership and followership through their definitions, participants for the most part offered individualistic (and therefore fairly unsophisticated) conceptualisations of the terms. Finally, in Chapter 4, the data also uncovered that different participant groups (training stage and clinical specialty) conceptualised leadership and followership in different ways. Thus, context in this study was an important factor in how leadership is understood.

This chapter explores the narrative data collected during the narrative interviews and reflexivity sessions. More specifically, the focus within this chapter is on participants' personal stories of leadership and followership incidents within the healthcare workplace. Analysis of the personal incident narratives (PINs) offered by participants throughout the research process, allowed me to investigate participants' lived experiences of leadership and followership. First, I will present the thematic analysis of the whole data-set, focussing on contextual themes and an overarching discussion of the content of the stories. Second, I provide a more detailed exploration of the content of the narratives and present a structural narrative analysis of three exemplar narratives. This section will pay attention to how participants construct

their identities as leaders and followers within the context of these narratives. This chapter concludes with a short discussion of what these narratives have revealed about leadership and followership in the interprofessional healthcare workplace, how they link to the previous results chapter and provide an introduction to the third and final results chapter within this thesis. In summary this chapter attends to RQ2 by addressing the supplementary research questions (set out in box 5.1 below).

Box 5.1 Chapter 5: research question and supplementary research questions

RQ2: How do participants narrate their experiences as leaders and followers?

Supplementary questions:

- What are participants' lived experiences of leadership and followership in interprofessional healthcare workplaces?
- How do participants construct their identities as leaders and followers within their narratives of interprofessional healthcare workplaces?

5.2 Thematic analysis

To begin, I will present an overview of the narratives collected throughout all phases of my research. I identified a total of 190 distinct PINs across the dataset. More specifically, the trainee interviews generated 173 PINs as I had purposefully conducted the interviews in a way that would draw out narratives. The other 17 PINs were offered by participants unsolicited during the video-reflexivity sessions and are included here because they extend beyond medical trainee experiences to include those of the interprofessional team (albeit small numbers). More specifically, 13 PINs were shared by participants that were not medical trainees (i.e. they came from nursing, AHP, CCT or non-clinical administrative staff groups). The theoretical underpinnings of this thesis of multiplicity and complexity and the enactment of crystallisation means that I should not exclude these 13 narratives (see Sections

2.3.1, 2.3.2 and 2.6.2) so I incorporate them here as part of the data presented within this chapter.

The following sections provide an account of the narrative data as a whole using the contextual, content and process-orientated themes described in the methods chapter (see Chapter 3). The focus of this section is on the secondary research question: What are participants lived experiences of leadership and followership in the interprofessional workplace?

5.2.1 Contextual themes

I identified six overarching contextual themes. The following sections will provide an overview of these themes (see Appendix K for the full coding framework).

5.2.1.1 Narrator position in story

Participants most often constructed themselves within the stories as followers (n=84), with around half as many PINs constructed from the position as leaders (n=48). Participants also shared narratives from both a position of leadership and followership moving between the two as the narrative unfolded (so mixed: n=26). Other stories were about events participants had observed, so participants were neither leader nor follower (n=27), or where participants recounted someone else's story, known as a 'second hand narrative' (n=5).

5.2.1.2 Story setting

Of the 190 PINs, 162 were based in a hospital setting (including the community hospital setting; n=9). Only 16 narratives were based in the GP practice setting; the majority of PINs from GP trainees were set in hospital (n=41/61). I suggest that this may be because many GP trainees (who shared 61 PINs, of which 41 were hospital-based) were only months into their training at the time of the medical trainee

interviews and recent hospital-based training was still uppermost in their minds[31]. Another explanation could be that most memorable experiences of leadership and followership happened in the hospital (Rees et al. 2013b).

5.2.1.3 Narrator job role

The majority of narratives were told by trainees due to the narrative interviewing techniques used within the trainee interviews (n=173). The job role at the time of the story was unclear in 39 of the narratives. Of the remaining narratives the narrator job role included early-stage medical trainees (n=77); higher-stage medical trainees (n=55); nursing staff (n=7); CCT (n=5); Allied Health Professionals (n=3); medical staff that were out of a training programme at the time of the story (n=2); non-clinical support staff (n=1); and finally one participant who narrated a story from the position as a patient (n=1).

5.2.1.4 Timing of story

Timing within the working week was unclear in many PINs (n=106). Of those PINs in which participants explicitly stated timings, 43 took place during normal working hours and 40 during out-of-hours. Just over half of the out-of-hours PINs (n=21/40) related to complex patient scenarios. Stories about formal clinical activities (n=10) for example, multidisciplinary meetings, ward rounds etc were most often recounted as happening within normal working hours (classed as Monday to Friday 0800 to 1800).

5.2.1.5 Activity within story

The activity that PINs were centred on was wide-ranging. They were most likely to come from the clinical environment and most commonly participants recounted

[31] GP trainees in the UK will spend a significant part of their training within hospitals (18 months of the 3 years; RCGP 2014).

stories related to clinical leadership activities (n=139). This included stories about complex patient scenarios (n=40), in which participants would describe a patient care scenario which was deemed to be out of the ordinary[32]. Different to complex patient scenarios but still related to clinical leadership, were stories about routine patient care (n=32) and acute emergency scenarios (n=29)[33]. Data also included stories about formal ward based actives (n=18) which included planned MDT meetings[34]; handover meetings[35]; and ward rounds[36]. Stories in which the primary activity was interprofessional team working (n=10) were also shared[37], as were stories about transferring patients between specialties, hospitals and from primary to secondary care and vice versa (n=10).

A few participants looked beyond clinical leadership and shared non-clinical leadership stories (n=51) in which the activity was a management activity (n=17)[38]; educational leadership (n=16)[39]; a change project (n=9)[40]; giving leader feedback (n=4)[41]; research supervision (n=3)[42]; a disciplinary procedure (n=1); and laboratory work (n=1).

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[32] For example, an early stage medical trainee describing the clinical leadership of a patient with an unusual diagnosis not normally seen within the specific specialty context.
[33] Examples of this include cardiac arrest scenario, obstetric emergencies, patient management within A and E.
[34] Multidisciplinary meetings in which more than one professional group are present to discuss patient care.
[35] Handover meetings are meetings in which patient care was "handed over" between professionals, for example, at the end of a shift.
[36] Ward rounds involves medical professionals going round visiting each patient's bedside and discussing care. This can be "grand round" style in which the consultants leads a group of doctors including students and nurses around the ward to a less formal situations
[37] For example discussion about leadership and communication practices between team members or a specific incident of teamworking.
[38] Leadership was described within the context of a management activity for example, rota management, holiday planning, and audit. Participants in these circumstances could be conflating leadership and management.
[39] This covered both formal and informal teaching activities including teaching sessions, ward-based teaching sessions, bedside teaching and specific workshops/ courses/ training programmes.
[40] This refers to PINs in which participant describe leadership in relation to a specific change project.
[41] This refers to providing feedback about a leader; this could be in the form of a paper exercise, an informal meeting etc.

5.2.1.6 Evaluation of experience

Narratives were evenly balanced between positively and negatively evaluated experiences (87 positive; 85 negative). For some participants, their experiences were evaluated as both positive and negative (so mixed; n=7) for example, where a positive resolution to a problem was reached as the story unfolded. Others evaluated their experiences in a neutral way (n=5), or it was unclear within their narrative how they evaluated their experience (n=6).

5.2.2 Content of the narratives

Moving to the content-orientated themes within the narratives, my focus turned to what the stories were about. Each narrative revealed multiple storylines (which I will explore further in the structural analysis section of this chapter: see section 5.3) but at this point in my analysis I was able to pinpoint the main storyline within each narrative and then code the entire narrative to that storyline. More specifically, I identified two overarching themes for the content of the narratives, these being, "static leadership relationships" and "emergent leadership relationships". Within each theme, I identified a number of subthemes which afforded more detailed analysis of the content of the narratives across the data-set. In Boxes 5.2 and 5.3 I have presented each theme and subtheme, with its definition and illustrative excerpts from the PINs. These excerpts are numbered and are referred to throughout this section. What now follows is a broad explanation of each theme along with a detailed exploration of the three most commonly identified subthemes within each theme.

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[42] This refers to stories in which participants describe the leader-follower relationship as a research supervisor-researcher relationship.

5.2.2.1 Static Leadership relationships

Static leadership relationships was the dominant content-related theme of the narratives (n=146/190). Within narratives coded to this theme, participants described how their relationships with others within their workplace affected the process of leadership. Within these narratives, who the leader was and who the follower/s was/were remained static throughout the story. These relationships were based on the traditional professional hierarchies found within the healthcare workplace.[43] Trainees described both uni- and interprofessional leadership relationships. From this, I identified 12 subthemes, some of which were seen to be facilitative to good leader-follower relationships, and some of which could be seen to be inhibitive to good leader-follower relationships (see Box 5.2). What follows within this section is a more in-depth exploration of the three most commonly identified subthemes within this theme: "Static leadership relationships facilitated by supportive dialogue or behaviours"; "Static leadership relationships inhibited by unsupportive behaviours or lack of dialogue"; and "Static leadership relationships as abusive".

Static leadership relationships facilitated by supportive dialogue and/or behaviours

This subtheme (n=28) categorised narratives of specific incidences in which participants perceived leaders to be entering into a supportive dialogue or behaving in a supportive way to facilitate the leadership process and leader-follower relationships. Perhaps unsurprisingly, all 28 narratives were evaluated as positive. Also, within these narratives, participants most often placed themselves in the position of follower (n=18/28).

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[43] For example, consultant as leader, medical trainee as follower or doctor as leader and nurse as follower

Without exception, the leader-follower relationship described within these PINs was part of the traditional medical or interprofessional hierarchies. To illustrate, as followers, medical trainees identified the leaders within the narratives as consultants, GP partners or more senior registrars (Box 5.2, Excerpt 1). As leaders, medical trainees talked about leading more junior trainees (most often foundation doctors: see Box 5.2, Excerpt 2). Finally, all PINs recounted within this subtheme were about clinical leadership.

Examples within the narratives included specific incidents in which leaders: entered into dialogue with followers about decision-making; supported and allowed junior colleagues to make their own decisions about complex patient cases; settled conflict; dealt with mistakes in a way that did not leave others feeling humiliated; contributed to the workload beyond what would be traditionally expected of them; appreciated the workload of more junior colleagues; showed awareness of exactly what was going on in the situation that surrounded them; and at times, revealed their own fallibility. Often, participants perceived evaluated that leaders had acted in the best interests of the patient regardless of outcome (see Box 5.2, Excerpt 3). As followers, participants described that they felt valued, respected and supported within these relationships and that they were conducive to learning. Participants identified that this type of leader-follower relationship was something to aspire to (see Box 5.2: Excerpt 1).

Although the majority of these narratives were constructed from the perspective of follower it is interesting to note that the protagonists within these stories were those described as leaders. Within this set of narratives, it was the follower's role to respond to the leader's behaviour.

Box 5.2: Static leadership relationships: narrative data

Theme: Static Leadership relationships Subthemes marked with * are defined in detail within this chapter and thus do not have an explicit definition within the table … - means talk missed out for brevity
Subtheme: Facilitated by supportive dialogue or behaviours (n=28)** ***Excerpt 1: *"…at night…we got called to a cardiac arrest and I had a medical student with me, who had evidently never been to a cardiac arrest…the registrar who was there…who in that situation was leading the team…who was very good at…knowing what everyone's limitations were and...telling you to do things without patronising you or making you feel silly…I was going too quick with chest compressions and he said you need a kind of learning point so you remember the advert…just sing that and he was very calm…you could see the medical student was…looking petrified…he gave them a job to allow them to feel involved but …not get too involved that they got scared…it was great, it was really something to learn from"* **(female-Foundation)** ***Excerpt 2:*** *"…a guy I worked with who was a year below me…I'd heard on the grapevine he'd…made a real [laughs] cock up of a discharge script…I saw him when he came in…I said to him "Look, you know something's happened but, you know…the patients are OK, but it's been identified that there's been an error…everyone recognises that its not you that's a crap doctor, it's just you are working in a chaotic system where you do a lot of work and actually these things happen. It just happens that it's you rather than me this time…the cynical side of me says that on one hand that sounds like great leadership, when I say it but on the other hand…if he has a breakdown or whatever then that's someone that's not going to be working with me that day…"* **(male-medical-early-stage)** ***Excerpt 3:*** *"…this lady was on the ward for a long time…the son…approached me…very aggressively…I phoned the consultant…it was late…and she came back and dealt with it when I was there…other consultants may well have said…I'll see them tomorrow morning but she realised the intensity and difficult nature of the complaints and the family dynamics…she took on that leadership role and you know sorted it out…which meant that we as a junior staff…wouldn't have that hanging over them…when the patient passed away on the ward about a month or so later (..) The family and partners thanked the consultant.."* **(female-GP-early-stage)**
Subtheme: Inhibited by unsupportive behaviours or lack of dialogue (n=24)** ***Excerpt 4: *"…in an acute setting,,,I was the junior at the time…the patient had come in and was very unwell, very elderly…it was actively discussed amongst the more junior people that would be taking care of her that erm resuscitation wasn't really appropriate and it was discussed with the registrar who said no she will be resuscitated…the person arrested erm and having been given specific instructions to resuscitate her…we have to do this…everybody felt it was undignified to do so…resuscitation at a ward based level until the registrar got here…everybody else present was in agreement, so the group worked well, but the leader just didn't work well for the group…the registrar halted in after he arrived but it would have been a lot better if our opinion were taken at the time…if you have experienced people junior to yourself or if it seems that people you're technically in charge of…have very strong opinions, you really have to consider why…"* **(female-service-early-stage)** ***Excerpt 5:*** *"…a consultant who didn't come up to the ward…when he did come up he was never that fussed if you were with him or not…he'd just leave you a list of things to do…it was a bit disheartening…you were never (..) completely reassured about what you were doing…it's almost like they don't have any trust in you and at the same time you never really get to grips with his actual overall plan…so you end up not feeling that important part in a team because it doesn't matter if you*

were there or not…you've to follow blindly what he wrote" **(male-medical-early-stage)** ***Excerpt 6:*** *"…leaders who are not good at communicating with the team kind of make it fall through a bit…it was an arrest…you had the doctors on the ward the initially and the nurses trying to deal with him and then the arrest team come so you've got a whole load of other doctors…it can be sort of messy…there's a lot of people that don't need to be there and maybe they could just stand back for a bit…they [the senior registrar] were sort of assessing and making sure they were covering all the possible causes…the outcome was the outcome we were going to get anyway but I don't know maybe using a bit more communication…it would have been more smooth"* **(female-foundation)**
Subtheme: Abusive (n=21)** ***Excerpt 7: *"…it was sort of years and years and years of psychological abuse but then finally picked up a clip board and bashed a junior doctor over the head with it… But she was just like, well actually compared to everything else he did to me that day, it was pretty good [laughter]."* **(female-GP-early stage)** ***Excerpt 8:*** *"He asked everyone to leave (..) which was a bit mortifying, so I had, I can't remember, a nurse and student and possibly even somebody else in the room at the time and he asked them to leave and told me off for something… I asked him questions about it because I didn't, erm, understand what he was talking about because it made no sense to me, (.) Erm, and so I asked him, I pointed out one part of it which had been nothing to do with me anyway,(.) but he was extremely emotional and angry about it and stormed out and that was fine…"* **(female-surgical-higher stage)** ***Excerpt 9:*** *"So when you get senior, you get bullying from the top, so when, when, when by boss used to bully me… and shout at me. I started [laughs] what I started doing then I used to shout at my juniors…I told them I'm going to shout at you if you do a mistake in front of the boss [laughs]"* **(male-service-higher-stage)**
Subtheme: Inhibiting team working (n=15) **Excerpt 10**:**"***we had a consultant…who insisted that the works department came and drew a red line on the floor at the entrance…nobody from out of the department was allowed to cross the line until they were invited in…nobody wants to come to [specialty name] so they wouldn't come and stand at the red line and wait to be invited in…"* **(female-medical-early stage)**
Subtheme: Conflictive decision-making (n=12): Participants described those perceived to be leaders in conflict/disagreement with each other ***Excerpt 11:*** *"I though better go down and see the patient…work out are they better coming to us…I go down there ten minutes later and I'd been told the patient had already left…because a consultant had overruled me. Now in my mind he should not have the power to overrule me, if he disagrees with my (patient) management…he should speak to my consultant…we're in a different department he should have no right to admit to a different department without agreement of that specialty* **(male-surgical-late)**
Subtheme: Fostering constructive team-working (n=10): Good leader-follower relationships fostering collaborative team working, perceived to be conducive to good patient care. ***Excerpt 12:*** *"…she worked with all the nursing staff on the ward, ehm with the junior doctors who were on the ward and with the rest of the [specialty name] consultants…she got everyone's opinion on the protocol and it made changes that are probably of benefit for the patients…"* **(female-GP-higher stage)**
Subtheme: Effective, based on clearly defined roles (n=9) : Where roles within a situation are clearly defined often as a result of having time to prepare for the situation

Excerpt 13: **"…** *bad trauma that we were involved in one weekend and, um, the consultant that was on, um, like, just had a great overview of what was going on, er, was speaking very clearly, everybody in the whole team knew what they were supposed to be doing and everything was happening… maybe that patient didn't have the best outcome, I don't think there was anything else as a team we could have done differently…and that's not just involving [specialty name] staff, other specialties were involved too"* **(female-medical-early stage)**
Subtheme: Ineffective due to unclear role definition (n=7): Described in situations when there is a perceived lack of leadership or when too many people are trying to take on the leadership role. ***Excerpt 14:*** *"…didn't realise how unwell the patient was getting while they were losing a lot of blood and things and in that situation, I think you come down as a surgeon and you find yourself adopting a leadership role, because you, you realise it's not been done properly and you sort of have to, and that was probably an example of it being done very poorly, it's where, it's less organised, roles aren't very clearly defined, you don't have enough people, erm, and everybody is working towards a different purpose."* **(female-surgical-higher stage)**
Subtheme: Identified through traditional clinical roles (n=7) For example: Dr as leader, nurse as follower ***Excerpt 15:*** *"sometimes you have a situation, which you may not want to be…leading something, so for example…the scariest thing to have done as an FY1 was being erm, the unfortunate person who was…the first doctor at an arrest call, and automatically no matter how many years of clinical experience the nursing staff had and had seen this a thousand times they look to the doctor to sort the problem... "***(male-surgical-early stage)**
Subtheme: Collective decision-making (n=5) Leader and follower sharing decisions ***Excerpt 16****:"…then the consultant who was in charge of the patient…came and sat down with every member of the team and said, what do you think is appropriate? What do you think is appropriate? What do you think is appropriate? And said OK fine this is what we're going to do....things suddenly got sorted out"* **(female-medical-early stage)**
Subtheme: Identified through traditional hierarchies (n=4) Most senior person present will automatically take lead. ***Excerpt 17:*** *"…she was very unwell and I felt she needed to go to the [specialty name] high dependency unit…as an FY2 I wasn't allowed to make that decision, it had to be the [specialty name] registrar…"*
Subtheme: Effective, based on practiced protocols (n=4) Often related to cardiac arrest scenarios in which protocols are practiced and the scenario is seen to "run" "smoothly" due to repeated practice of these scenarios. ***Excerpt 18:*** *"…they've all been trained in emergency resuscitation and everyone knows what they need to do, and it's just a case of someone standing back and saying, 'Well, you do this bit now', and you do that. So it's part of what they've been trained for; and the only knack to it is to keep everything in order…"*

Static Leadership relationships inhibited by unsupportive behaviours and/or lack of dialogue

This content-related subtheme could reasonably be described as the antithesis of the previous subtheme. This subtheme (n=24) categorised narratives in which leaders were described as unsupportive and/or often lacked dialogue with their colleagues. Of these narratives, most were evaluated as negative experiences (n=21/24). Once again, participants most often placed themselves in the position of follower (n=18/24). As with the previous subtheme, the leader-follower relationship was based on traditional professional and interprofessional hierarchies. However, contextual activities depicted within these narratives extended beyond clinical leadership to include educational leadership (n=2) and management activities (n=3).

Once again, despite their positions as followers, participants depicted the leader as the main protagonist within the stories. Examples of these narratives included incidents in which leaders: were unilateral in their decision-making; avoided or ignored conflict; did not listen (to wider team opinion or feedback); blamed others; lacked awareness of the wider situation; did not communicate well; did not take responsibility; were inconsistent; placed colleagues in situations that they were not comfortable with; and lacked appreciation of followers' needs (see Box 5.2, Excerpts 4-6). Similar to the previous subtheme, participants constructed followers as the recipient of and respondents to these behaviours. Trainees' responses included a lack of mutual respect; a loss of confidence in themselves and the leader; and a feeling of lack of validity and inclusion. Participants specifically described incidents in which this lack of dialogue was detrimental to patient care (see Box 5.2, Excerpt 4).

Static leadership relationships as abusive

This content-related subtheme categorised narratives around direct and indirect experiences of what constituted abuse as perceived by interviewees (this included undermining and humiliation). Of the 190 narratives, I identified 21 as abuse narratives. Perhaps unsurprisingly, 18/21 were evaluated as negative experiences (1= neutral, 2=contradictory). The majority of abuse narratives were constructed from the position of the follower (n=13/21). Participants also narrated stories about abuse they had observed (n=6), recounted another's story (n=1), and from the position of leader (n=1). Participants were most often the recipients of abuse, but they also narrated incidents in which they witnessed consultants, nursing staff and medical students being the recipients of abuse. The abuser was most often identified as the consultant they were working with at the time of the narrative. They also reported being recipients of abuse from other trainees (more senior than themselves) and nursing staff. One trainee narrated a PIN in which he identified himself as the abuser of a more junior colleague, having been "bullied" in the past himself (see Box 5.2, Excerpt 9). Abuse most often revolved around clinical leadership (n=18/21), during routine patient care (for example surgical theatre) or formal activities such as the ward round or ward meetings (see Box 5.2, Excerpts 7 and 8). The types of abuse participants narrated included undermining (including accusation, having decisions questioned and open criticism), humiliation (often in front of colleagues and patients), verbal, physical and racial abuse. Participants reported negative emotional responses to these experiences and talked about feeling humiliated and "not human"; getting angry; the need to keep going and "survive" training; and being careful to avoid situations in which abuse was likely.

5.2.2.2 Emergent leadership relationships

A total of 44 of the 190 narratives were coded to the content-related theme "emergent leadership relationships" (see Box 5.3). Within the narratives I coded to this theme, trainees described leadership as an emergent process. Unlike the previous theme (static leadership relationships) in which who the leaders were and who the followers were within the narratives was static, leaders were identified (or emerged) according to the task in hand. Participants recounted how a combination of the individuals involved, the context (and the task in hand), the relationships within that context and the wider systems in which they were working affected who emerged as the leader within a story.

Leadership emergence was more likely to be categorised in narratives that related directly to patient care scenarios, namely: complex patient cases; routine patient care; and acute emergency care. Interestingly, no narratives in which formal clinical activities were being undertaken were categorised within this theme, indicating more static (and possibly traditional) leader-follower relationships within these formalised clinical settings.

I identified six subthemes within these narratives; some which described the dominant factor which facilitated leadership emergence and some which describe the dominant factor which inhibited leadership emergence within the narratives (see Box 5.3). What follows is a detailed description of the three most commonly identified subthemes within this theme. These being: "Emergent leadership relationships facilitated by individual knowledge or experience"; "Emergent leadership relationships facilitated by lack of engagement of expected leader"; and "Emergent leadership relationships facilitated by systems and protocols".

Box 5.3: Emergent leadership relationships: narrative data

Theme: Emergent leadership relationships

***Subtheme: Facilitated by individual knowledge or experience (n=22)**

Excerpt 19: *"in general practice where I was there for one day only and one of the most senior GPs there faced a patient who come screaming… this patient was in labour and she have no experience in doing labour at all… then I came to the room…the GP stepped down and I led the team that I'm doing the examination and assessment and then get each one of them a job… just ask them, okay can you do blood pressure, can you do sats and then I ask the GP can you phone the ambulance for us because the patient actually she'd got, a rupture of placenta and she was bleeding and so on. So it doesn't mean that the most senior who can do it. I was not senior, I was trainee.... And they agreed, and accepted it. Just, they stepped back and then they let me just give clear instruction…because everyone was in hassle… they doesn't know what to do …I mean first time for them to receive a lady in labour…because I was just finished my gynae training and so, yeah, I know what will going to happen…"* **(female-GP-higher stage)**

Excerpt 20: *"…I wasn't going to just sit, sit at the desk when the nurse came and let other people take care of him, but, but yes, although everyone was kind of looking at me, then I, I noticed that one of the nurses was managing to get through to the patient and kind of getting him to listen to him and, erm, yes and I thought, I think this is when I should be quiet and let this nurse deal with it and I just did what the nurse said…"* **(female-foundation)**

Excerpt 21: *"…the actual undergraduate teaching in itself… they dedicate and focus a lot of their energy on the post graduate teaching… really leaves them absolutely no time …contribute to undergraduate teaching…it was very hotchpotch… I came along, I wasn't even an official trainee in the department… I came up with this idea… to give a holistic, er, programme and not of just bits and pieces. And it took a whole year… we eventually spoke about it during one of the consultant's meetings… eventually, we did gather a group of individuals who were keen to sit down and write, you know, kind of a draft curriculum… eventually, it went through and now it's it's an official part of the programme…I think, that was the biggest, you know, step to go against management and tell them, listen, this is essential… I had a strong belief in it …it happened to coincide with the right time that our college was making a push for it… now was sending out, kind of, publications… I tend to do a bit more than the others, because I had material from when I was doing my fellowship programme…plus I also organise together with one of the other consultants, the student selected component, as well, which happens twice a year, so I, kind of, that, kind of, is my little baby as well"* **(female-service-higher stage)**

***Subtheme: Facilitated by lack of engagement of expected leader.(n=9)**

Excerpt 22: *"…at home, who was on call, who probably hadn't been called in like forty years … to say can you contact the medical registrar and we were kind of saying, well I don't think this person needs resuscitating because they got quite unwell and he just didn't have a clue what to do. He said, well that's not really my, my area and kind of then deposited it back to us and said well if you think they're not for a resuscitation, then you take the decision, kind of fill it in. So that was a bit, I'd kind of, who, we'd phoned him because that was what it was, but then he was kind of not really living up to what we'd hoped…"* **(female-GP-early stage)**

Excerpt 23: *"…the most senior junior doctor in our department, erm, was …obstructive to getting a problem solved…his approach was that he didn't want to ruffle any feathers or stick his head above the parapet even though he was the most natural person to sort out the problem, it was a problem with staffing… I was the second most senior trainee at the time and…I sent a group e-mail or (.) in sort of chatting to people just decided that…everybody wanted it sorted out in advance …and so*

because everybody was in agreement apart from this one person we held a meeting and we got it all sorted out…And I suppose I just was slightly (..) bossy at the time.[laughs]…" **(female-surgical-higher stage)**
Subtheme: Facilitated by systems and protocols (n=7)** ***Excerpt 24: *"… I was starting my on call and I was kind of waiting for hand over from the FY1 who was looking after someone with hypokalaemia … they were managing it in a way that I thought this is not quite right… I sort of thought while he's doing this I'll go and look at the protocol, looked at the protocol, I thought he's not doing this right and I kind of almost tried to take a little bit more authority and go well why don't we do this… you're still another FY1 but we need, I need to kind of step forward a little bit so that it gets done right, we're not harming someone as a result of this…I tried to play naive, I said… I can't remember what the protocol says, I'll, I'll look it up… then I was saying, oh we, we do that, h-, hold on, how about I go and get this started…"* **(female-foundation)** ***Excerpt 25:*** *"…we'd had 15 minutes lead time to kind of get it all prepared. But the consultant… seemed to be in hand and that she didn't need to do anything… it was all about preparation and everyone knowing the role that I needed them to fulfil. So it was about the theatre staff knowing that they needed to get the oxygen sorted and the blood warmer sorted, and organising blood products... It was letting the labs know …bloods that were going to be coming and things that we were going to need. It was about the anaesthetist knowing that this lady needed to be put off to sleep and making adequate preparations for that. … you knew what you were doing and everybody did what needed to be done. Part of that comes from all the drills that you do and all the practising that you do… I didn't tell them specifically what their role was but we between myself and the anaesthetist, we decided…"* **(female-surgical-higher stage)**
Subtheme: Facilitated by timing (n=3): Due to timing of incident trainees will take on leadership e.g. at night ***Excerpt 26:*** *"…so staffing is very thin at the weekend. It was just a standard time of day. So in another, in any other, during the week it wouldn't be the same, this wouldn't have happened, wouldn't have been quite as, erm, thin on the ground. But it was because we were genuinely thin. The seniors weren't ignoring me, they were dealing with something else (..) as equally as emergent as this was. So it was, it was difficult, difficult for all parties because all parties were being stretched…"* **(female-foundation)**
Subtheme: Inhibited by systems and protocols (n=1) Where systems do not allow leadership to emerge e.g. consultant to consultant referral systems. Often linked to perceptions of traditional medical hierarchies ***Excerpt 27:*** *"And a lot of them were saying, well look we want to, we want to speak to your consultant…consultant was sitting in the corner of the office signing prescriptions for me…"* **(female-GP-early stage)** Note this PIN will be explored further in the following section.
Subtheme: Inhibited by lack of knowledge or experience (n=1) : Trainees describe an individual who "steps into" the leadership role but is unable to take on that role due to lack of experience or knowledge. ***Excerpt 28:*** *"…this little thing when the practice manager was on holiday so the kind of deputy practice manager ehm, I guess struggled to take the role a bit…So simple things that the practice manager probably does day to day, so it's when somebody is not used to that role of leadership and they have to step into it, some people maybe don't cope as well…"* **(female-GP-higher stage)**

Emergent leadership relationships facilitated by individual knowledge or experience

Within this content-related subtheme (n=22) leadership relationships emerged according to this situation. Unlike the static leadership relationship narratives, within these narratives (and all other emergent relationship narratives), leadership was not automatically assumed through the traditional medical or interprofessional hierarchies. The focus of leadership emergence was the activity (often a patient scenario as discussed above) being undertaken and who the best person was to take on leadership within that given situation. The main catalyst for leadership emergence within stories coded to this subtheme was based on individual experience, knowledge or previous training experiences (see Box 5.3, Excerpt 19).

For example, unlike the subthemes previously described, medical trainees narrated these 'emergent leadership' PINs most often from a position of leadership. They described incidents as junior trainees in which their broad-based training experience made them more 'expert' than those whose training had become more specialised, such as a medical problem occurring with a patient in a surgical ward.

Slightly more PINs within this subtheme were interprofessional (n=12) than uniprofessional (n=10). For example, participants narrated incidents in which nurses and other members of the interprofessional team took on leadership (see Box 5.3, Excerpt 20). Participants narrated this as emergent because it was perceived that they were working in a context where traditional interprofessional hierarchies which meant that doctors were expected to be leading. These interprofessional emergent leadership relationships were attributed to experiences and time-served. Perhaps unsurprisingly, participants inevitably saw leadership emergence occurring in the best interests of the patients. One participant also described an incident in which they

perceived the patient becoming the leader due to personal experience of their condition.

Relationships were also a factor contributing to this subtheme. In order for leaders to step forward and out of traditional hierarchical boundaries, participants narrated the process of "stepping back" on the part of traditional leaders. This was at times perceived to be difficult and participants described (from a traditional position of follower) feeling strongly enough about a course of action to use their experience and training to push themselves forward into a leadership role: sometimes with success (see Box 5.3: Excerpt 21). In other incidents, relationships were perceived to be good enough that those with more experience and/or knowledge took the lead easily through mutual trust and respect. Consequently, most PINs within this subtheme were evaluated as positive experiences (n=20/22).

Emergent leadership relationships facilitated by lack of engagement of expected leader

Within narratives coded to this content-related subtheme (n=9), participants described being pressed to take on leadership roles due to what was described as lack of engagement in the leadership process by those they perceived should be leaders in the given scenario. Here, narrators positioned themselves as leaders (n=3), followers (n=2) and as taking on both leader and follower roles (n=4). The perceived leader was identified through traditional medical and interprofessional hierarchies but often did not take on the role. Narrators suggested reasons for this were lack of recent experience of a particular clinical problem (see Box 5.3, Excerpt 22); the perceived leader not wanting to cause argument with colleagues; the perceived leader not recognising a particular issue as being part of their role; and job transience of those in traditional clinical leadership roles.

Whilst not actively seeking to take on leadership, participants described within these narratives how circumstance required them to shift position from follower to leader or seek others to do so (see Box 5.3, Excerpt 23). Unlike the previous subtheme, this type of emergent leadership relationship was more likely to be evaluated negatively (n=6/9).

Emergent leadership relationships as facilitated by systems and protocols

Within this subtheme (n=7), participants described how the use of practiced systems and protocols facilitated emergent leadership relationships. Within this subtheme examples of practiced procedures were provided in acute and complex clinical scenarios as well as routine patient transfers and the implementation of new policies. Within these stories, systems or protocols were an important factor in leadership emergence and dictated who took on the leadership role or roles (see Box 5.3, Excerpt 24).

Another factor participants described as important within this subtheme were effective working relationships and lines of communication between leaders and followers. This was seen to facilitate successful emergent leadership interactions (see Box 5.3, Excerpt 25). Six of the seven narratives within this subtheme were evaluated as positive experiences.

5.3.2.3 Process orientated themes

Within this section I provide a brief overview of the three most common process-related themes I identified within the narrative data. I explore these in more detail in the following section when I look at the interplay between what was said and how it was said (in other words between the content- and process-oriented themes) in my structural narrative analysis. The three process-related themes I choose to focus on

are pronominal, emotional and metaphoric talk that participants used to make sense of their experiences. Examples of each theme, a brief explanation and illustrative examples can be found in Boxes 5.4 to 5.6.

Pronominal Talk

From the position of follower, participants often used the pronouns “we” and “us” to describe themselves and their contemporaries (for example a group of medical trainees) and “them” and “they” to describe a group of leaders (for example a consultant group) within their PINs (see Box 5.4, Excerpt 29) indicating a perceived separation (and potentially adversarial relationships) between the two groups. This was particularly apparent within the negatively evaluated PINs. When followership experiences were evaluated more positively and leadership and the leadership process was seen to go well, the pronouns “we” and “us” would be used to describe the whole team including both leaders and followers (see Box 5.4, Excerpt 30).

From the position of leader, participants often used the pronoun “I” when describing leadership decisions, which seemed to indicate their agency and autonomy within the situation (see Box 5.4, Excerpt 31: Skelton et al. 2002; Rees and Monrouxe 2008).

Box 5.4 Pronominal talk excerpts

Excerpt 29:**’They’ and ‘we’**
*“And **they** (nurses) said, well you can fail to get access on that side while your colleague fails to get access on this side. And **they** were really dismissive of all the doctors and **they** really didn’t want **us** to be there and **they** all knew each other very well… even though **we** were technically more senior, **they** were more experienced and it was a really difficult power struggle…”* (female-GP-early)

Excerpt 30: ‘We’
*“…discussion about a decision that had been made…It was like, well **we** should really… this and that and the other, and he said… fair enough…”* (male-surgical-early)

Excerpt 31: ‘I’ and ‘my’
*“ bring back information about that and **I will** have a discussion and **I’ll** support you on that, and if there is any change, if there is anything better we can do, then **I can give my views** on it.”* (male-medical-late)

Emotional Talk

Perhaps unsurprisingly, participants used positive emotional talk within their stories evaluated as positive experiences (see Box 5.5, Excerpt 32) and negative emotional talk within the stories evaluated as negative experiences (see Box 5.5, Excerpt 33). To add to this, participants also would often use other techniques such as intensifiers (e.g. "very", "highly"), pauses and/or hedges (e.g. "I think", "sort of", "possibly") to narrate their stories (see Box 5.5, Excerpt 34). Use of emotional talk will be explored in more detail in the following section of this thesis, where I present structural narrative analysis of three exemplar narratives.

Box 5.5 Emotional talk excerpts

Excerpt 32: Positive emotional talk
*"it was probably the **happiest** professionally **happiest** time"* (male-medical-early)

Excerpt 33: **Negative emotional talk**
*"I just **hated** being part of it…", "it was **difficult**…", "it was **very awkward** yes"* (female-service-higher)

Excerpt 34: Intensifier and negative emotional talk
*"**really scary** things"* (female-surgical-higher)

Metaphoric talk

Finally within this section, I turn to the metaphoric talk participants used within their stories to make sense of their experiences. Across the 190 narratives, I identified over 700 metaphoric linguistic expressions (MLEs: Schmidt 2005). Although it is not within the scope of this thesis to undertake a systematic metaphor analysis, I was however able to identify broad groups of conceptual metaphors which revealed participants understandings of, leader-follower relationships, experiences of medical training, patient care and the hospital workplace (Schmidt 2005; Rees et al. 2007; Rees et al. 2009). Of particular relevance to this thesis was the metaphoric talk

participants used to describe the leader-follower relationship. Focussing on this, I identified eight overarching conceptual metaphors. These were LEADER-FOLLOWER RELATIONSHIP AS: WAR; HIERARCHY; PARENTALISM; SPORT; CONSTRUCTION; MACHINE; JOURNEY; and TRANSACTION[44]. See Box 5.6, excerpts 35-42 for specific examples of these conceptual metaphors. The conceptual metaphors I identified (for the leader –follower relationship, see box 5.6), could be described as either oppositional (for example war, hierarchy, transaction and parentalism), or collaborative (for example, construction and journey: Rees et al. 2009). LEADER-FOLLOWER RELATIONSHIP AS SPORT could be described as both oppositional (for example when talking about opposing teams) and collaborative (for example, when talking about being part of a high performing team: Rees et al 2009). Arguably LEADER-FOLLOWER RELATIONSHIP AS MACHINE could be constructed as collaborative when talking about different parts of a machine fitting together (but Rees et al. 2009 also argues that this metaphor de-humanises the relationship).

5.4 Structural narrative analysis

While the previous section provided a general overview of the 190 PINs identified across the dataset, this section provides opportunity for more detailed exploration of specific narratives. For this purpose, I have selected three narratives. In Table 5.1 below, I provide detail of the contextual coding applied to each narrative.

I chose these narratives first, because at this level of detail they illustrate the complex and multi-dimensional nature of leadership and followership within the interprofessional workplace. Second, these narratives represent diversity in

[44] The convention of cognitive linguistics requires that conceptual metaphors are presented in small capitals (Rees et al. 2009)

Box 5.6 Metaphoric talk excerpts

Excerpt 35: LEADER-FOLLOWER RELATIONSHIP AS WAR

*"…first thing he started to do is just to…**attack, attack** other consultants …and started to just to **stab** …even in the same team you're supposed to share the same targets and because if the **ship sinks, everybody will sink**"*(male-GP-early)

Excerpt 36: LEADER-FOLLOWER RELATIONSHIP AS HIERACHY

*"I mean there's one person… if **it was monkeys in the zoo**, there's one person who's very much the **dominant personality, and the alpha male**…he's very clear at any kind of whole unit meeting that, you know, this is his view, and he'll **shout it from the rooftop**" (male-medical- early)*

Excerpt 37: LEADER-FOLLOWER RELATIONSHIP AS PARENTALISM

*"There's no doubt about it, she gave 110 per cent to her patients. And we used to talk about ourselves as students, and **we wanted to be like her when we grew up**" (female-GP-early)*

Excerpt 38: LEADER-FOLLOWER RELATIONSHIP AS SPORT

*"And the number of times you felt like a **piggy in the middle**. You were being **batted backwards and forwards**. At the end of the day you're just trying to do the best for the patient who is outside your expertise" (female-GP-early)*

Excerpt 39: LEADER-FOLLOWER RELATIONSHIP AS CONSTRUCTION

*"Other ways of optimising influence of people around you, you just kind of like learn gradually through working, through **building working relationships**…" (male-surgical-higher)*

Excerpt 40: LEADER-FOLLOWER RELATIONSHIP AS MACHINE

*"… it works really well and **very efficiently** and suddenly everyone kind of **clicks into gear**…the*
*senior registrar will be **running it**…" (male-GP-early)*

Excerpt 41: LEADER-FOLLOWER RELATIONSHIP AS JOURNEY

*"He's been a good enough leader that day, we'll do it, we'll go that **extra mile** for him." (male-surgical-higher)*

Excerpt 42: LEADER-FOLLOWER RELATIONSHIP AS TRANSACTION

*"…good managers are probably **effectively good sales people** so you have to treat each person individually…" (male-surgical-early)*

participants (or narrators) in terms of job role, positioning in story and narrative setting (although all of the narratives are hospital-based, the settings are very different, see Table 5.1). However, I maintain that they cannot be said to be 'typical' illustrative narratives because my theoretical underpinning for this thesis of complexity and multiplicity argues that every event is bounded by individuals, relationships, context and timing (Law 2004; Mann et al. 2011).

The layout of this section of is as follows: each narrative is presented within a box using Labov's approach to narrative structure (Labov 1997); each line of the narrative is also numbered for ease of reference within my analysis. As I commented in section 5.2.2 of this chapter, each narrative revealed multiple storylines, thus, following each narrative I provide a detailed level of coding to these storylines which supplement the details I have provided about each narrative in Table 5.1. I then provide a detailed analysis with a focus on identity construction in order to address the research question: How do trainees construct their identities as leaders and followers within their narratives about the interprofessional healthcare workplace?

Table 5.1: Contextual details for exemplar narratives

Contextual codes	**Narrative 1: "A fresh pair of eyes"**	**Narrative 2: "I got absolutely annihilated"**	**Narrative 3: "Where's your daddy?"**
Narrator position in story	Narrator as Leader	Narrator as follower	Narrator as both leader and follower
Narrative setting	Hospital: medical	Hospital: surgery	Hospital: psychiatry
Narrator job role	Medical specialty trainee	Surgical specialty trainee	GP specialty trainee
Timing of experience	Normal working hours	Normal working hours	Out of hours
Primary Activity	Complex patient care	Routine Patient Care	Complex patient care
Evaluation	Positive	Negative	Negative

5.4.2 "A fresh pair of eyes"

'Scott'[45] is a white male, in his 40s. At the time of this narrative, Scott was a medical specialty trainee working within a remote and rural hospital (see Box 5.7). Scott shares a narrative in which he presents an account of a terminally ill patient who he perceives (for various reasons) is not receiving proper end-of-life care. The focus of this scenario is on taking the decision to DNR[46] which Scott describes himself as taking the lead on.

Box 5.7: "A fresh pair of eyes"

Lines	Narrative**
	Abstract
1	Scott: … one, in particular, that I felt shows bad and good leadership and l-, l- I'm talking
2	about, here, leading, er, medical teams clinically on the care of a patient, does that seem
3	reasonable?
4	Lisi: Yeah, that's absolutely fine, yeah
	Orientation
5	Scott: Yeah. Well, basically, when I came into this current job, I suppose, with a fresh
6	pair of eyes and noticed that a lady (1.0) who had, erm, end stage, ehm, multiple sclerosis
7	ehm, (1.0) was terminal really, erm, palliative and, by definition, terminal
	Evaluation #1
8	Now (1.0) she (1.0) was well known to the local community (1.0) and because of that
9	reason, a lot of the nursing staff were friends with her and she was a previous nurse, so she
10	was, knew them all, not only personally, but also, erm, (1.0) as a colleague, so you can
11	imagine a lot of emotions here
	Most Reportable Event
12	And no one wanted to lead with her care at all, actually, and that is nursing care and medical
13	care,
	Evaluation #2
14	So (1.0) her best friends were nursing her and there's lots of ethical issues there, obviously,
15	of course, but in a small community these things have to be addressed and dealt with as best
16	they can and (1.0) she was terminal, but she was not (1.0) she did not, no one had ever
17	approached her (1.0) DNACPR[47], which is, obviously, not for resuscitation, or for
18	resuscitation status. So I'd come in as a (2.0) as a, sort of, fresh pair of eyes and was able to

[45] All participant names within exemplar narratives are pseudonyms to maintain anonymity.
[46] DNR= Do Not Resuscitate
[47] DNACPR= Do Not Attempt Cardiopulmonary Resuscitation

19	look at this as what it was and (1.0) it was a very interesting scenario, because the
20	consultant truthfully (1.0) dodged the issue completely, erm, probably (1.0) because,
21	personally, he wasn't comfortable with making the decision and maybe also wasn't really
22	(1.0) had worked with her previously and didn't want to- certainly didn't want to address it
23	and, obviously, the nurses didn't want to address it,
	Resolution #1
24	so I addressed it and felt that she shouldn't be for resuscitation and signed the form and,
	Evaluation #3
25	ehm, out of courtesy,
	Resolution #2
26	I thought I would, ehm, have a word with her, erm, so I did have a word with her and
27	communication wise,
	Evalutaion #4
28	it went very well
	Resolution #3
29	and it was decided that she was not for resuscitation,
	Complicating Action #1
30	this, obviously, caused a lot of hoo-hah and a lot of problems with, with (1.0) with nursing
31	staff…the consultant supported me
	Evaluation #5
32	and I was doing everything right by the patient so what I'm, so coming back a bit to what
33	you mean by leadership, erm, **I, as a junior** was trying to lead this all this clinically with
34	communication, trying to get the nurses on board, why **I** was taking this path of action and
35	it was the appropriate goal, the goal was, obviously, to let this lady die peacefully and as
36	symptomless ehm, as possible. And (1.0) but it was *very, very difficult*, so I didn't feel
37	anyone at all, well, actually nobody was leading this at all, erm, nobody was leading her
38	care, it was all very much day-to-day and the worst case scenario wasn't, erm, ex, er,
39	wasn't, sort of, addressed, so that's from a bad side of eh, leadership, **I felt** that could have
40	been improved on and it would have been consultant, at that stage, because, you know,
41	essentially, **they're** responsible for the overall care of this, of this lady.
	Complicating Action #2
42	**Anyway, I took over that**
	Evaluation #6
43	and I felt that due to communication skills,
	Orientation #2
44	it took about a week, week and a half, a lot of different high powered individuals wanted to
45	change my management,
	Evaluation #6
46	but **I** was able to stick to my guns and explain why **we** should be taking this action…

	Resolution #4
47	So, in the end, this lady did die peacefully
	Evaluation #7
48	and (1.0) was very comfortable and had all her wishes addressed…which I did not think
49	would have happened if someone hadn't have came in and taken a, taken the, sort of, bull
50	by the horns as the phrase is and, sort of, tried to address that.
	CODA
51	Now, I know that's a clinical scenario, because I haven't really been fully involved with
52	any, sort of, management directorial stuff, but as a clinical case of leading someone's care, I
53	thought that showed quite a striking, you know, difference, you know.
	Editing notes: …=speech edited out for brevity **Linguistic features: , = micro-pauses in speech (2.0)=pauses in speech, number indicates number of seconds - = run-on hesitations Metaphors underlined Interesting pronoun use in **bold** Emotional talk in *italics*

Scott introduces this narrative by stating that he is going to show me "good and bad leadership"; more specifically medical leadership and asks if that seems reasonable (Box 5.7; lines 1-3). The way in which Scott introduces this narrative is similar to many of the narratives I encountered in which participants were keen to offer me a "good story".

In terms of content of the story, for me the key gist of this narrative is that Scott himself emerges as leader within this scenario and provides what he evaluates as good leadership, due to lack of engagement throughout of those he would expect to lead (in this scenario the consultant). However, I identified other content-related themes throughout, some that could be seen as facilitative to the leadership process such as Scott's own knowledge and experience, which facilitates his leadership emergence (e.g. line 43) or at one point supportive behaviours on behalf of the consultant which enable Scott's leadership (e.g. lines 31). Other themes I identified

seemed inhibitive to the leadership process, for example, the apparent lack of dialogue between the consultant whom he perceives should be leading (identified through traditional hierarchies) and the nursing staff involved in this patient's care (lines 37-41).

This is an interprofessional scenario in which several main actors are involved including Scott, the patient, nursing staff and the consultant. I explore these concepts further in the following paragraphs through exploration of the ways in which Scott constructs the identities of these actors (including himself) and how they interact together. Through Scott's description of these interactions we can see how he paints a picture of his own successful leadership.

The dying ex-colleague, Scott as the emotionally distant leader, the nurses and the consultant as the grieving friends and colleagues

As the story's main protagonist, Scott constructs his own identity as the emotionally distant leader of this scenario. He introduces himself into the scene by using the metaphoric linguistic expression that he is "a fresh pair of eyes" (lines 5 and 6). Using this visual metaphor, Scott is possibly suggesting he has the advantage of "all seeing" objectivity. He proceeds first and foremost to construct the patient's identity through her diagnosis of "end-stage multiple sclerosis". By doing this, he simultaneously constructs his own identity within this situation as being emotionally distant and further defines the patient by her diagnosis by stating that this patient is "palliative, and by definition terminal" (line 7).

At this point (line 8), however, Scott moves away from the patients diagnosis to add additional layers to the patient's identity as he states that the patient is well known within the local community as an ex-nurse. Here, he describes her not only as a

colleague of the nurses involved in her care but as their friend. Thus he constructs the nurses as her grieving friends and suggests that there is a lot of “emotion” (line 11) involved, which he suggests interferes with their ability to cater for the all the patient’s needs. He places further emphasis on their emotional involvement by stating “her best friends were nursing her” (line 14) and suggesting that there are “ethical issues” involved, thus further removing the nurses from their professional identities and emphasising his own emotional distance.

As he describes the issue to be “dealt with” (line 15) that no-one has “addressed”, this patient’s resuscitation status, Scott re-states that he is a “fresh pair of eyes” (lines 18) and once again continues to use the visual metaphor to emphasise his emotional distance and “look at this as what it was” (line 19).

At this point (line 20) Scott introduces the consultant to the narrative. Scott expresses the consultant’s discomfort with making a DNR decision as he has also worked with this patient in the past. Unlike the nurses’ emotional involvement as friends, however, Scott constructs the consultant as a colleague of the nurse who he sees should be responsible for her care but is focussing “very much day-to-day and the worst case scenario wasn’t addressed” (lines 38 and 39). Scott constructs the identity of the consultant as someone who is emotionally involved in the situation and avoiding making any decisions. This further highlights his construction of his own emotional distance. This emotional distance he constructs as enabling him to take on leadership where he sees that the consultant has not. For Scott, being able to step back from a situation and be emotionally detached is an important part of the leadership process in this scenario.

Scott as the communicative and heroic leader

In the second half of this narrative, Scott adds another layer to his own identity as a leader, not only does he have emotional distance from the situation but he is also an adept communicator. He takes action and "addresses" the issue by signing off the patient's DNR (lines 24). The tone within this part of the narrative changes and Scott uses stronger language as the narrative goes through to conclusion as he describes how he has to account for his actions which causes a "hoo-hah" (line 30). Scott's repeated use of "I" throughout this part of the narrative suggests his own sense of agency within this scenario and that he feels that his actions alone will resolve the situation (e.g. lines 33 and 34).

He then describes a set of interactions he undertakes in order for his actions to be deemed acceptable. He constructs these interactions with the patient as "going well" (line 28); as being able to "get the nurses on board" (line 34); and finding that the consultant supports him (line 31). Scott puts the success of these interactions down to his "communication skills" (line 43). Through his narrative Scott indicates the importance he places on effective and flexible modes of communication and how this contributes to the success of his leadership within the context of this narrative.

Finally, to further emphasise his success as a heroic leader Scott talks about being able to convince a lot of "high powered individuals who wanted to change my management" (lines 44 and 45). Scott uses the LEADER-FOLLOWER RELATIONSHIP AS WAR metaphor of "sticking to his guns" (line 46) which indicates that while this interaction may have been successful, it was conceptualised by Scott as adversarial between himself and the unnamed "high powered individuals". This metaphoric talk also adds to the sense that throughout the latter half of this narrative, Scott continues

to construct himself as determined and heroic. He feels that his actions were part of doing the right thing by the patient. He qualifies this by stating that the patient dies peacefully with all her wishes addressed (line 47 and 48). Scott continues this theme of determination by stating that if he hadn't taken "the bull by the horns" (the "bull" being addressing the DNR issue with colleagues) that this would not have happened (lines 49 and 50). Use of this metaphoric talk suggests a perception that his actions are brave, further adding to the concept of heroic leadership. In his narrative, Scott uses oppositional metaphoric linguistic expressions when he was narrating his external relationship with wider systems within his healthcare organisation. For example, LEADER-FOLLOWER RELATIONSHIP AS WAR: usually associated with interactions that have declined into disagreement (Rees et al. 2007). In contrast he uses collaborative metaphoric linguistic expressions when talking about internal relationships with work colleagues. For example, LEADER-FOLLOWER RELATIONSHIP AS JOURNEY: more associated with partnership (and thus possibly shared leadership; Rees et al. 2009). Although Scott does not specifically state this within this specific narrative, later in the interview Scott also talks about how his own knowledge of wider systems and protocols helped support the defence of his actions. The main focus within Scott's narrative was his internal relationships; it is therefore perhaps unsurprising that he evaluates this incident positively.

Interestingly, to add my interpretation of Scott's constructions of himself as emotionally distant, I noted that Scott's narrative lacks emotional talk (in contrast to the two narratives I present later in this chapter). In fact, I identified only one point in which Scott uses negative emotional talk (line 36) in which he describes the job of persuading others to agree with his course of action as "*very, very difficult*". His use of intensifiers at this point emphasises his point and enhances his construction of

himself as the “heroic leader” working against the odds. Other linguistic features such as pauses and “erms” are evident within Scott’s speech pattern throughout this narrative, in particular at the beginning. Listening back to the audio of this interview, I would suggest that the pauses were there for three reasons: firstly as Scott attempted to maintain the anonymity of those involved; secondly in order to choose his words carefully to maintain a professional stance; and thirdly, this was a telephone interview thus Scott and myself did not have the advantage of non-verbal communication. I would therefore suggest that some pauses may have been there to leave space for me to interact verbally as part of the narrative construction.

To conclude, Scott’s leadership narrative shows a complex set of interactions that Scott has to undertake in order to lead and maintain leadership. Scott is not the leader in the traditional sense (as part of the medical hierarchy) but as a junior trainee he emerges as the leader within this context for a variety of reasons. Individually, Scott puts the success of his leadership within this context down to his emotional distance and contrasts this to his less successful nursing and consultant colleagues who he perceives are too emotionally involved with the patient take on leadership effectively. Although Scott does not specifically state during his narrative, later in the interview he also talks about how his own knowledge of wider systems and protocols helped defend his actions. He also sees effective communication skills as an important aspect of leadership in this situation in order to develop relationships with others (the patient, the nurses and the consultant) that enabled him to take this course of action.

5.4.3 "I got absolutely annihilated"

'Alice' is a white female in her 20s. At the time of her narrative she is a surgical trainee. This narrative concerns an event which takes place during routine patient care in a surgical theatre (see Box 5.8 below). The narrative comes from a focus group in which all participants were surgical trainees. Although the other participants do not contribute verbally to the story, the laughter noted within this transcript comes from Alice and all participants within the group.

Box 5.8 "I got absolutely annihilated"

Lines	Narrative**
	<u>Abstract</u>
1	Oh I've, I've got a good story,
	<u>Orientation</u>
2	I was vascular SHO with a [names a military position], who I hadn't really operated with
3	before, and we were doing a procedure under local anaesthetic or spinal or something,
	<u>Complicating Action #1</u>
4	anyway the patient was awake and **I** was getting quite heavily criticised and (1.0) *really*
5	*badly* criticised and being, my name being shouted out at me [laughter] and then **I, I** don't
6	know, **I** had the sucker on and I accidentally started sucking up a graft or something,
7	[laughter]
	<u>Evaluation #1</u>
8	it wasn't a very good idea and <u>I got absolutely annihilated</u>…
	<u>Most reportable Event</u>
9	But (.) **he** shouted at me so much that <u>I froze</u>,
	<u>Evaluation #2</u>
10	I had *no confidence* to move my hands at all, because I thought whatever I do will probably
11	kill the patient,
	<u>Resolution #1</u>
12	and at the end of the operation the patient wakes up and goes whose [participant's name]?
13	[laughs]
	<u>Evaluation #4</u>
14	because poor old patient is just there just thinking, what *absolute liability* is touching me
15	with a knife…you know, *it's just the fear of that poor patient* and, er, I don't know that was
16	definitely not a way to do it, and…a *very scary*, normally *scary*, scrub nurse offer me a cup
17	of tea, a hug, and then a Gin and Tonic. [laughter] I had a very reserved anaesthetist trying

18	to tell me a few words of wisdom, you know, "sometimes you learn more on a bad day than a
19	good day", and they probably saw my chin wobble, and I didn't do anything more than have
20	a wobbly chin, but the utter,[laughs] I mean it's, it's one of those things you think, uh, uh, and
21	luckily there are a lot of other people who aren't like that, but that totally froze me
	Editing notes: …=speech edited out for brevity **Linguistic features: , = micro-pauses in speech (2.0)=pauses in speech, number indicates number of seconds - = run-on hesitations Metaphors underlined Interesting pronoun use in **bold** Emotional talk in *italics*

This story is an abuse narrative which concerns Alice in the position of follower being the recipient of verbal abuse from a surgeon during a routine surgical procedure in which the patient had had either local anaesthetic or a spinal anaesthetic (see Box 5.8; line 3). Alice identifies the surgeon as the leader through the traditional medical hierarchies. As part of the surgical procedure Alice describes making a mistake and then goes on to describe the surgeon's negative response to this. Within this story, Alice describes several interactions including one between herself and the surgeon, herself and the patient, and herself and her interprofessional colleagues (an anaesthetist and a scrub nurse).

Surgeon as villain, Alice as the victim

Alice constructs the scene by explaining that she is operating for the first time as a SHO with a consultant she has not worked with before to whom she allocates a military title (Box 5.8; lines 1 and 2). Her colleagues are described by their interprofessional healthcare roles. This construction of the surgeon serves to give immediate sense of a hierarchy and is possibly Alice's explanation of the way in which he communicates with her (in a stereotypical militaristic way). Alice constructs herself at this point in the narrative as the recipient of verbal abuse who is "*getting quite heavily criticised*" and has "*my name being shouted out at me*" (lines 4

and 5). Although she does not directly say that the surgeon is the one doing this, it is implied through the way she sets up the scene. She also uses negative emotional talk and repeats that she has been "*really badly criticised*" (line 5) along with intensifiers to emphasise the negative emotion of this experience.

It is interesting to note the pronominal use within this section of the narrative in relation to the surgeon. It is not until line 9 that Alice uses the pronoun "he" to refer to the surgeon although she repeatedly uses "I" and "me" to refer to her (lines 4-8). This may be to construct distance between herself and the surgeon and to emphasise her own central role in the scenario as the recipient of the abuse (Rees and Monrouxe 2008).

In line 8, Alice describes how she makes an error and that she gets "absolutely annihilated" as a result. I would suggest that such metaphoric talk helps reveal how Alice conceptualises her relationship with the consultant as war, emphasising the adversarial relationship that she has constructed between herself and the surgeon and the aggressive nature of his response to her mistake. Alice then goes on to evaluate and describe her own response. She talks about having "no confidence" (line 10) and how she "froze" (line 9). Through these descriptions Alice narrates not only an emotional reaction to this abuse but also a physical reaction as she constructs herself as a victim of this abuse. Her response to this verbal abuse is akin to one of the ways in which animals respond to perceived attacks endangering their lives (freezing as opposed to fight or flight).

Interestingly, all the way through the first half of this narrative and until this point where she freezes, Alice is sketchy about the details of the surgical procedure. For example she describes the patients as being under "local anaesthetic or spinal, or

something" (line 3) and when she describes an error she uses hedges, saying "I don't know…accidentally sucked up a graft or something" (line 6). These descriptions were accompanied by laughter from her and the other focus group participants. A possible reason for this is that because Alice 'froze' she cannot remember the peripheral detail of the incident, only central details.

Alice as a "liability", Patient as a fearful recipient

However once Alice has been the recipient of this abuse she describes the effects is has on her confidence in her surgical abilities. She describes how she can't move her hands as she catastrophises that she is worried she will kill the patient (line 11). She introduces the patient into this narrative as during surgery he/she has clearly heard Alice's name called repeatedly (line 12). She constructs the patient as being fearful of her surgical abilities and wondering "what liability" had been operating on him/her. Inclusion of the patient in Alice's narrative as being a conscious witness to the abuse, serves to deepen the humiliation of this experience in which constructing herself as a liability serves to de-professionalise herself in front of the patient.

Alice as the victim and her interprofessional colleagues as rescuers

Finally, Alice describes the reactions of her interprofessional colleagues. Again, Alice uses a physical description to construct her own response to what has happened. She talks repeatedly about her "wobbly chin" (lines 19 and 20), perpetuating her construction of herself, as a victim. She constructs her nurse colleague as "normally scary" (line 16) who gives her a "hug" and offers her tea and a drink constructing the nurse as her rescuer. Her anaesthetist colleague then gives her "words of wisdom" (line 18) again emphasising her own position as victim and her interprofessional colleagues as her rescuers.

Unlike the previous narrative, in which a complex interplay of various factors affected leadership emergence, this narrative is focussed on static leader-follower relationships based on the medical hierarchy. It clearly illustrates the physical and emotional affect abusive leader-follower relationships can have on the recipient of the abuse.

5.4.4 "Where's your daddy?"

'Carol's' narrative concerns an event from her time as a trainee in psychiatry. Carol is a white female in her 20s. It is not explicitly clear what grade of training Carol is at the time of the story but through her use of language and the events she narrates she is clearly junior to the other actors she depicts within the narrative. This narrative comes from a focus group in which all participants were year one GP trainees. Although the rest of the group do not contribute to the narrative verbally, they do laugh along with Carol as identified within the transcript (see Box 5.9). At the time of recalling this narrative, Carol is a few months into her training as a GP. Carol presents a complex patient scenario in which those that had been in contact with a particular patient needed to have prophylactic treatment for meningococcal disease. The focus of Carol's story was her personal experience of trying to take leadership in order to undertake these required actions as her psychiatry consultant has stated that he does not have the experience to do so. Carol describes how attitudes, systems and protocols become barriers to fully undertaking leadership in this scenario.

Box 5.9: "Where's your daddy?"

Lines	Narrative**
	Evaluation #1
1	Carol: I had an interesting thing
	Orientation
2	when I was doing psychiatry and we had a patient who, they phoned me on a Saturday at
3	lunch time
	Complicating Action #1
4	to say that she'd tested positive for meningococcus[48] and it was, eh was in air, in a sputum
5	sample, so it would have aero-cised.
	Most Reportable Event
6	So **they** said everybody who'd been the ward for the last two weeks plus relatives plus staff
7	all had to get, erm, prophylactic treatment for meningococcus.
	Evaluation #1
8	And (1.0) I mean **I** was phoning sort of infectious disease and occupational health and public
9	health and everybody.
	Complicating Action #2
10	And (1.0) a lot of **them** were saying, well look **we** want to, we want to speak to your
11	consultant.
	Evaluation #2
12	But the consultant hadn't done anything that wasn't psychiatry for 40 years and he had *no*
13	*idea* what to do.
	Complicating Action #3
14	So literally the consultant was sitting in the corner of the office signing prescriptions for me,
15	while **I** [laughs while talking] organised everything,
	Evaluation #3
16	because he was, he was *largely useless*.
	Complicating Action #4
17	Erm, but **they** kept sort of saying, 'well does your consultant know what you're doing? Can
18	I speak to someone more senior?'
19	Lisi: And how did you find that then? How did you find that situation?
	Evaluation #4
20	Carol: It was *difficult* because
	Complicating Action #2
21	I, I mean I'd, I'd phoned the consultant first just to let him know, and (1.0) he just said, 'well
22	look I have no idea what to do, can you manage this?'
	Evaluation #5
23	And **I** was *really confident* that **I** could manage it **myself**, and **I did**. But it was just sort of,

[48] Meningococcus is a bacterium that can cause meningitis, prophylactic treatment can include the administration of antibiotics.

24 25 26	(1.0) the people looking over your shoulder going, sort of (1.0) 'Where's your daddy' kind of thing [laughter]. It was just, it's a bit *frustrating*. And it sort of *undermines how you feel* as a leader a wee bit.
	****Editing notes:** …=speech edited out for brevity ****Linguistic features:** , = micro-pauses in speech (2.0)=pauses in speech, number indicates number of seconds - = run-on hesitations Metaphors underlined Interesting pronoun use in **bold** Emotional talk in *italics*

Related to story content, for me the key gist of this narrative is that Carol's ability to take on leadership is inhibited by the wider systems in which she works. However, I also identified other themes related to the content of her narrative, which like Scott's narrative could be seen to both facilitate and inhibit the leadership process. Within this scenario, Carol describes facilitative aspects to the leadership process such as her own potential emergence as leader due to her own knowledge and expertise in contrast to the consultant's unwillingness to engage in leadership due to his own lack of experience, leading to him to supporting her leadership emergence. However, apparently inhibitive to this leadership process, is Carol's description of the expectations of others that traditional systems and protocols should prevail and the consultant should be leading through the traditional medical hierarchies.

This narrative begins with a statement that she has an interesting thing, inviting the group (including myself as interviewer) to listen. Within this narrative Carol describes different interactions with different sets of actors. Firstly, there is the interaction between herself and the consultant she is working with within this specialty. Secondly, there is the interaction she has with a group of people she repeatedly describes as "they" or "them". Throughout the narrative it is not entirely

clear who "they" are. In Box 5.9; lines 8 and 9, she lists a group of specialties (infectious diseases, occupational health, public health) but then goes on to say "and everybody". At no point within the narrative does she provide specifics. In the following paragraphs I will explore how Carol constructs her identity both as a leader and follower differently in relation to these two interactions.

Carol as a capable leader, the consultant as supportive follower

When Carol narrates her interaction with the psychiatry consultant, she constructs herself as a confident and capable leader. She describes a discussion with her consultant in which responsibility for dealing with the situation becomes hers (lines 21 and 22). When evaluating this event, she uses positive language with intensifiers, to construct herself as "really confident" that she can handle the situation (line 23) and qualifies this with the short statement that she "did". Within this interaction, Carol identifies herself as the leader through regular use of "I" (lines 8 and 15) to indicate her agency and control of the actions that she takes. This is despite of the fact that she describes the consultant as having a part in the process; she chooses not to use the pronoun "we". To contrast and possibly reinforce her identity as a strong leader, she constructs her consultant as a supportive follower who is undertaking tasks for her and "*literally… sitting in the corner of the office signing prescriptions for me*" (line 14). Early in the narrative, Carol reinforces her control through her use of derogatory language to describe the consultant within this story as having "no idea what to do" (lines 12 and 13) and as being "largely useless" (line 16).

Carol as child, consultant as daddy

The second interaction within this narrative reveals a contrasting picture. Throughout this narrative Carol describes an ongoing interaction with a group of people known

only as “them” or “they”. Their express desire is to speak to the consultant (lines 10 and 11), “they” ask Carol if her consultant knows what she is doing (line 17), “they” want to speak to someone more senior (line 18). Carol’s pronoun use at this point places distance between her and this group and gives this part of her narrative a confrontational feel. Unlike Scott’s narrative in which he is able to persuade others to agree with his desired actions, Carol narrates that she is powerless to change systems which expect the consultant to be in the position of leader and thus within this interaction Carol shifts her own position from leader to follower. Carol’s use of pronouns ‘they’ and ‘them’ instead of ‘we’ or ‘us’ adds to the sense of a divide (Rees and Monrouxe 2008).

Carol uses negative emotional language such as “difficult” (line 20) and “frustrating” (line 25) to express how she finds this and this interaction has an effect on how she ultimately constructs her identity. Key within this narrative is Carol’s use of metaphoric linguistic expression which reveals her conceptualisation of her relationship with external systems as oppositional through use of the metaphoric linguistic expression LEADER-FOLLOWER RELATIONSHIP AS PARENTALISM (line 24).

Through use of this metaphoric linguistic expression (‘where’s your daddy’). Carol constructs the group as positioning her as a child and the consultant as her father. Thus, in contrast to the way in which she constructs her own identity as a leader earlier in the narrative, at this point in the narrative she constructs herself as a child through others positioning her as such and the consultant as the parent. Thus revealing that she thinks others see her as junior within the wider healthcare system. Indeed, worthy of mention here is the fact that Carol states that the consultant is in fact required to sign the prescriptions in order for the task to be fulfilled and thus

protocol reinforces this traditional hierarchy (line 14). She finishes the narrative by expressing that this (childlike) identity imposed on her ultimately undermines how she herself feels as a leader (lines 25 and 26).

This narrative reveals a complex and at times contrasting interplay between individuals, context, relationships and systems, which seem to simultaneously facilitate and inhibit Carol's emerging leadership identity. As an individual, Carol feels confident that she can cope with the situation and her relationship with the consultant is such that she feels able to move away from traditional hierarchies to take control, which within this context she feels is appropriate due to her superior knowledge of how to approach the situation. However, through this narrative Carol also describes the frustrations of trying to take on leadership in a wider system in which protocols and traditional hierarchical attitudes prevent her from fully undertaking the role and ultimately position her as "childlike" and "undermined".

5.5 Conclusion

This results chapter has explored the narratives that participants shared about leadership in the interprofessional healthcare workplace. Through thematic and structural narrative analysis of the stories participants offered, I have revealed a complex picture of how the leadership process is experienced in the interprofessional workplace. Stories about traditional hierarchical leader-follower relationships dominated but were also shared alongside stories in which leadership relationships were dynamic and emergent and did not align with the traditional medical and interprofessional hierarchies. Focussing on three exemplar narratives, I have uncovered an ever-more complex picture of leadership and followership, in which many factors could be identified as affecting the process. Attention to how the stories

were told and the linguistic features participants used alongside the content revealed how participants constructed their identities as leaders and followers within the context of their stories. Scott and Carol’s narratives revealed that emergent leadership relationships are not always easy. Both narratives articulated difficulties in undertaking the leadership process within a wider administrative system that was not necessarily set up to facilitate (or for that matter recognise) leadership emergence. Whilst Alice’s narrative revealed the emotional and physical effects that an abusive leadership relationship can have. What follows in the next two chapters (Chapters 6 and 7) is an analysis of how leadership was enacted in the interprofessional healthcare workplace.

CHAPTER 6: RESULTS- ENACTING LEADERSHIP I: A wide-angled view

6.1 Introduction

This is the third results chapter of my thesis. This current chapter pays attention to analyses the data I collected during the video-observational stage of my VRE study. I will present data from the video observations I undertook within a hospital ward and GP practice. Although I do provide some initial opportunity to compare the two sites and explore similarities and differences, data from both sites are, for the most part, presented together.

The results presented within this chapter and within the following chapter (Chapter 7) represent a change of gear within this thesis for two reasons. First, as I explore leadership and followership enactment within the interprofessional workplace, the results presented within this chapter depict a shift in focus from medical trainees to the whole interprofessional team. Second, whilst in previous chapters I presented audio-data as written transcripts embedded within tables and boxes, I will also present visual data, both in photographic format within both chapters and in the memory stick that comes with this thesis[49].

As within previous results chapters, I begin by presenting a broad overview of the data, before narrowing my lens to specific aspects. Initially, I introduce the two fields in which the data were collected thereby providing some contextual grounding. Then, I present an analytical summary of the leadership and followership interactions I filmed during the video-observation phase of the VRE study. To recap, the

[49] For the purposes of maintaining participant anonymity, this memory stick is embargoed and only for viewing by the research team and thesis examiners. All participants depicted in the videos and photographs gave their consent to be included in this thesis.

overarching RQ3 and corresponding supplementary questions that this chapter is concerned with are presented in box 6.1 below.

Box6.1: Chapter 6: Research questions and supplementary research questions

RQ3: How is the leadership process enacted within the context of interprofessional healthcare workplaces?

Supplementary questions:

- What types of leadership interaction occur in interprofessional healthcare workplaces?
- What are the typical features of leadership interactions within interprofessional healthcare workplaces?

6.2 Introducing the "fields" and the video-observation data

Here, I begin by contextualising further the data through a detailed introduction to each of the sites in which I undertook the VRE study (note I provided an outline of each site in Table 3.2, in Chapter 3). I then go on to provide an outline and analysis of what was captured during the video-observational phase.

6.2.1 Introducing Site A

Participants within site A described it as a medium-sized GP practice (approximately 8600 patients) in which there were eight partners and one salaried GP. It was situated in a small UK town with rural surrounds. It was also a registered training practice and had GP specialty trainees (from all years) affiliated to the practice. During my research, senior students (year 5) from the nearby medical school were also present on clinical attachment. The practice was managed by a practice manager, an assistant practice manager and an administrative team of nine. Nursing staff involved in the practice included three practice nurses, five district nurses, two health visitors, a school nurse, a midwife, a visiting MacMillan nurse and two health care assistants.

Allied health professionals included a part-time pharmacist and part-time phlebotomist.

The practice was housed in a purpose-built building constructed 10 years previously. One of the GP partners and the practice manager had been involved in its design. Administrative staff worked in an open plan reception area next to the patient waiting room on the ground floor. This reception area opened onto a doctor's room at the back and a door to a corridor that led off to the consultation rooms (which could also be accessed from the patient waiting area). Upstairs, as well as various offices for the nursing staff, the practice manager and allied health professions, there was a large meeting room and large communal area with a fully-fitted kitchen, seating and an outdoor balcony space.

Within the grounds of the practice was a small community hospital (16 bedded; one male ward, one female ward) to which the GPs in the practice provided medical support during the hours of 8am until 6pm on weekdays. This medical support came from the patient's own GP. The type of care provided within the community hospital included, step-down bed provision from the stroke unit in the nearby acute hospital and palliative care. There was also a minor injuries unit (MIU) attached to the community hospital for which GPs were on-call Monday to Friday 8am until 6pm. Staffing at the hospital included a senior charge nurse, around six staff nurses and healthcare assistants and part-time physiotherapy, occupational therapy and social work.

6.2.2 Introducing Site B

Site B was a 30-bedded elderly rehabilitation ward in an acute general hospital in a small UK city. Patients were admitted to the ward for the most part via the acute

medical unit at the hospital and would typically have multiple co-morbidities. The focus of this ward was on rehabilitation and timely discharge.

Two consultants were attached to this ward but also had responsibilities to other wards within the hospital. At the time of my research, the ward had a full-time foundation trainee who would rotate on a monthly basis and previous to my coming to the ward there was also a senior specialty medical trainee who had been placed elsewhere at the time of filming but was still involved in the reflexivity stage. The ward had a large cohort of nursing staff consisting of one senior charge nurse, two charge nurses, approximately 15 staff nurses and 11 health care assistants who all worked shift patterns. Also in the nursing cohort were bank nursing staff and mental health liaison nurses who were not formally attached to the ward but were regularly present. Allied health professionals included occupational therapy, physiotherapy, technical instructors and a pharmacist who had specific responsibilities for the patients on the ward. Dieticians and speech and language therapists would be called on an ad-hoc basis. Non-clinical staff included a ward clerk who was based on the ward and a consultant's secretary who worked off the ward.

The ward was typical for a UK hospital with six four-bedded bays and six single side-rooms arranged along a wide corridor. Half way up the corridor was the nurses' station, beside which, was a white board on which patient names and dates of discharge were written. Behind a wall at the back of the nurses' station was an open-plan doctors' desk area and the senior charge nurse's office.

6.2.3 Video-observational data

In total I captured 12 hours 38 minutes and 15 seconds of video-observational data (7 hours 23 minutes 43 seconds in Site A; 5 hours 14 minutes 32 seconds in Site B).

Table 6.1 below provides an overall summary of the video-observation data collected.

Table 6.1 Summary of video-observational data

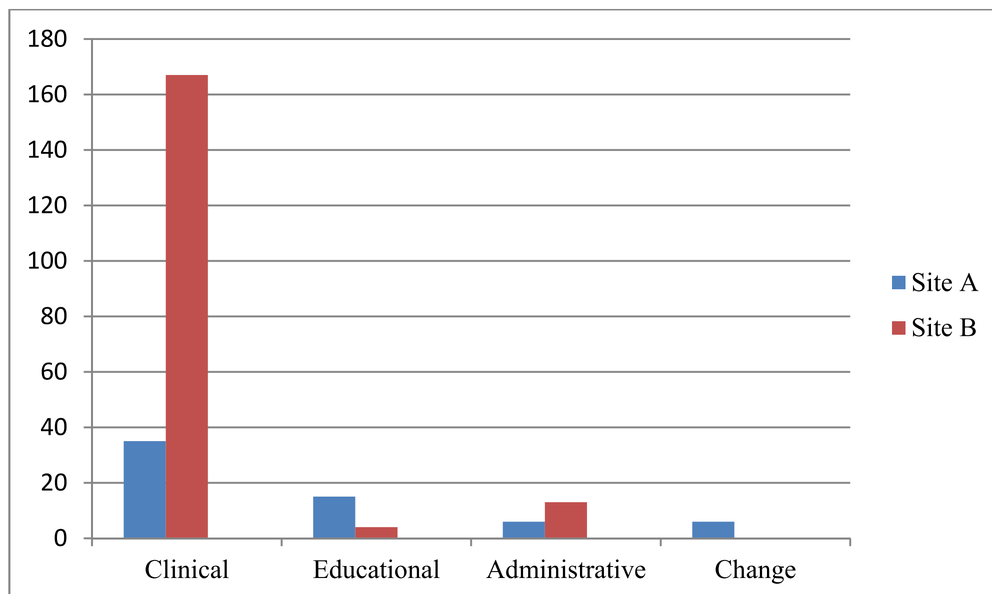
Site A			
Context	**Length hr:min:sec**	**Summary of Participants**	**Outline summary of footage content**
Communication Meeting: GP meeting room	00:56:02	All practice GPs; GP trainees; practice manager; district nurses; practice nurses; community hospital nurses; health visitors; MacMillan nurse; practice pharmacist; medical students.	Weekly meeting to discuss the management of complex patients in the practice, community and community hospital. Chaired by the practice manager.
Diabetic Meeting	00:27:24	GP and practice nurse.	Weekly meeting to discuss management of diabetic patients in the practice.
Educational Meetings	02:32:19	Various GPs; GP trainees; pharmacist; practice nurses.	Weekly educational meeting led by a member of staff, various subjects.
Community Hospital	00:11:25	GPs, community hospital nursing staff.	Unplanned interactions at community hospital
Practice Manager Shadowing	00:08:14	Practice manager; nursing staff.	Footage from 2 hours spent shadowing practice manager in her office
Reception Area	00:15:57	Reception staff; GPs; nursing staff.	Footage of unplanned interactions from 2 hours spent in GP reception
Trainee shadowing	02:52:17	GP trainees (ST1 and ST3); GPs.	Footage from shadowing the 2 GP trainees in the practice
Total time	07:23:43		
Site B			
Board Rounds: Nurses station white board	00:44:00	Both ward consultants; ward nursing staff; social worker; physiotherapists; occupational therapists	Twice-weekly meeting (Monday and Thursday morning) to discuss discharge plans for ward patients: chaired by nursing staff
Multidisciplinary meetings: storage room off ward	02:38:56	Nursing staff; medical consultants; social worker; occupational therapist; physiotherapists; nursing students; medical students	Weekly multidisciplinary meeting to discuss all patients' progress and planning.
Ward round	01:15:37	Medical consultants; foundation trainees; medical students; various nursing staff	Twice weekly consultant's ward rounds in which medical issues discussed and patients seen
Informal interactions: various ward based venues	00:36:29	All consented staff	A range of informal interactions captured during out with formal activities above.
Total time	05:14:32		

6.3 Influential acts of organising: Leadership in the clinical context

This section focusses on the video-observational data as a whole. It details my interpretations of the 12 hours 38 minutes and 15 seconds of raw video data I

collected across both sites during the observational stage of my VRE study. As I previously discussed in the methods chapter (section 3.6.1), the focus of my analysis at this stage was leadership as it occurred in context as an 'influential act of organising' (IAO). Across the video data, I coded a total of 246 IAOs (n=62 were coded in the GP setting; n=184 were coded in the hospital setting). Within these IAOs, I was able to identify different "types" of IAO which are detailed below. Thus, the focus of this section is the supplementary research question: What types of leadership interaction occur in the interprofessional healthcare workplace?

Figure 6.1 Types of Influential Acts of Organising (IAO)



The bar chart in Figure 6.1 provides a summary of the data and Boxes 6.2 to 6.5 provide examples from the data of the different types of IAO I identified.

6.3.1 Clinical leadership

Of the 246 IAOs, I coded a total of 202 as clinical leadership. This could be defined as leadership interactions in which the focus of the IAO was a decision about ongoing patient care. Of these clinical leadership IAOs, 35 were coded from the GP footage and 167 from the hospital footage (see figure 6.1). The types of activities in

which the majority of clinical leadership IAOs were captured was during formal clinical activities (n=164): this included hospital 'board rounds'[50] (n=62); hospital multidisciplinary team meetings (n=49); hospital ward rounds (n=32); and GP communication meetings (n=21). Other activities included routine patient care (n=26); complex patient scenarios (n=10); patient transfer activities (n=1); and management activities (n=1).

The settings in which these clinical leadership interactions were filmed varied. In the GP practice (site A) this included: the meeting room (n=20); consultation rooms (n=10); the community hospital office (n=4); and the community hospital treatment room (n=1). In the hospital setting (site B) this included: the white board (n=70); an off ward storage room used for meetings (n=49); the ward corridor (n=36); the doctors desk (n=7); and the nurses station (n=5).

Within these clinical IAOs it was also possible to describe who the leaders and who the followers were. In site A, I identified the leader to be a GP (n=22); a nurse (n=7); an IAO in which there was more than one leader (n=4); and an allied health professional (AHP; n=2). Followers included: nursing staff (n=15); more than one member of the MDT (n=8); GPs (n=6); specialty trainee (n=5); and AHP (n=1).

In site B, I identified the leader to be a consultant (n=123); a nurse (n=29); an IAO in which there was more than one leader (n=8); an AHP (n=5); a foundation trainee (n=1); and clinical support staff (n=1). Followers included: more than one member of the MDT (n=126); nursing staff (n=17); a foundation trainee (n=16); AHPs (n=5); nursing students (n=2); and a consultant (n=1).

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[50] Board rounds happened twice weekly involving the interprofessional team gathering round the ward white board to discuss discharge planning for each patient in turn. Their intention is to be brief and focussed on discharge dates, with wider issues to be discussed in other formal settings (for example the weekly MDT meetings or medical ward rounds).

Box 6.2 below depicts a typical clinical leadership IAO taken from the hospital footage. The context is one of the weekly multidisciplinary meetings and depicts a patient case discussion in which I understand the clinical leadership IAO to be undertaken by the hospital consultant. In this example, the followers are the whole MDT present at the meeting.

Box 6.2 Clinical Leadership IAO.

[View video Excerpt on memory stick: IAO_Clinical Leadership]

Still 6.1: Clinical Leadership IAO.

(left to right: consultant(cons); charge nurse(CN); social worker (SW); occupational therapist (OT); physiotherapist (PT); staff nurse (SN); nurse student [top of head]

Turns	Transcript**
1	**Cons:** …so she's [the patient] maybe a bit more confused this morning
2	**SN:** yeah
3	**Cons:** she's maybe got a UTI [urinary tract infection] [clip edited]…is she still mobile?
4	**PT:** Yes, A of 1 with a zimmer, A1 transfers [clip edited]…
5	**Cons:** eh [OTs first name]?
6	**OT:** Ehm, well I would actually say she's independent getting up and she's independent with her transfers with supervision
7	((**Cons:** OK, OK)) [clip edited]
8	**OT:** certainly towards the end of last week I would say she was not far off being ready to go home, ehm,
9	**SW:** She [the patient] was talking to me about four-times-a-day care package
10	**Cons:** Right [clip edited]…I was away to say I think we will be needing that much home support
11	**OT:** Yeah
12	**Cons:** [clip edited]…so we had her for the seventeenth ehm, Friday
13	**OT:** Friday
14	**CN:** Friday

15	**Cons:** ehm (4.0) just given that she's got a possible UTI and a bit of haematuria we'll ehm, maybe push it back til the Monday…
****Editing notes (for all 4 examples in this chapter):** **Written in bold:** Who is talking (..) or (5.0)= indicates a pause durations either number of dots or number in brackets in seconds {} indicates a feature within the talk such as interruption or laughter (( )) double brackets indicate overlapping speech Written in [ ] are notes on physical actions within the clip or general notes about clip	

6.3.2 Educational leadership

An IAO involving educational leadership could be described as a situation in which the IAO occurred during an educational activity. I coded a total of 19 educational IAOs, 15 in the GP setting and 4 in the hospital setting (see figure 6.1 above). In site A the settings for these educational IAOs were formal educational settings and included IAOs that occurred during the educational meetings (n=12); and GP trainee tutorials (n=3). In site B the settings were less formal and the educational IAO took place within a ward round (n=2) and during the weekly MDT meeting (n=2).

Within site A, the leaders for these educational IAOs included: more than one leader (n=5); GPs (n=4); specialty trainees (n=3); an AHP (n=2); and a nurse (n=1). The followers were members of the MDT (n=12) and specialty trainees (n=3).

In site B, the leaders of these educational IAOs included: consultants (n=2) and nursing staff (n=2). The followers were: nursing students (n=2); and medical trainees (including 1 foundation doctor and 1 medical student).

Box 6.3 Educational Leadership IAO

[View video Excerpt: IAO_Educational Leadership]

Still 6.2: Educational Leadership IAO

(left, GP; right GP trainee: ST1)

Turns	Transcript
1	**GP Trainee (ST1):** she's had recurrent episodes of shingles over the last, probably 10 years has had shingles on and off but has never managed to get to the doctor's when she's had the rash [clip edited]
2	**GP:…**where does she get it?
3	**ST1:** she's had well, she's had mostly on her lower, on one side of her lower back, this time it was in a patch across her right buttock [clip edited]…I thought it was probably better to do her bloods if she's not, she's having recurrent episodes of shingles
4	**GP [nods]:** Uh-hmm, uh-hmm
5	**ST1:** why is she getting recurrent episodes of shingles, so I took two purples and two yellows but I wasn't 100% what I should be sending for apart from full blood count
6	**GP:** What should you do if someone's getting recurrent shingles or recurrent herpes infection? But you'll need to speak to her to consent her
7	**ST1:** What an HIV test? [GP nods] Yeah well I was thinking that [clip edited]…but (2.0) I thought that was a bit (2.0) I don't know
8	**GP:** I know we sort of think it's a bit over the top
9	**ST1:** I know {laughs}
10	**GP:** But, uhm, the latest advice is, the latest advice is that if someone is getting recurrent things like thrush or shingles and stuff we should be checking…[clip edited]
11	**ST1: …**uhm she gets it then it sort of settles down and then it'll be OK for a few months and then it's coming back, multiple episodes really
12	**GP:** I mean it sometimes I have found patients like this who actually have recurrent herpes more than the, it's the same sort of virus anyway, more than the shingles, but they tend to get it just itchy and they get like a pettiform, herpetic rash
13	**ST1:** Yeah
14	**GP:** Uhm, I've had a couple of patients and it's always been on the buttock
15	**ST1:** Right
16	**GP:** and they get it two or three times a year
17	**ST1:** Oh maybe it's that then
18	**GP:** It could be that

Box 6.3 depicts a typical educational leadership IAO. This IAO takes place in a GP consultation room following morning surgery in which the specialty trainee (ST1) is given the opportunity to discuss each patient with the supervising GP. In this scenario, I perceive the GP to be undertaking an educational IAO which has influence on the ST1's patient treatment.

6.3.3 Administrative leadership

Of the 246 IAOs, I coded nineteen as administrative leadership. Examples of this type of leadership included appointment management in the GP practice and bed planning within the hospital setting. I identified the occurrence of six administrative IAOs in site A and thirteen IAOs in site B. All nineteen administrative IAOs occurred during a management activity.

In site A the settings for the administrative IAOs included: the GP reception (n=3); the community hospital office (n=1); the meeting room (n=1); and the practice manager's office (n=1). In site B the settings for administrative IAOs included: the ward nurses' station (n=11); the ward corridor (n=1); and the doctors' desk (n=1).

In site A the leaders of these administrative IAOs included: administrative staff (n=5) and nursing staff (n=1). Followers were: administrative staff (n=3); GPs (n=2) and AHPs (n=1). In site B the leaders of these administrative IAOs included: nurses (n=10) and consultants (n=3). Followers were nursing staff (n=8); consultants (n=2); the MDT (n=2); and foundation trainee (n=1).

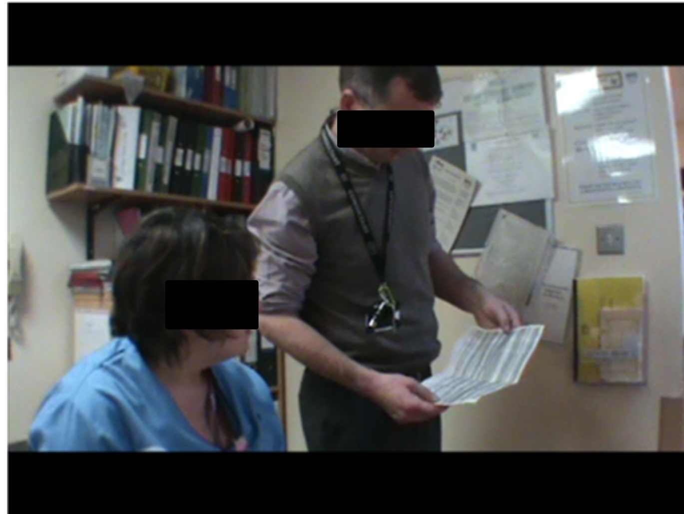
Box 6.4 depicts one of the typical administrative leadership IAOs I recorded within the hospital setting. It depicts a discussion at the nurses' station between one of the ward consultants and one of the ward charge nurses. Within this short clip (which is also hard to hear due to background noise) there is a discussion revolving around bed

planning and management within the ward. Within the context of this clip I coded the charge nurse as the leader and the consultant as follower.

Box 6.4 Administrative Leadership IAO

[View video excerpt: IAO_Administrative leadership]

Still 6.3: Administrative Leadership IAO



(left to right: ward charge nurse (CN); ward consultant (cons))

Turns	Transcript
	[A lot of background noise throughout this clip]
1	**Cons:**…did I take her off? [walks over to computer and looks at screen]
2	**CN:** No
3	**Cons:** Uhm (.) equally she might just get home. I would, I think
4	**CN:** Maybe leave her?
5	**Cons:** I'll just sort out her care package I think long term we'll just
6	((**CN:** No, No, no)) seems silly to come
7	**Cons:** [looking at piece of paper he's holding] Ehm, I don't think
8	**CN:** {interrupts} No that's fine. If you're over on your travels you can just, have you got a board round over there?
9	**Cons:** Yeah
10	**CN:** Yeah, well you might pick up (.) somebody, give me a (.) little phone [smiles]

6.3.4 Change leadership

Finally, within this section, I identified IAOs that revolved around change leadership. Across the raw video footage, I identified six IAOs focussing on change leadership. These took place in Site A only and occurred during the various meetings

held in the GP meeting room. The focus of these change leadership IAOs included proposed changes to prescribing systems (n=3); changes to medical input to the community hospital (n= 1); system changes proposed as a result of a significant event analysis (n=1); and policy changes proposed as a result of new knowledge (n=1).

Within these IAOs, I identified the leaders as: GPs (n=2); a specialty trainee (n=1); a nurse (n=1); administrative staff (n=1); and incidents where I identified there to be more than one leader (n=1). Followers included members of the MDT (n=5) and nursing staff (n=1).

Box 6.5 on the following page depicts a clip of a change leadership IAO from an educational meeting in which the practice pharmacist was providing a medicines update. This excerpt is taken from near the end of the meeting in which one of the GPs is introducing a new paperwork system for medicines reconciliation between home, community hospital admission and/or secondary care. In this clip, I coded the GP as leader and the whole MDT present in the meeting as the followers.

6.4 Features of these influential acts

What follows within this section is a description of the various subthemes I identified to be characteristic of the process of these IAOs (see Appendix K for my full coding framework). Also within this section I present an overview of typical human-human interactions and human-material interactions that I identified within the leadership interactions as they occurred. Throughout this section, I will return to the data examples presented in Boxes 6.2 to 6.5 to illustrate my discussion. The supplementary research question that this section is concerned with is: What are the

typical features of a leadership interaction within the interprofessional healthcare workplace?

Box 6.5: Change Leadership IAO

[View video excerpt: IAO_Change leadership]

Still 6.4: Change Leadership IAO

(round table clockwise from left: practice nurse (PN); GP1; GP2; Pharmacist (Pharm); GP Trainee (ST3); medical student; GP3)

Turns.	Transcript
1	**Pharm:** I assume this is getting clipped on to the
2	((**GP2:** Yeah))
3	**Pharm:** other sheet that comes down?
4	**GP1:** ((the, the)) it follows on really from [GPs first name]'s sort of significant event
5	**Pharm:** Yes, Uh-huh
6	**GP1:** and its something that we brought in at the previous that I worked at
7	**Pharm:** ((oh, OK))
8	**GP1:** because (..) yeah similar kind of thing just (.) near misses rather than actual events
9	**Pharm:** (mmm-hmm) [clip edited]
10	**GP1:** …and then you just have that as well, all you have to do is stick a label on the front of that one, have a quick look to see basically are they on anything as they come in. Are you stopping as they come in…[clip edited]
11	**Pharm:** …OK so I've decided I'm going to stick with the cardex all the time because I'm going there every week and also because, I know the patients much better and I can come back and check their vision records about why they're started or stopped and I'll actually write in that sheet that means it's there for you… [clip edited]…right so when do you want to start using these just out of interest
12	**GP1:** Ehm [sits back in seat] (4.0)
13	**GP 3:** Tomorrow
14	**GP1:** (..) Tomorrow, yeah we can try it whenever
15	((**Pharm:** Yeah?))
16	**GP1:** basically so that we [clip ends]

6.4.1 The leadership process

The subthemes I present in this section allowed me to break down aspects that I would suggest are common to leadership processes. This includes information exchange; leadership negotiation or non-negotiation; volunteering to take on leadership; discussion and agreement of a plan or passive compliance with a plan.

6.4.1.1 Information exchange

As a social process, I observed that leadership interactions would typically involve some form of information exchange between those identified as leaders and those identified as followers. For example, information regarding a patient's progress would facilitate a clinical leadership IAO. In Box 6.2, turns 4 to 9, a range of members of the MDT provide information (including the consultant, OT, physiotherapist and social worker) which ultimately enables a clinical leadership IAO about the patient's ongoing care made by the consultant. Interestingly, within this MDT meeting context, information was shared between team members when the consultant was not present (prior to the excerpt). However no decisions were made until the consultant arrived, thus reinforcing her clinical leadership. As well as verbal information exchange, I noted that information was also gathered through paperwork (for example, patient notes) and computer screens (for example, x-ray reports).

6.4.1.2 Negotiation of leadership

Negotiation of who would lead often followed this information exchange. I observed and identified, leaders and followers negotiating and then "granting" leadership to the most appropriate team member that could take on the leadership role. This could be due to the information that was exchanged prior to the negotiation. This granting

could happen overtly through direct designation of the leadership role or covertly through questioning or non-verbal interactions (I will explore this in more detail later in Chapter 7). This is demonstrated in Box 6.3, turn 5 were the specialty trainee (ST1), by saying she is not sure what to do, overtly invites the GP to take leadership, which evolves into an educational IAO.

6.4.1.3 Non-negotiation of leadership

Often, I identified that there was no leadership negotiation and leadership was assumed through professional or interprofessional hierarchies. This assumption of leadership could happen overtly through clear statements of decisions or the designation of tasks and responsibilities. It could also happen covertly through, for example, the way questioning was used (this will also be explored in more depth in Chapter 7).

Returning to Box 6.2, although there is information exchange between the MDT within the meeting, which ultimately influences the consultant's decision, there is no negotiation about who makes that final decision (see turns 10 and 15).

6.4.1.4 Discussion and agreement of a plan

Following information exchange and leadership negotiation (or non-negotiation), I identified that there could be a discussion between leaders and followers about a plan of action to which all parties would agree. For example, this could relate to the ongoing treatment of a complex patient. These discussions were particularly apparent when the actors within an interaction held senior professional roles (for example, the interaction between a GP and the practice pharmacist in Box 6.5). Each person within these interactions could be seen to actively contribute to planning. This could be seen through questioning, confirmation by verbally repeating their

understanding of the required tasks, non-verbal interactions or contribution to final decision (this will be explored in greater depth in Chapter 7). This is also demonstrated in Box 6.4, where there is ongoing discussion throughout between one of the ward charge nurses (identified by me as the leader within this interaction) and one of the ward consultants (identified by me as the follower within this interaction) about bed planning.

6.4.1.5 Passive compliance with a plan

In contrast to the above subtheme, followers were sometimes seen to passively comply with the IAO, without offering opinion, planning, or any discussion. I could often relate this to professional and interprofessional hierarchies (for example, a ward round interaction between a consultant and a foundation trainee). This theme was often enacted through directives which will be discussed in depth in the examples presented in Chapter 7. Although not overt within the examples provided in Boxes 6.2- 6.5, I would suggest that through lack of verbal interaction in Box 6.5, the practice nurse, the GP specialty trainee (ST3) and the medical student could be constructed as passively complying with the plan to implement a new paperwork system at the community hospital.

6.4.2 Human-human interactions and human-material interactions

This section will take a more in-depth look at these interactions by exploring the human-human and human-material interactions I found to be typical across the video-observational data. This includes non-verbal interactions; control or use of material artefacts; the use of language; and the use of para-language.

6.4.2.1 Non-verbal interactions

The use of video-recording, allowed me to analyse non-verbal interactions, as well as the verbal interactions. Participants used various non-verbal strategies to indicate that they were listening (or not listening) as part of a leader-follower interaction. For example, nodding was identified throughout the interactions above to indicate engagement with the decisions (see Boxes 6.2 and 6.3).

I identified two key non-verbal strategies which contributed to the leadership process in either a facilitative or an inhibitive manner. First, physical positioning played an important role in the negotiation of leadership. For example, in still 6.1 (see Box 6.2) the participants are arranged sitting in an inclusive circle around the room, all present are able to see each other in a way that is conducive to information sharing. However, examining the still more closely, it can be seen that all participants are turned toward the consultant as she makes the clinical leadership decision. In still 6.2 (see Box 6.3), both participants lean in toward each other indicating engagement in the interaction. However, through physical positioning with the GP in the consultation chair and the ST1 in the slightly lower 'patients chair' could indicate the ST1's follower status within this interaction. In still 6.4 (see Box 6.5), the body position of GP3 (leaning back in his chair with hands behind his head) could indicate a lack of engagement with the interaction.

Second, I identified eye contact (or lack of eye contact) to be a key strategy in the leadership process. For example, in still 6.2 (see Box 6.3), eye contact is used in this interaction to indicate that each participant is listening and engaged in the discussion. Lack of eye contact was also identified as a non-verbal strategy in the leadership process and will be discussed further in Chapter 7.

6.4.2.2 Control/use of artefacts

I identified that the control and/or the use of artefacts was an important factor in the leadership process across the dataset. One indicator of traditional interprofessional hierarchies could be whether participants wore uniforms or not. All nurses and AHPs in the hospital setting wore uniforms, while all doctors wore their own clothing. The only exception was the social workers who wore their own clothing. In the GP setting, most nursing and administrative staff wore uniform, whilst all medical staff, the practice pharmacist, the practice manager and health visitors wore their own clothing (see stills 6.2-6.5 above). Medical artefacts including stethoscopes; name-tags with “doctor” or “consultant” written on the ribbon; control of patient notes trolleys (for example, who decided when it would be moved to the next bay during a ward round) could all be seen to construct traditional medical and interprofessional hierarchies.

Patient data in its various forms was a key human-material interaction across the video-observational footage. Control of materials like paperwork, who wrote and what was written in them, for example, patient notes and nursing notes; computer screens and the keyboard; and who was deciding which patient to discuss on the hospital ward’s white board could be seen to be key strategies in the negotiation of leadership. Those that were in ‘control’ of this data were the participants who tended to be in the position of leadership within the interaction. In Box 6.3 above we see that although the patient they are discussing has been seen by the ST1, the GP has access to the computer and therefore control of information about the patient (see

still 6.3). Later on in this interaction (not depicted in the video clip) the GP also looks through the BNF[51] to provide the ST1 with prescribing advice.

6.4.2.3 Use of language

I identified three key linguistic features that were typically used across the interactional data to indicate how participants constructed leadership and followership in context. First the use of directives was indicative of leadership. For example the charge nurse saying to the consultant “give me a little phone” (see Box 6.4; Turn 10) or GP1 saying “all you have to do is stick a label” (see Box 6.5; Turn 10: this will be explored further in Chapter 7).

Secondly, questioning was typically used to construct leader-follower relationships, for example, the consultant asking the physiotherapist “is she still mobile?” (see Box 6.2; Turn 3) or the GP asking the ST1 “where does she get it?” (see Box 6.3; Turn 2) are all examples of direct questioning from leaders to followers with the aim of obtaining information that facilitates the IAO. Alternatively, questioning was used as a way of negotiating professional boundaries and leadership identities (this will be explored further in Chapter 7).

Thirdly, I identified the use of personal pronouns and the words they were co-located with to be a way in which leader-follower identities and relationships could be negotiated. For example, the pharmacist’s repeated use of “I”, (For example, “I’ve decided”, “I will” and “I can”: see Box 6.5; Turn 11) indicates her own authority and identity as a leader in aspects related to her own professional expertise. Alternatively, the consultant’s use of “we” when making a decision about ongoing patient care (Box 6.2; Turn 10) could indicate her desire for team-working and

[51] BNF is the British National Formulary: which provides up-to-date prescribing information

shared leadership. I also noted regular use of hedges co-located with pronouns such as “I think”, or “maybe we”. I will explore this language use further in chapter 7.

6.4.2.4 Use of para-language

I identified interruptions, over talk and laughter as key para-linguistic features of the leadership interactions. I noted laughter used in different ways, for example: to soften directives; jokingly to encourage participation and agreement; and as a face-saving technique[52]. Interruptions and over talk were common throughout the different interactions I captured on video. This was used, for example, to maintain participation in a leadership interaction (Box 6.5; Turns 2 & 4), to retain leadership (Box 6.4; Turn 6) or even at times to disagree with the leadership process.

6.5 Conclusion

Within this chapter, I provided a wide-angled view of the video data and introduced my initial analysis of the video footage collected during the video-observational stage of the VRE phase of my research. This chapter has detailed the types of IAO I videoed; the typical process involved in an IAO; and has begun to look more closely at the data in terms of typical interactional processes that occurred during an IAO. In the following results chapter I will narrow my lens to a more detailed analysis of selected interactions. In addition, I will also present the data from the video reflexivity sessions in relation to the selected clips.

[52] Drawing on Goffman (1959), Brown and Levinson (1987 cited from Rees and Knight 2008) used the concept of *face* (a person’s public self-image) to explain how individuals will make efforts to preserve their own and other people’s self-image needs. It is argued that speech acts can maintain or threaten ‘face’ (Rees and Knight 2008). Factor contributing to the maintenance or threat of face include power and relational distance (for example medical hierarchies) and (relevant to my research) whether the interaction is observed (Rees and Knight 2008). These face acts will be explored further in Chapter 7.

CHAPTER 7: RESULTS- ENACTING LEADERSHIP II: A close-up view

7.1 Introduction

In this fourth and final results chapter, my lens narrows to a more detailed analysis of interactions which occurred within a selection of excerpts. This compliments the previous chapter in which I provided a broad overview of the video-observational data. This level of analysis allows me to investigate in detail how leadership was enacted. In addition, and adding a further layer to the analysis of the video data presented, I will include participants' own analysis of the excerpts by presenting extracts from the reflexivity sessions.

The chapter begins with a detailed description of the edited video clips I used within the video-reflexivity sessions, details about who attended each video-reflexivity session and which clips were shown within these sessions. Following this, I present an in-depth analysis of four leadership interactions, including discussion I had about these specific interactions within the video-reflexivity sessions. Finally, I turn more specifically to the reflexivity sessions and consider what participants learned from viewing themselves in practice. The research questions and supplementary questions are presented in this chapter is concerned with are presented in Box 7.1.

Box 7.1 Chapter 7: Research question and supplementary research questions

RQ3: How is the leadership process enacted within the context of interprofessional healthcare workplaces?

Supplementary questions:

- How is leadership constructed through interactions within interprofessional healthcare workplaces?
- How is leadership enactment influenced by individual, relational, contextual and material factors?

7.2 Introducing the data

In this results section I will provide details of the edited video data that was shown within the video-reflexivity sessions as well as information about the video-reflexivity sessions. This forms the basis for the in-depth analysis of four leadership interactions presented later in this chapter.

7.2.1 Edited video data

In preparation for the video-reflexivity sessions I edited footage from Site A down to 22 minutes and 40 seconds and from site B down to 20 minutes 10 seconds. Appendix L provides a detailed description of the edited clips that were shown in the video reflexivity sessions.

7.2.2 Reflexivity data

Finally, within this section Table 7.1 below provides details about who attended each reflexivity session and how long the sessions lasted and which of the edited clips were shown and discussed within each session.

7.3 Analysing leadership interactions

7.3.1 Introduction

Each clip within this section has been chosen because it illustrates particular aspects of leadership interactions that were typical across the data. They depict examples of different ways in which leadership was enacted within the workplace. They also reflect the breadth of contexts I observed, as well as the variety of participants that were involved. Within this part of the chapter, each excerpt is presented in the following way: following a brief introduction of the excerpt, the reader is directed to the appropriate video excerpt on the memory stick; selected stills from the excerpt are then provided, along with a full transcript of the excerpt. Following this is an

analytical discussion underpinned by the themes presented earlier in chapter 6, as well as excerpts from the video-reflexivity sessions.

Table 7.1: Summary of reflexivity sessions

Session	Length	Attendees	Clips shown*
GP Practice: Session 1	00:59:10	District nurse x 2; health visitor x 2; GP trainee (ST1); practice pharmacist; practice manager; medical student; GPs x 5	Communication meeting clips 1-4 Interprofessional interactions (admin) clips 1-3
GP Practice: Session 2	00:10:44	Receptionist; assistant practice manager	Interprofessional interactions (admin) clips 1-3
GP Practice: Session 3	00:46:51	GPs x 3; practice pharmacist; practice nurse	Interprofessional interactions clip 4 (diabetes meeting) Educational meetings clips 1-3
GP Practice: Session 4	01:08:37	GPs x2; GP trainees x 2 (ST1 and ST3)	Educational meeting 3 Trainee tutorial GPST1 and GPST3 shadowing
GP Practice: Session 5	01:01:29	District nurse; GP; Community hospital senior charge nurse; GP trainee (ST3)	Communication meeting clips 1-4 Community hospital patient
Hospital: Session 1	01:06:34	Ward occupational therapist (OT); physiotherapist	All site B clips
Hospital: Session 2	00:36:32	Ward staff nurses x2; social worker	Board round clips 1-3 Informal Interaction clips 1-13 MDT meeting clips patients A-E
Hospital: Session 3	01:14:03	Ward consultants x 2; physiotherapist	All site B clips
Hospital: Session 4	01:14:31	Medical specialty trainee (ST6)	All site B clips
Hospital: Session 5	00:53:21	Foundation trainee	All site B clips
Hospital: Session 6	01:02:07	Mental health nurse; mental health OT	All site B clips
Hospital: Session 7	01:01:34	Ward charge nurses x 2	All site B clips
* see Appendix L for details of clips			

7.3.2 Negotiating influence

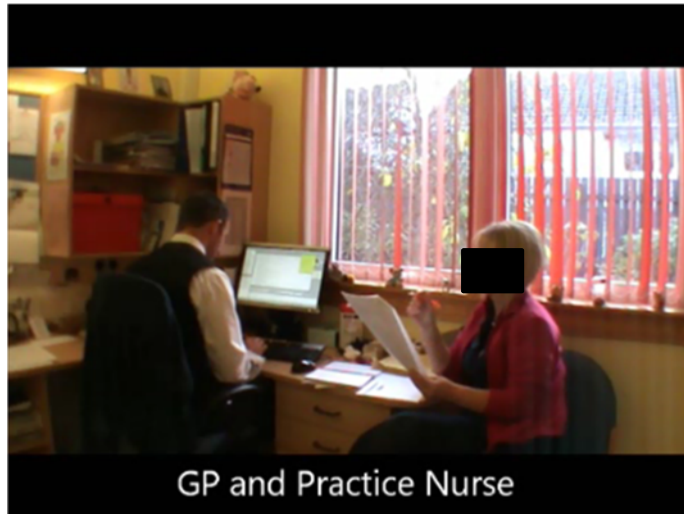
[View video excerpt: Diabetic meeting]

This edited clip features a discussion about a diabetic patient between a GP ('Jason') and practice nurse ('Fiona')[53] during a weekly meeting set up within the GP practice to discuss diabetic patients (See Still 7.1 below). This is the first diabetic meeting that Jason has been involved in (he is a new partner in the practice), but Fiona is an experienced practice nurse who regularly takes part in this meeting with another GP

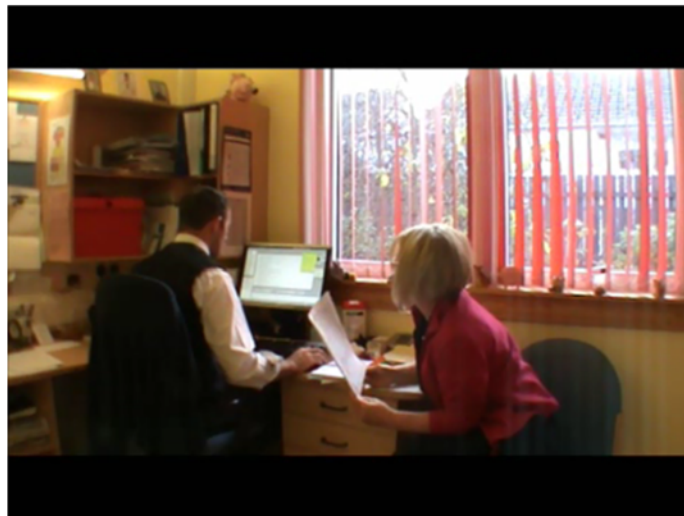
[53] All names used in this chapter are pseudonyms

partner (who is on holiday). The clip takes place in Fiona's consultation room in which Jason is sitting at the consultation desk with his back to the camera facing a computer screen and keyboard. Fiona is sitting on a chair (the lower patient's chair) to the right of the desk (partially facing the camera and partially facing Jason) holding paperwork, which she holds on to and refers to throughout the interaction (See still 7.1).

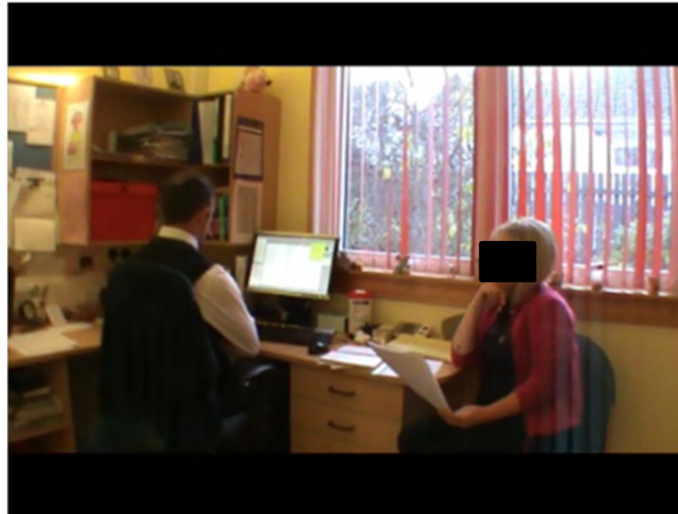
Still 7.1: The diabetic meeting; GP 'Jason' (left) Practice Nurse 'Fiona' (right)



Still 7.2: Fiona leans in to look at computer screen



Still 7.3: Jason leans back and folds his arms



Box 7.2 Transcript of Diabetic Meeting Excerpt

Turns.	Transcript**
1	**Jason:** [typing on keyboard]**…that's 5.1**
2	**Fiona:** [looking at paperwork she is holding] **Mm-hmm, and her blood pressure diastolic is too high.** [Jason continues to type and look at keyboard] **BP's 138-95** (8.0) [during pause in talk, Jason continues to type and look at screen, Fiona looks up from her notes, leans forward and looks at the computer screen. (See still 7.2)] ***I don't know whether she's got scope to increase her glycoside?*** (5.0) [during pause in talk, Jason manoeuvres mouse loudly then rubs left hand over face]
3	**Jason: Sitagliptan 100, enalapril 5 so she's got scope to play with that** (2.0) **ehm** *(2.0)* ***anything else that she's on that's not helping?*** [continues to look at computer screen and manoeuvre mouse] (2.0)
4	**Fiona:** [refers to the notes she is holding and then looks back up at screen] ***is she ordering her rosuvistatin*? (2.0)**
5	**Fiona and Jason together: ((Yes))** [both looking at screen]
6	**Jason: she had it on the 21st**
7	**Fiona: {interruption}** [referring to her notes] **uh-huh** ***how much glycoside does she take*? I've got a 160 milligrams in the morning**
8	**Jason:** [looking at screen] **Yeh**
9	**Fiona:** ***Is that all*? Mind you that's as much**
10	**Jason {interrupts}** [takes right hand off mouse and holds it up in direction of nurse, eye still on screen]: **((But then that's Dr. S's suggestion** [both glance up and look at each other briefly nodding]**((they're not likely to get any benefit))**
11	**Fiona: ((as Dr S said we should give))** **Yeah, from anything else and she can't tolerate metaformin, (3.0) due to side effects** [looks up at Jason who continues to look at screen] (3.0)
12	**Jason:** ***Bowels*?**

13	**Fiona: Yeah, well it just says side effects**
14	**Jason: {interruption}: ((just says side effects))**
15	**Fiona: that was even the MR preparation so**
16	**Jason:** [leans back in chair and folds arms continues to look at screen] (See still 7.3) **well I mean, (1.0) certainly the diabetic controls is certainly going in the right direction, I reckon I would be happy to**
17	**Fiona: {interruption}** ***see her back in four months*****?**
18	**Jason: Yeah, I would be happy to sort of, keep going with that its gonna be the (2.0) blood pressure and the**
19	**Fiona: Uh-hmm**
20	**Jason: (..) cholesterol that's the, the issue** [Fiona looks up from notes at Jason] e**hm**
21	**Fiona {interruption}:** ***can you discuss that over the phone or?***
22	**Jason: {interruption} Yeah, I was gonna, yeah I think I'll probably give her a call and then ehm…** [Fiona writes in notes, Jason picks up mouse and leans back toward screen]
	****Editing notes:** **Written in bold: Speech and who is talking** (5.0)= indicates a pause durations either number of dots or number in brackets in seconds {} indicates a feature within the talk such as interruption or laughter (( )) double brackets indicate overlapping speech Written in [ ] are notes on physical actions within the clip *Writing in italics:* indicate question use Underlined writing: pronoun use

In terms of the leadership process, this interaction moves through several of the stages described in section 6.4.1. Initially, there is an exchange of information (Box 7.2: Turns 1 & 2) between the two professionals about the patient, then there is a period of what I have identified as leadership negotiation between Jason as the GP and Fiona as the experienced practice nurse (Box 7.2: Turns 2-9). At this point, leadership and its associated influences appear to be shared and moving back and forth between the two. Following further information exchange a plan is discussed and agreed by both parties (Box 7.2: Turns 11-22).

To explore this excerpt in more detail, I turn to the second-level of analysis in which I examine how leadership and influence is constructed and negotiated through a

complex interplay of multiple communication strategies between Jason and Fiona. In particular, I focus on physical positioning, the use and control of artefacts and the strategic use of questions (of which there are many examples of in this excerpt).

At the beginning of the interaction, Fiona is selecting and providing detail about the patient from her notes, focussing on the patient's blood pressure (see still 7.1). Within this interaction, Jason has no access to the information that these notes hold and thus Fiona controls the situation through her choice of what information to share with Jason. This also happens later in the interaction (Box 7.2: Turn 7) in which Fiona chooses to share information about a specific drug. In turn 2, once Fiona has supplied the information she wishes to be considered during a pause in talk she lifts her eyes from the notes and leans forward to look at the computer screen to explore the information that Jason has via the computer screen (see still 7.2, above). Thus Fiona gains access to all of the information available in contrast to Jason who only has what is available on screen (and thus arguably some control of information).

The physical positioning within the consultation room is interesting within this interaction. I knew that I was coming to Fiona's consultation room to film this interaction so I was surprised when I entered the room and discovered Jason sitting at the desk with Fiona sitting in the lower positioned consulting chair. I interpreted this as a visual representation of a static hierarchical leader-follower relationship (with the doctor as leader in the higher chair at the desk; and the nurse as follower in the lower consulting chair).

Questions within this interaction were used strategically to do a number of things, for example, in turn 2, Fiona begins her question with "I don't know whether…". This opener is used as a hedge to indicate an awareness of professional boundaries and soften what could be face threatening for Jason as pressure is placed on him to

move the course of action with this patient in a particular direction. At the same time, Fiona establishes her own leadership identity, knowledge and experience of the patient's condition through indication of the direction that she thinks this discussion should take (in this instance a review of the drug this patient is taking). Jason responds to Fiona's question by providing drug information, he also states that the patient "…has scope to play with that" in reference to the information he has on the screen (turn 3). By stating his opinion, Jason is negotiating his own influence and reaffirming his own leadership identity as the one who can make decisions about this patient's drugs. He follows this statement up by asking Fiona what other drugs this patient is on "that aren't helping". Although this is a more direct question in which Jason is requesting information he is also seeking Fiona's opinion by asking her what drugs she thinks are not helping the patient. This marks professional courtesy and respect for Fiona's knowledge and experience. Fiona responds with a further question (turn 4) for which they seek out the answer together on the computer screen before she asks once again about the patient's glycoside (turn 7). Thus, through this set of questions and later in the interaction (turns 17 & 21), Fiona carefully negotiates her influence in the process and the direction of the discussion without challenging her colleague's professional identity as traditional hierarchical leader. Pronoun use is also a prominent linguistic feature within this interaction. More specifically Jason uses the pronoun 'I' in different ways as illustrated in turns 18 and 22. Firstly, he collocates 'I' with verbs such as 'I would' (turn 18), 'I'll' (turn 22) which could indicate his own agency and desire for authority in the decision-making for this patient (Skelton et al. 2002). Second, and conversely, Jason also collocates 'I' with 'thinking' verbs such as 'I mean', 'I reckon' (turn 16) and 'I think' (turn 22). This could indicate a wish to soften his own position as leader given the Fiona's

knowledge and experiences which are clear from the suggestions she makes about the possible course of action (turns 17 & 21: Skelton et al. 2002). In summary in-depth analysis of this interaction has revealed a complex interplay of multiple communication strategies that were used to negotiate leadership. Physical positioning, control and use of artefacts and strategic use of questioning were used by both parties in various ways to: establish and maintain leadership identities; to manage professional boundaries; and soften what could be construed as face threatening acts.

When this excerpt was discussed within the video- reflexivity sessions, in contrast to my own analysis of shared leadership, the practice nurse Fiona was adamant that this was not her role, but regularly contradicted herself by also suggesting that she was bossing (ie leading) Jason:

> Quote (a)
> *"**Fiona:** …and I prob (laughs while talking) I was probably bossing him about there (laughs) wasn't I*
> ***Pharmacist (Amy):*** *(Fiona laughing) that's because it was his first time, you were making sure he knows what he was doing (laughs)*
> ***Fiona:*** *I felt very bossy there (laughing)…no it was his first and eh, I think he had sat in on one but only for about (1.0) 15 minutes before with [other GP's first name] and I doing it so yeh.*
> ***Me:*** *So did you feel like you were leading that, that session*
> ***Fiona:*** *No (shakes head vigorously) no, no (laughs and looks at Christina (GP) who is also present in video-reflexive session) not by any means but (2.0) …I was just trying to (1.0) (moving hand in circular motion) keep things moving at a (1.0) rate of knots like we normally have to"*
> **(GP Practice: Video-reflexivity session 3, See still 7.4)**

Through this discussion within the video-reflexivity session we can see the practice nurse verbally describing a static leadership relationship based on the traditional interprofessional hierarchy. Interesting, however, within this discussion is Fiona's use of laughter. She repeatedly laughs as she describes her own part in the excerpt

perhaps to try to cover embarrassment at seeing herself as "bossy". She looks at others present in the video-reflexivity session and invites them to laugh along with her, which they do. Through this and her adamant denial of her own leadership, the practice nurse expresses her discomfort at the consideration that leadership may be more shared than she has considered before viewing herself in practice (Quote (b) below).

Quote (b)
*"**Me:**…so although you didn't feel like you were taking leadership*
***Fiona:** (interrupts and points at screen, Still 8.4 below) it looks as though I was (laughs and looks at Christina)*
***Christina:** (says jokingly) maybe you were (laughter)*
(GP practice: Reflexivity Session 3, See still 7.4 below)

Still 7.4: Reflexivity session 3 (from left, researcher, practice nurse 'Fiona', pharmacist 'Amy', GP 'Christina')

Similar to the practice nurse, Jason also seems verbally clear of his position in the interprofessional hierarchy:

Quote (c)
*"**Jason:** …so, from a leadership point of view …it's about knowledge transfer and at the start of each interaction…[Fiona]'s got the information (1.0) ehm and (3.0) and then (1.0) it's just a (1.0) discussion I don't think there's any kind of (2.0) significant hierarchy (1.0) Although I suppose from*

an overall decision-making process (2.0) ultimately I suppose the call is (1.0) is mine… I'm pretty sure she would disagree if she thought I was talking rubbish (laughs)… And I (1.0) I would expect that" **(GP practice reflexivity session 5: see still 7.5 below)**

Although Jason clearly respects the practice nurse's professional knowledge he also states that the call is his thus identifying his role as clinical leader (see quote (c) above). He is hesitant in his speech, indicating that he is choosing his words carefully. He also hedges using "I suppose" when stating that he is the overall leader, again perhaps indicating a degree of uncertainty as to proposition that he is truly the ultimate leader within this interaction. Jason further acknowledges the value of information exchange and clearly respects his nurse colleague's experience as he describes the planning phase of the process (see quote (d) below).

Still 7.5: GP Practice: Reflexivity session 5 (from left to right) District Nurse 'Sally', GP 'Jason', senior charge nurse 'Vicki' and GPST3 'Elaine'

Although it is outside the scope of this thesis to analyse in-depth the interactions that were occurring within the reflexivity sessions, it is notable that as well as Jason, the senior district nurse within the practice ('Sally') and the senior charge nurse from the

community hospital ('Vicki') were also present when this excerpt was discussed with Jason (See still 7.5 above). Thus his careful choice of words may have reflected who was listening.

> Quote (d)
> "***Jason:*** *...that's fairly typical interaction I think... (3.0) it tends to be a bit of a (3.0.) [moves both hands together in a swinging motion, See still 8.5] a swing weighted interaction for each patient because ... If there is something that needs to be modified or discussed again sometimes [Fiona]'s quite happy to take it. She's been doing it for (2.0) , ehm, a good while. But if there are particular things that I probably need to discuss with them[the patient] (2.0), ehm, or if there are significant modifications with their regime or we're going to have to ask secondary care to get involved, ehm, then I usually take that on (1.0)..."* **(GP practice video-reflexivity session 5).**

In quote (d), Jason uses an interesting metaphor to describe the interaction as 'swing weighted', moving his hands back and forth in a swinging motion. This could suggest that he is aware of the complexity of the interaction and that the boundaries between the leader-follower relationships are more blurred than would be suggested by a static hierarchical one.

7.3.3 Traditional medical leadership: two different interactional approaches

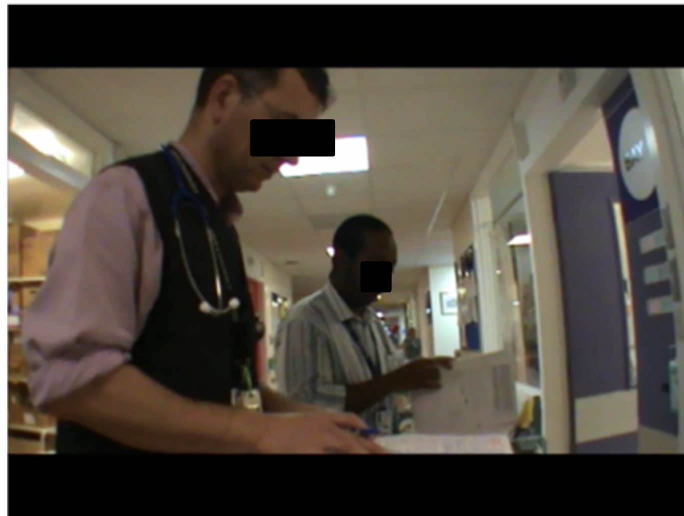
[View video excerpt: Ward round]

This excerpt from site B focusses on traditional medical and interprofessional leader-follower relationships. I have chosen a set of two edited clips here, taken when observing the weekly consultant ward rounds. I will split the transcript of these clips into Part A and B (see Box 7.3 below). Part A depicts the medical consultant 'Dr James' on a ward round with Foundation trainee 'Douglas' and Part B depicts the

medical consultant ‘Dr Martin’s’ ward round with Foundation trainee ‘Anna’, a male medical student ‘Saul’ and a staff nurse ‘Liz’. Stills 7.6-7.8 are taken from part A and stills 7.9-7.11 are taken from part B.

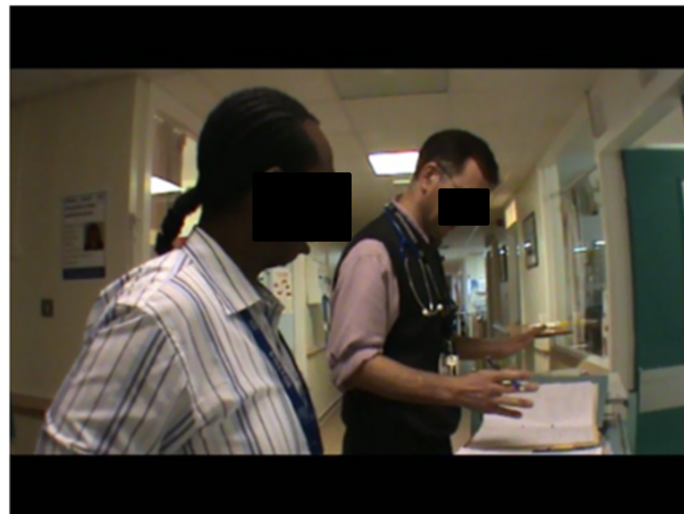
Across the footage I collected during ward rounds in Site B, I identified a total of 35 leadership interactions (clinical IAOs, n=33; educational IAOs n=2). Of these 35, I identified a consultant as the leader in 34 of these interactions. Thus it is unsurprising that within both of the edited clips above I identified ‘Dr James’ and ‘Dr Martin’ as the leaders undertaking clinical leadership IAOs. In part A, I identified the foundation trainee ‘Douglas’ as the follower and in part B, I identified the MDT (including a nurse ‘Liz’; a foundation trainee, ‘Anna’; and medical student ‘Saul’) as the followers.

Stills 7.6 to 7.8 “Dr James’s” Ward round



Still 7.6 (left to right, ‘Dr James’ and ‘Douglas’)

Still 7.7: Dr James leans over to check Douglas's notes

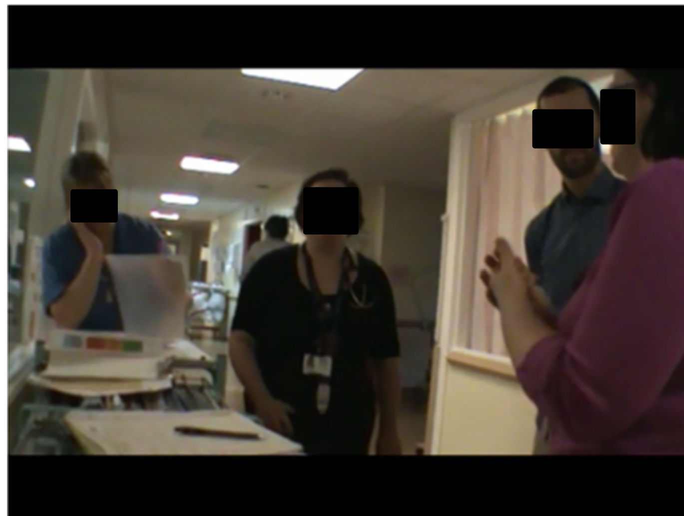


Still 8.8: Dr James says "you can't push it"

Stills 7.9 to 7.11 "Dr Martin's" Ward Round

Still 7.9 (left to right: 'Liz', 'Anna', 'Saul', 'Dr Martin')

Still 7.10: Walking in to see the patient



Still 7.11: Discussing a plan

Box 7.3: Transcript of ward round excerpt

Turns	Transcript**
	Part A: 'Dr James's' ward round Present from the left (See still 7.6) are: Consultant 'Dr James' and Foundation trainee 'Douglas' standing around patient notes trolley outside a patient bay.
1	**Dr James:** [looks up at Douglas from notes, Douglas continues to look at notes] **You said she's still in pain didn't you** [Douglas nods flicking through notes. Dr James looks back down at notes] (4.0) [Dr James continues writing in notes, pharmacist walks out of patient bay, voices of nurses can be heard in background] **<u>I'm going to</u> cut down her codeine a little bit, just cause the nurses, just cause it will** [sound of door squeaking open in the

	background] **knock her off a bit…**[edited section]
2	**Dr James:** [holding up notes] **Yeah,** ***just say she's uhm*** [talking while walking over to put the notes back in file outside bay Douglas writes in notes] ***doing well…[***edited section]
3	**Dr James:** [back at trolley looking at notes] **you've done a** ***<u>can you</u> just check Mrs, uhm*** *[name edited out]* ***haemoglobin blood results please*** [Douglas puts down patient notes and moves over to a folder and starts to flick through as Dr James continues to look down at his notes] (3.0) [Dr James looks up and moves over to look over Douglas shoulder at the notes, See still 7.7] **well see you won't have todays up to date results will you?**
4	**Douglas: Eh, no**
5	**Dr James: ((no))** [Dr James moves back to his notes] **Yeah, well that's fine** ***just leave it…***[clip edited] [cut to Dr James and Douglas now looking together at one set of notes]
6	**Dr James: <u>Did we manage</u> to do his bloods again** [looks up and makes eye contact with Douglas]
7	**Douglas:** [Returns eye contact with consultant shakes head] **Eh no he's still refusing**
8	**Dr James:** [nods and puts left hand up in "halting motion"] **OK** [flicks through notes] **refusing** [Douglas nods] (..) [Dr James points at the notes and then points toward the bay where the patient is with his pen] **<u>I'll ask</u> him today but** [glances at Douglas and puts both hands in a halting motion, see Still 7.8] ***<u>you</u> can't push it*** [Douglas nods]…[clip edited] **Part B: 'Dr Martin's' ward round** Present from the left Staff Nurse 'Liz', Foundation Trainee 'Anna', 'Saul' medical student, Consultant 'Dr Martin'. All standing around patient notes trolley outside patient bay on ward (see still 7.9).
9	**Dr Martin:** [flicking through notes and looking up at Anna]: **…hasn't moved his bowels for (..)** [looking over at Liz] **Two weeks?**
10	**Liz:** [Looks up at Dr Martin and smiles] **seems to be yeah** [both Liz and Dr Martin look down at notes]
11	**Dr Martin: And <u>you</u> always supervise him going to the loo or the commode, it's not like he goes by himself…**[clip edited]…**has there definitely been no bowel movement?** [looking directly at Liz]
12	**Liz:** [looking down at her notes] **<u>I don't think</u> a proper one it says he's been faecally incontinent over night, but** [shaking head] **I actually don't see**
13	**Dr Martin: ((what does)) that mean then?** [clip edited]…**are we definitely recording?**
14	**Liz:** [looks up from notes] **Not always because it's sometimes first thing in the morning, maybe <u>they're</u> finding it and it's been** [sweeps arm to side] **overnight**
15	**Dr Martin: ((Yeah))** [all look back to Dr Martin] ***can, can we start a*** *((***Liz: a chart***))*
16	**Dr Martin*****: a chart, yeah*** **cause <u>I kind of really need</u> to know what's going on** [looks

	down at notes][clip edited cut to Dr Martin, Anna and Saul walking into bay to see patient, see still 7.10]
17	**Dr Martin:**[clip edited to Dr Martin, Anna and Saul exiting patient bay] <u>***I think***</u> ***what we should do in the first instance, ehm, if the nurses get him back into bed later on, ehm, is PR him again just to see if things*** {laughs while talking} ***are moving down and*** [looks at Anna who is taking down notes] <u>**I would**</u> **probably** ***get another just a plain abdominal X-ray just to see what's happened because it did*** [shakes head and shrugs shoulders] ***say query bowel obstruction***
18	**Anna:** [looks up from notes at Dr Martin] **yeah that's**
19	**Dr Martin: Yeah,** [goes back to notes then looks up at nurse] <u>**I mean**</u> **to be honest he's not got any symptoms** [shaking head holding both hands palms up] **of an obstruction** [looks back at notes].
	****Editing notes:** **Written in bold:** Speech and who is talking (5.0)= indicates a pause durations either number of dots or number in brackets in seconds {} indicates a feature within the talk such as interruption or laughter (( )) double brackets indicate overlapping speech Written in [ ] are notes on physical actions within the clip *Italics*- indicates use of a directive <u>Underlined</u>- indicates pronoun use.

In terms of the leadership process depicted within each clip, I identified that information exchange occurred in both interactions. In part A, involving Dr James, this information was exchanged mainly through looking at paperwork, with less verbal interaction (see Box 7.3: turn 1). In part B, involving Dr Martin, information was more often exchanged verbally in both directions between leader and followers (see Box 7.3: turns 9-12). In both clips I suggest that there is no negotiation of leadership and each consultant assumes the leadership role throughout. In part B, there is discussion and agreement with the ongoing plan for the patient (turns 18-20), in contrast to part A in which Douglas appears to passively comply with the plan for each patient (see turns 2, 5 and 8).

Turning to the second level of analysis, I examine how traditional medical leadership is enacted in different ways by each consultant in context by considering the multiple communication strategies they use. More specifically, I focus on physical positioning, the use of directives and pronoun use within these interactions.

In still 7.6 we see the physical positioning that was typical throughout the interaction between Dr James and Douglas. Both actors stand side-by-side facing the patient notes trolley (and into the patient bays) looking through paperwork. This position emphasises the focus on paperwork and seems to discourage eye contact throughout the interaction. In still 7.7 we see Dr James ‘leaning over’ Douglas, checking the notes; again this positioning was noted regularly in this interaction and seemed to be done for the purposes of ‘checking’ what Douglas was writing or has written (see Box 7.3; turn 3). I would suggest that this reinforces the leader-follower relationship between Dr James and Douglas. In still 7.8, Dr James holds his hands up in a ‘halting gesture’ whilst making a statement about not pushing a patient into having blood taken (see Box 7.3; turn 8). Through this hand gesture, Dr James emphasises that this course of action is not up for discussion and it could also serve to emphasise his role as leader.

In stills 7.9 and 7.11 (above) we see more ‘open’ physical positioning within Dr Martin’s ward round, all members of the medical team (Dr Martin, Saul and Anna) positioned slightly away from the patient notes trolley and their bodies positioned in a way that they can make eye contact. At the point in the ward round in still 7.9, all eyes are on Liz as they wait for information from her about the patient. In still 7.11, as they discuss the plan for treatment of this patient, again all participants stand in a semi-circle, encouraging eye contact. Dr Martin prefers to use verbal discussion and

eye contact to elicit information from Liz. This could indicate a desire for a team-based approach to leadership. Throughout this interaction, Saul does not take part in any of the discussion; he is there in an observational capacity. His physical positioning, slightly back and with his hands behind his back in a gesture of politeness highlights his observational role.

Liz's physical positioning is different from the rest of the group; she leans her head on her hand and has less eye contact with the others looking through the notes for information (stills 7.9-7.11). This could indicate her disinterest in the interaction which has emphasis on medical issues whereas her role is to provide information rather than be part of the decision-making process. However, this could also be seen as a protective gesture because Dr Martin questions her in-depth about how the ward nurses have monitored this patient's bowel movements (see Box 7.3; turns 11 & 13).

Still 7.10 depicts the medical staff walking into the bay to see the patient. What is interesting within this still is that the participants have moved position so that they can go to see the patient in the order of the traditional medical hierarchy (consultant first, then foundation trainee, then medical student). In order to achieve this, Anna and Saul are required to step back and let Dr Martin take the lead. This all serves to emphasise the leader-follower relationship.

Use of directives showed the different ways in which the leader-follower relationship was enacted. The purpose of these ward rounds was to review and if necessary change medical treatment. As I have already established, this was clearly led by the consultant in each case. Thus I would suggest that it would be expected that each clinical leadership IAO would contain directives from the consultant to others on the ward round. In both parts A and B, I noted several incidents of the use of directives.

In part A I noted four incidents in which Dr James provides directive to Douglas (see Box 7.3; turns 2,3,5 & 8), in part B Dr Martin provides two directives, one to Liz (see Box 7.3; turn 15) and one to Anna (turn 18).

Dr James and Dr Martin use directives in different ways however. Dr Martin uses a more collaborative manner, in particular with Liz in order to express her directive using "can we" (turn 15) which softens the directive and encourages Liz's participation in the directive interaction (turn 16). She also uses the pronoun "we" in this directive and the other directive "I think what we should do" (turn 18) which could also indicate her desire for a collaborative approach to leadership (Skelton et al. 2002). She also provides explanation for her directives (turns 17 and 18) which aids clarity for the recipients and encourages their participation in planning (turns 16 and 19).

In contrast, Dr James's directives are delivered more frequently and are expressed as explicit imperatives, for example, "just say she's uhm, doing well" (turn 2) or "can you just check" (turn 3). There is less explanation for each directive (there is less verbal interaction overall in this interaction), which may affect clarity and understanding of the reasoning for the directives for the recipient.

The two consultants also use pronouns in different ways. For example, Dr James tends to use "I" collocated with 'doing words' such as "I'm going to" (turn 1) or "I'll ask" (turn 8) which could indicate his authority in this situation (Skelton et al. 2002). Dr Martin tends to use 'thinking words' and hedge more often when using "I", for example "I don't think" (turn 12) or "I would probably" (turn 18) which again may indicate her desire to soften her own position of authority (Skelton et al. 2002). In the interaction with Liz, Dr Martin asks her if "you always supervise" the patient's

bowel movements (turn 11). By 'you' she in fact means all members of nursing staff but by using 'you' she is placing responsibility with Liz. Liz responds by talking about the patient's night-time bowel habits and says that 'they're finding it' (turn 14). By using 'they' Liz removes some of the responsibility to others that Dr Martin has placed on her, which could be seen as a face saving technique on the part of Liz.

When these clips were discussed in the reflexivity sessions both Dr James and Dr Martin identified that they were in the position of leadership (quote (e) below). Dr James described the relationship as 'unambiguous' indicating an awareness that in this context that there was a clear hierarchical relationship between himself and Douglas.

> *Quote (e):*
>
> *"**Dr Martin:** it looks as though {laughs while talking} we're doing the leadership*
>
> ***Dr James:** ((Yeah)){interruption} I would say with [Douglas] there's a pretty unambiguous relationship [nods] … something that's evolved in medicine is that, I probably knew more about the patients than him, whereas years ago he would be telling me about the patients, it's just a fact the way medical training's evolved…this sounds bad but they don't really have anything useful to tell us, that sounds awful [looks at Dr Martin] you know what I mean*
>
> ***Dr Martin:** [nodding] it's true*
>
> ***Dr James**: …I'll say can you get the blood results and everything but to a large extent it's very much me directing him…they're rotating so much …they're used to that relationship. In [name of ward] potentially they could..(2.0)take more of a kind of assertive role or whatever but I think they're used to just going on ward rounds and being more kind of 'have you done this?', 'can you do this?'…you kind of realise it more watching that…""* **(Hospital: Video-reflexivity session 3, see still 7.12)**

Still 7.12: Hospital reflexivity session 3 (left to right: 'Jenny'; 'Dr Martin'; 'Dr James'; Researcher)

Dr James then went on to explore reasons why this leader-follower relationship was so clear, stating that the frequent rotation of foundation trainees affects their opportunities for more active involvement in the planning of patient care. Dr Martin agreed with this analysis. Dr James also discussed how this affects his approach to leadership, stating it was 'very much me directing him' and how watching it on the video emphasised this (Quote (e), above). Dr James accepted that leadership in this context was very much part of the responsibilities of his role as consultant (see quote (f) below). He also stated the importance of role of the other members of the interprofessional team in clinical leadership IAOs. Quote (f) below depicts the discussion between himself and the ward physiotherapist on that subject. Dr James talked about decisions being 'offered' to him to 'rubberstamp' because 'that's how the hierarchy works'. Thus systems and protocols facilitate Dr James (and for that matter Dr Martin) into a formal position of leadership.

Quote (f)

***Dr James**: I think in terms of decision-making I think it is (3.0) I feel most of what I do is making decisions…being given information and making decisions*

***Physiotherapist 'Jenny'**: I think from being part of the mob on the ground as it were, we would always look to that as well…*

***Me:** [to Dr James] so ultimately it's your responsibility is that what you're saying?*

***Dr James**: to, to, to a degree yeah, and I think that's the expectation you (3.0) you know you make decisions based on you know the information you're given… around kind of discharge issues, CPR[54] issues, you, you are usually expected to (2.0) make the final decision. But often the decision is (4.0) you, you're, you're offered the decision to make if {laughs} you see what I mean…*

***Jenny**: you're informed by whatever info you're getting from us*

***Dr James**:…which is fine, so for example like CPR decisions the nurses will initiate that and if they ever come to me and say 'do you think this patient should be for CPR, uhm, they are not going to come to me if they think that they should be (2.0) they'll come to me in the expectation that I'll write 'do not attempt resuscitation' … yeah, I make the decision, but many times the decision is made and I kind of rubber stamp the decision because that's how the hierarchy works…"* **(Hospital: Reflexivity session 3)**

When I discussed these clips with a higher stage specialty trainee ('Katie') who had worked on the ward (although was not there at the time of filming) she also recognised the clear role of the consultants as leaders and the different ways in which leadership was enacted in the two clips. She also noted physical positioning (see quote g). This identification of differing individual behaviours was a common theme discussed across the video-reflexivity sessions by nurses (reflexivity sessions 6 & 7) and AHPs (reflexivity sessions 1 & 6). Also commonly discussed within the reflexivity sessions were time pressure placed on both consultants by issues off the ward (see quote g).

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[54] CPR meaning cardio-pulmonary resuscitation

Quote (g):

"Katie*:…in Dr James's ward round he is the clear leader in that he sees the patients and makes a decision…in Dr Martin's ward round I think she (1.0) is clearly the leader again and takes on that role but perhaps more clearly looks at the whole team before, you know she's probably the leader of the whole team rather than just being, I'm not saying Dr James is paternalistic because it's not like that but…even just standing round the trolley there's more openness ... whereas the other videos were kind of writing over the trolley, speaking to the FY1 writing again, moving away so he can see the FY1's writing…they [the consultants] just have so much to do and I think that the way the hospital works is that they do board rounds on the other side of the hospital at 9 o clock and have patients in other wards…and then their clinics…"*

(**Hospital: Reflexivity Session 4**)

Contextual factors may also have had a part to play in the differences in leadership interactions between these two ward-round video clips. Different foundation trainees were present as well as a nurse and medical student being present on Dr Martins round. This clearly would produce a different interactional dynamic. Indeed when the ward round was discussed in a video-reflexivity session with Douglas he stated that he was not aware of differences between the two consultants in their approach to ward rounds (see quote (h) below). Within the reflexivity session Douglas also emphasised his own position as junior in the leader-follower relationship. He described his role within this work environment as very much task-focussed (quote (h) below).

Quote (h)

"Douglas: *….I can't think of any major striking differences between how Dr James did a his ward rounds and how Dr Martin did hers so they were quite similar…it's mainly just making sure that the paperwork is up to date…it's just making sure that all the information for the ward round is there for the consultant… usually from the ward round there would be like a set of jobs to be done…it's our job as junior doctors to try and carry out those jobs…"*
(**Hospital: Reflexivity Session 5)**

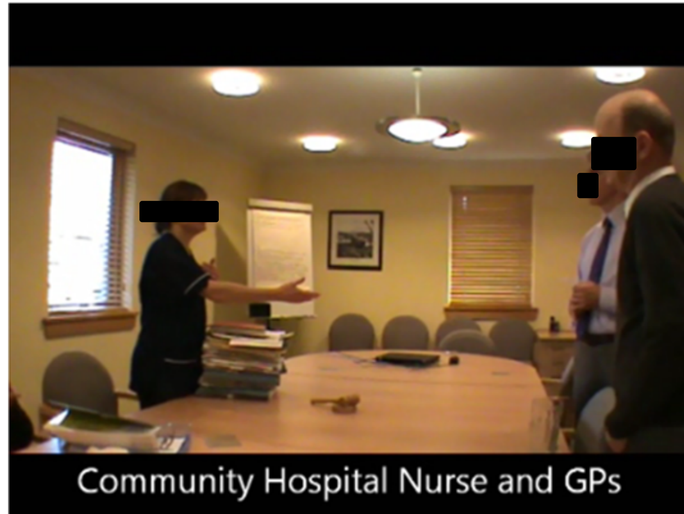
7.3.4 Negotiating change for the community hospital

[View video excerpt: Negotiating change for the community hospital]

This edited clip features a discussion between the Senior Charge Nurse at the community hospital 'Vicki' and two of the GPs ('Alan' and 'David') from Site A (see stills 7.13-7.15). The interaction takes place at the end of a weekly communication meeting in which a large number from the practice (GP, nursing, administrative staff and AHPs) have attended. The discussion is unplanned and occurs after most meeting attendees have left. The core subject of the discussion is the way in which the GPs input medically into the community hospital which had previously been highlighted to me during the observational phase as a system that Vicki would like to change (Box 7.4 below presents the transcript of this interaction).

This interaction represents the very early stages of a change to GP input to the community hospital that Vicki as senior charge nurse is trying to instigate. I would suggest that this clip depicts a conflict scenario because I can identify that the participants disagreed more than three times: in turn 2, Vicki begins the interaction by stating that she wishes to discuss how the nurses communicate to the GPs thus presenting the initial arguable action; Alan responds with initial opposition (turn 3) stating that there is a system in place already; then Vicki responds with counter-opposition by suggesting that this system is unsatisfactory (turn 4). GP David joins the discussion later whilst Suzy (the practice manager) and Christina (another GP) initially carry on a separate conversation and then later in the interaction observe.

Stills 7.13-7.15 Community Hospital Charge Nurse and GPs



Still 7.13: left to right Vicki, Alan and David

Still 7.14: Alan looks to David for support (Suzy on phone in background)

Still 7.15: Vicki says "Oh I see!"

Box 7.4: Transcript for negotiating change for the community hospital excerpt

Turns	Transcript**
	Left to right at beginning of clip another GP 'Christina', Practice manager 'Suzy', Vicki, Alan and David. Christina and Suzy are talking throughout the beginning of clip but the focus is on the interactions between Vicki, Alan and David.
1	**Vicki:** [standing in front of table beside a pile of patient notes opposite the table Alan and David who are also standing, See still 7.14] {talking slowly and clearly}**…how the nurses communicate to you** [gestures with whole right arm, palms upward between herself and the GPs] **about what it is that they want** [stands with palms open]
2	**Alan:** [Looking over at Suzy and Christina clasping fingers together] **Well we've got this system when the visiting doctor deals with anything that's urgent** [phone starts to ring in background]
3	**Vicki:** {talks more quickly and forcibly} **Yeah well but lots happens when they come in** [shrugs shoulders]
4	**Alan: ((Well the)) thing is if you're on to do all the day surgeries you might not actually** [moves hands apart] **have any time at all** [Vicki nods] **and it's one o'clock** [talk between Suzy and Christina gets louder as Suzy gets up to answer ringing phone] **and if you're visiting doctor you might have visits and you might not get back til 2 or 3. So anything that needs done before** [looks at David who tilts head slightly; still 7.15]
5	**Vicki: So it might be David's patient is ill** [lifts right arm up and points at David]
6	**Alan: ((mid-afternoon before we actually get there)) I don't know** [looks at David again and holds eye contact] **I know that's potentially how long it can take**
7	**Vicki: ((Uh-huh, I know))**[puts arm down]
8	**David: Yeah and sometimes it just is a bit crap but as long we understand why** [laughs while talking, Vicki laughs] **you know, it's less of an issue**
9	**Vicki: ((Yeah well it is for)) you but it's not for us cause sometimes it's something about something on a TPR and we feel we can't give it because it's not prescribed properly** [David takes a step back holding his plate and cup, Alan follows and also steps back holding arms across body] **there's no (.)**
10	**David: ((Yeah))**
11	**Vicki: is that what you mean by** {whispers} **crap** {laughs}
12	**David: Yeah, no, by crap I mean it's like it's just the system** [looks over at Suzy who is now off phone and standing beside Vicki] **isn't that great it's not**
13	**Vicki: ((Oh)) I see!** [smiling]
14	**David: ((Just the)) way we work it it's never going to be right**
15	**Vicki: I though you meant the nurses** [laughs]
16	**David: No, no ((all over talk and laughter))**[see still 7.16]
	****Editing notes:** **Written in bold:** Speech and who is talking

	(..) or (5.0)= indicates a pause durations either number of dots or number in brackets in seconds {} indicates a feature within the talk such as interruption or laughter (( )) double brackets indicate overlapping speech Written in [ ] are notes on physical actions within the clip

In my initial analysis, I identified that there was more than one leader in this interaction, Vicki, Alan and David are all trying to negotiate their own leadership by presenting their arguments either for or against the proposed change. In terms of followership, I coded the multi-disciplinary team as followers because there was more than one type of professional present. However, it could also be argued that there are no followers in this interaction as all three involved are trying to lead. The consequence in terms of the leadership processes that were occurring was, whilst I identified information exchange and leadership negotiation as the conversation moved from one participant to the other, no conclusion or ongoing plan is agreed. Thus, I would suggest that this conflict ended as a 'standoff' as there was no change in 'position' of those involved and the participants consent to stop opposing each other at the end of this interaction, perhaps because the subject of the discussion was a wider organisational issue that could not be decided by those present alone (Norrick and Spitz 2008). I later discovered that various actions had come out of this interaction, which I will discuss below when I present the reflexivity data corresponding to this clip.

In terms of second level analysis, I examined how this complex scenario unfolds by exploring the multiple interactional strategies used within this context. More specifically, I focus on physical positioning, the use of voice tone, over talk, laughter and humour.

In relation to physical positioning, throughout the clip the three participants maintain the same physical positioning; all standing, Vicki on one side of the table, standing behind a pile of notes and the two GPs on the other side (See still 7.13). Although this is serendipitous as this is where each participant was sitting during the preceding meeting, this adds to the confrontational feel that this interaction has. No participant attempts to change the dynamic of this general position by moving. The clip begins with Vicki explaining that she wants to talk about how the nurses at the community hospital communicate with the GPs in the practice (see turn 1). This does not begin as a confrontation and Vicki gestures with her palms open and turned upwards (see still 7.13). She accompanies this open unchallenging physical positioning with slow clear talk in a soft tone.

Alan responds by explaining the current system (turn 2). Although essentially Alan is disagreeing with Vicki that change is required, his physical positioning at this point seems relaxed and non-confrontational; his gestures are also open palmed. In turn 3, Vicki's voice tone changes and she talks more quickly as she responds to Alan by disagreeing with him. In turn 4, Alan continues his explanation of the current system and at this point he looks at David (Still 7.14). This could be seen as a way of bringing David into the discussion. He is rewarded with a slight head tilt from David which would appear to be agreement with Alan's argument. In response (turn 5), Vicki herself brings David into the conversation by pointing directly at him while she gives an example of a scenario in which she perceives this system to be problem. Unlike the non-confrontational palms-up gesture at the beginning of the interaction, pointing could be seen as a more challenging gesture. In turn 6, Alan looks at David once again holding his gaze seeking his support which this time he receives (turn 8). In turn 9, Vicki is now responding to David's comment, once again

disagreeing with what David has said and explaining the nurses' perspective. Whilst she is talking David takes a step backward and is quickly followed by Alan who folds his arms (defensively) across his body. This change in physical positioning could indicate a discomfort with the interaction and a desire to exit on the part of both GPs. In turn 12, David now looks over to Suzy who is off the phone and standing beside Vicki trying to involve her (as practice manager) in the discussion. At this point (turn 13) Vicki leans forward picking up the patient notes (still 7.15) indicating her own desire to terminate the interaction. Thus, through physical positioning all participants in this interaction consent to stop opposing each other (as discussed above) ending the interaction without resolution.

Over talk is a regular feature of this interaction (turns 4, 6, 7, 9 10, 13, 14 and 16). I would suggest that, in alignment with my analysis that there is more than one leader in this interaction, the over talk is used as an attempt to gain the floor and maintain control and involvement in the discussion.

Finally, I would suggest that humour and laughter are used in different ways within this interaction[55]. In turn 8, David uses the word 'crap' in reference to the system. He uses what could be construed as unprofessional language in an attempt to use humour to defuse the conflict (Norrick and Spitz 2008). He accompanies this comment with laughter, possibly to indicate that his comment is meant to be humorous. It may also be an attempt at aligning himself with Vicki. In response Vicki also laughs briefly at the use of the word 'crap'. However, David's desire to lighten the mood of the interaction backfires as Vicki misinterprets what David has said, thinking that David is referring to the nurses as 'crap' (as revealed in turn 15)

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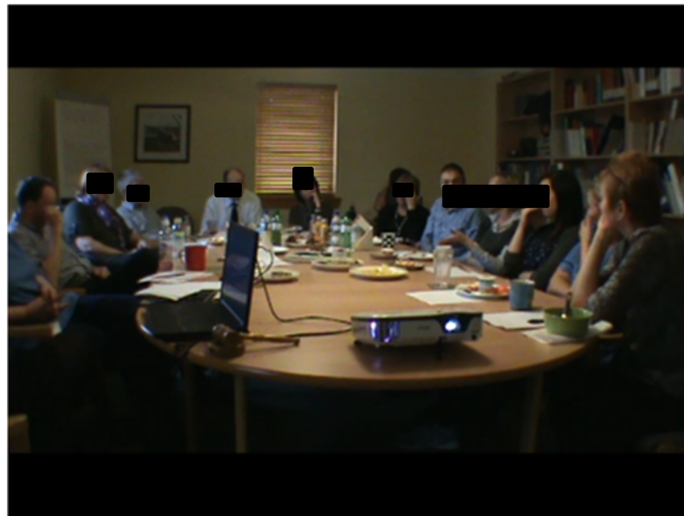
[55] Laughter has been seen to play a role in the articulation of student-clinical teacher power differentials in medical education (Rees and Monrouxe 2010a).

and responds with disagreement. Again, Vicki laughs briefly as she uses the word ‘crap’ (which she whispers). This laughter could indicate discomfort with the use of the expletive in a professional situation. The last use of laughter is towards the end of the interaction when Vicki realises she has misunderstood what David has said (turns 13, 15 and 16). At this point laughter along with physical positioning (as discussed above) serves to mollify the situation and leads to the end of the interaction.

When this clip was discussed within the reflexivity sessions 1 and 5 (see stills 7.16 and 7.17), participants recognised that this was a conflict scenario (Quotes (i) and (j) below):

Still 7.16: GP reflexivity session 1
Round table from left: researcher; staff nurse ‘Mel’; GP ‘Arthur’; Health visitor ‘Helen’; ‘Alan’; ‘David’; GP ‘Pam’; Male Medical student ‘Stewart’; ‘Suzy’; GP ‘Graham’; Pharmacist ‘Denise’; GPST1 ‘Laura’; Staff nurse ‘Naomi’; Health visitor ‘Rosemary’



Quote (i)
"***Graham:*** *Was there a misunderstanding about that? She seemed to say 'OH!'*
Alan: *When David said that's a bit crap meaning that we wouldn't always be available but I think she though he meant*
Rosemary:*... seemed to be clarifying what the system was so that both sides knew what was expected or what was possible*
Graham: *you had to backtrack a little bit because she was getting a bit accusatory she was saying 'are you saying you have a problem with what we are doing' is that right? [looks at Alan and David]*
David: *I think there was a misunderstanding of what was said that ehm generally its just rubbish and there's generally no way round it...* "
(GP reflexivity session 1: See still 7.17)

Still 7.17: GP reflexivity session 5
(from left to right) District Nurse 'Sally', GP 'Jason', senior charge nurse 'Vicki' and GPST3 'Elaine'

Quote (j)
"Vicki:... *I was saying well it might be crap for you but it's not for us... Essentially what we were talking about is the GPs response to patients who require GP review in the hospital...is very ad hoc and ehm I I was trying to suggest that we could make that a little bit better...."*
(GP reflexivity session 5: See still 7.17)

However viewing of the video on the video-reflexivity sessions provided opportunity for participants to reflect on why such a change was necessary. During the discussion GP trainee 'Elaine' came up with a potential solution (quote (k) below).

Quote (k):

*"**Elaine:** Maybe that's part of the problem though is the hospital doesn't really have a leader at the moment. Because Vicki's there and she's the senior charge nurse and it's her role to oversee things but perhaps there's too many cooks in terms of doctor involvement in the hospital and maybe it should be that one person takes a leadership role for the hospital and then Vicki would have a go to person if there was something at the hospital*
***Graham:** [looks at Alan] that's a very good idea"*

(GP: reflexivity session 1)

Similar to my own analysis of the excerpt, participants in the video-reflexivity sessions recognised that there seemed to be more than one leader in this scenario, or at least the desire to take on leadership by all participants, Vicki also saw it as her role as senior nurse to take on leadership (quote (l) below).

Quote (l):

***"David:** I think maybe we were all trying to be leaders"*
(GP: Reflexivity session 1)

***Vicki:** from the nursing perspective and from my senior charge nurse role I need to facilitate some sort of change that's going to suit the nursing role and the smooth management of the hospital..."* **(GP: Reflexivity session 5)**

Although they recognised the importance of this discussion, participants also identified that timing was important when instigating change leadership. There was a suggestion that having this discussion ad-hoc at the end of a meeting meant that Alan and David were not receptive to the notion of systems change. However, it was also acknowledged that this had opened up the discussion for change as a meeting had been arranged on the back of that (quote (m) below).

Quote (m):

*"**Graham**: …conversations like that often happen at the end of a meeting when folk are trying to get away [pharm nods and says Hmmm] and she has a serious point to make about is there any other way of doing...*
***Suzy**: from that we are having a meeting on Monday to discuss that has come out of that she coming on Monday to have a talk about how we can improve things...*
***Graham**: Because it just shows that having those little, (2.0) catching people when they're not really receptive doesn't work...to try and catch them to make a decision about how to change things at the end of a meeting when not everyone is around to discuss it…"*
(GP Reflexivity session 1)

Similarly, Vicki and Sally (senior district nurse) recognised that timing for this discussion was inhibitive to the leadership process (quote (n) below).

Quote (n):

*"**Sally**:...it's not the right eh, timing because they're under pressure, because [pretends to look at watch] they have 2 o'clock surgeries and whatever, you have to get back, it wasn't a planned meeting about*
***Vicki:** {interrupts} I didn't feel it was really up for discussion it was more a you know we were finished and it was a little add on and actually I thought 'I'm keeping them back here, I can't launch into something else…"*
(GP reflexivity session 5)

The video-reflexivity session in which Vicki discussed this clip followed the arranged meeting. Vicki had had the opportunity to present the change to the practice GPs and an open discussion had occurred. Vicki described that although the issue was recognised, there was requirement for her to do some auditing and get 'hard evidence' for the change (quote (o) below). Although for Vicki this was not ideal, as the change was not moving quickly enough for her, Vicki recognised that she was still developing relationships with the GPs (she had been in post for 6 months at the time of filming). In quote (o) below she also suggests that she as an individual affects the leadership process as she may be the first senior charge nurse that the community hospital has had that wants to talk about systems change. Interestingly,

despite the tense interaction described above, Vicki stated that she felt she had 'buy-in' from Alan and David, possibly as a result of their initial discussion.

Quote (o):

"***Vicki:**: So since then we did a session at the GP forum and presented it a bit more succinctly than that and ehm there was (.) a bit of a discussion about it, I'm not sure if we came to any solutions but (..) everybody was open to, to, acknowledged that it was an issue to some degree, and ehm, then I was sent away to do a bit of auditing… but I'm kind of feeling my way about. But I suppose I'm at that stage where I'm still building up relationships with ehm, the GPs and I'm kind of picking out GPs that I think I can get buy in from… and David was one of them and Alan I think is one… maybe because they've never had these discussions before, there's never been a, they've never had somebody come to them and say I want to speak about this in a non-clinical way"* **(GP reflexivity session 5)**

7.3.5 Leadership emergence from informal interactions

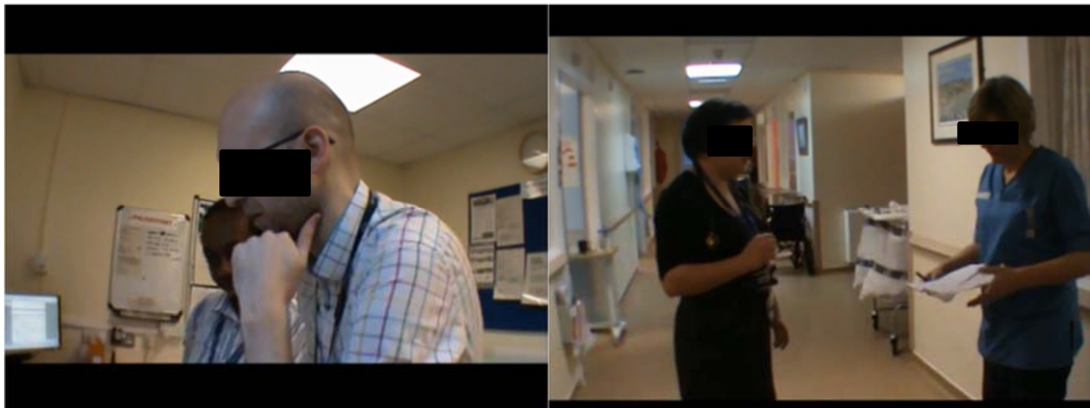
[View video excerpt: Informal interactions]

The four interactions presented in this section are an edited version of the thirteen informal interactions that participants viewed in reflexivity sessions in Site B (see Appendix L). It is important to note that the reason these clips have been chosen for this chapter is that the verbal interactions can be heard. Often, within these informal interactions talk was difficult, if not impossible, to hear due to background noise in various forms (this will be discussed further below).

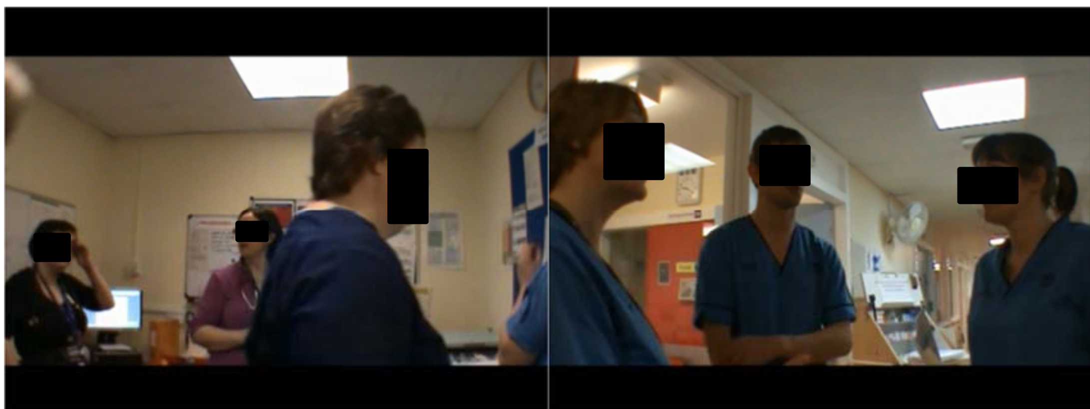
This video data will be explored differently from the clips I have presented in previous sections. I will focus on the discussions had within the reflexivity sessions in response to viewing these informal interactions. This excerpt depicts four informal interactions that I have identified as clinical leadership IAOs (see stills 7.18-7.21 and Box 7.5). Interaction 1 depicts a discussion between the ward pharmacist 'Jim' and foundation trainee 'Douglas', regarding a patient's medication (see still 7.18). Within this interaction I identified Jim as leader and Douglas as follower. In the

second interaction, foundation trainee ‘Anna’ takes the lead in a discussion with staff nurse ‘Pam’ about a patients discharge (see Still 7.19). Interaction three depicts a discussion amongst Senior Charge Nurse ‘Kathy’, staff nurse ‘Liz’ and consultant ‘Dr Martin’ about a patient who has been unsettled overnight (see Still 7.20). Within this interaction, I identified both Kathy and Dr Martin as taking leadership whilst the interprofessional team were undertaking followership. The final interaction depicts a discussion between ‘Jenny’ the physiotherapist, ‘Gary’ a visiting mental health occupational therapist (OT), and ‘Sandra’ the senior ward OT about a patient’s ability to undertake a home visit (See Still 21). Within this interaction, I identified both Jenny and Sandra as taking leadership whilst Gary is involved in the process as a follower.

Stills 7.18-7.21



Still 7.18 (from left): FY1 ‘Douglas’; pharmacist ‘Jim’ Still 7.19: (from left) FY1 ‘Anna’; staff nurse ‘Pam’



Still 7.20
(from left) FY ‘Anna’; Dr Martin; Charge Nurse ‘Kathy’; Staff nurse ‘Liz’

Still 7.21
(from left) OT ‘Sandra’; Mental Health OT ‘Gary’; Physiotherapist ‘Jenny’

Box 7.5 Transcript of informal interactions excerpt

Turns	Transcript**
	Interaction 1: Jim and Douglas close together looking at pharmacist's laptop screen. Laptop is placed on a high trolley which Jim is leaning on (see still 7.18). Nurses' voices can be heard in background throughout**.**
1	**Jim: No, no** [nods] **he is on 8- 500 now, but he was also on that when he came in**
2	**Douglas: OK**
3	**Jim: So I feel we should say that is stopped**
4	**Douglas:** [nods] **Yep**
5	**Jim: ((this was)) also the guy that I said was on bisoprolol before he came in** [looks at Douglas]
6	**Douglas: Ah right**
7	**Jim: bit it's been (1.0) it's disappeared**
	Interaction 2: Anna and Pam are in the corridor outside the patient bays discussing a possible patient discharge (see Still 7.19).
8	**Pam:**[looking at the piece of paper she is holding]**…so were are aiming for home tomorrow is that ((right))** [steps back and looks up at Anna]
9	**Anna: ((Yeah)) yeah, depending on her calcium but probably** [Pam is looking down flicking through paperwork] **so I've just scribbled off on the thing that** [makes a scribbling gesture with her right hand which is holding a pen]
10	**Pam: that's lovely right** [both start to walk away in opposite directions] **I'll go and {inaudible}**
11	**Anna: Thanks**
	Interaction 3: Setting is around the patients' notes trolley beside the doctors' desk and at the door of Kathy's office. Foundation trainee 'Anna' is in the background by doctors desk observing the interaction and staff nurse 'Liz' standing at notes trolley with her back to the camera (see still 7.20).
12	**Kathy:** [walking toward her office] **she** [the patient] **was bad the night before I think she was upset** [Pam walks past in front of shot, Dr. Martin, with one hand on notes trolley nods]
13	**Liz:** [not looking up from notes] **Eh was that overnight**
14	**Kathy:** [standing at the door of her office off-camera] **Overnight, I think she was up most of the night so** [Dr Martin nods and moves round to face Kathy]…[clip edited Kathy now in shot standing at the door of her office facing Dr Martin] **she can probably get one at lunchtime** [Liz walks off away from notes trolley toward nurses' station]
15	**Dr Martin: Ehm have you asked [mental health OT's name] the OT** [loud banging noise in background]
16	**Kathy: {interruption} yeah I thought they were going to come up yesterday** [walks out of

	office toward nurses station] **will I give them a buzz?**
	Interaction 4: Jenny, Sandra and Gary are standing outside a patient side room discussing a patient (see still 7.21). In background a buzzer is going off, there is an IV line alarm going and nurses talking.
17	**Jenny:** [shaking head] **she's so far off stairs**
18	**Gary: really**
19	**Sandra: ((but)) she had done stairs**[shaking head] **and she was independent on the stairs**
20	**Jenny:** [nodding] **((Yeah, yeah)) there's no she's just**
21	**Sandra: ((cause))** [looks at Gary] **I spoke to her about a home visit last week and we were talking about the beginning of this week but her mobility has deteriorated** [looks at Jenny, who nods]
22	**Gary: do you think she would manage a home visit?**
23	**Sandra:** [Jenny and Sandra both shake their heads] **No**
	****Editing notes:** **Written in bold:** Speech and who is talking (..) or (5.0)= indicates a pause durations either number of dots or number in brackets in seconds {} indicates a feature within the talk such as interruption or laughter (( )) double brackets indicate overlapping speech Written in [ ] are notes on physical actions within the clip

In terms of leadership processes, common across the four interactions depicted is information exchange and discussion and agreement of ongoing plans. I noted that leadership appeared to be negotiated according to the subject of discussion and who was in the best position to undertake leadership (this could be for various reasons including expertise; timing; patient needs etc.). Thus, leadership could be described as emergent as it was in immediate response to unpredictable situations. Across the whole dataset, I observed that leadership emergence included staff who would be considered to be in more junior positions in the traditional hierarchies, for example, foundation trainees or healthcare assistants. Within the interactions depicted above

leadership was negotiated through face to face communication, at times, with the support of artefacts (such as Jim's laptop in interaction 1).

In the reflexivity sessions, some participants also noted that leadership moved around according to the task in hand. Quote (p) below depicts a discussion between the two ward charge nurses ('Rhona' and 'Marilyn': quote (p) below):

> *Quote (p):*
>
> **"*Marilyn***...*each person's got their own little job in that it [leadership] moves along depending, it moves all day cause it can even be that when you go to the patients cause they're looking at you for that as well and the relatives when they come in and then it'll be a different interaction...it depends on what's happening*
> ***Rhoda:*** *every situation*
> ***Marilyn:*** *yeah, it depends what's happening"*
> **(Hospital reflexivity session 7)**

In quote (p) above Marilyn talks about leadership something that is moving around. Use of this language would suggest that Marilyn sees leadership as a process rather than something that belongs to an individual. Others identified these interactions as leaderless. It was perceived that the focus of these interactions was team working rather than leader-follower interactions, (which were conceptualised as hierarchical). Key to the success of these interactions was seen to be the sharing of information across professional groups. For some, hierarchies did exist but only within professional groups (for example, nursing and medicine) whilst between professional groupings there was perceived to be no hierarchy within these informal interactions (see quote (q) below).

Quote (q):

*"**Physiotherapist 'Sophie'**: not even so much leadership certainly between the [looks at OT 'Sandra'] AHPS[56] and the nurses [Sandra nods.] I mean it's all very much, you know, it's a sharing of information as opposed to any kind of delegations of tasks or anything...you saw it with the consultants they were delegating tasks to other members of their team whereas out with the teams, so interprofessionally...across the teams it was much more eh, not so much leadership as everyone was part of the team"*
(Hospital reflexivity session 1)

As a junior medical trainee, 'Douglas' saw this lack of leadership in the traditional sense as an opportunity to take on leadership himself (see quote (r) below):

Quote (r):

***"Douglas**:...it's is a bit of a free-for-all to be honest {laughs} ehm, I think the whole leadership thing especially when it comes to informal conversations just goes straight out the window…The whole kind of like leadership or seniority thing just kind of just goes out the window...we're all pretty much on the same level trying to achieve the same things...there's no kind of like leadership or hierarchy as such...it works better that way 'cause I think if there was kind of like a leadership role or even like a seniority kind of thing in the informal situations then it's it gets a bit more chaotic and more hectic because then you have to chase the person above you to get the decision...you spend more time chasing people asking for permission...rather than actually just getting the work done...the informal conversations there's no structure to it uhm it can happen any point any time so you kind of have to be a bit more, a bit more flexible whereas with the ward rounds and the MDTs* [meetings] *you've got more time to prepare things...with the informal things anything can happen...I think as a junior doctor there's more opportunities for it [leadership] to occur"*
(Hospital reflexivity session 5)

Within the quote above, Douglas talks about time being an important factor within these interactions, the leadership decisions were seen to be time sensitive and working through traditional hierarchies inhibitive to the flow of activity. For Douglas, this was in contrast to the more formal ward-based activities in which traditional hierarchies were present and there was time to prepare, when he saw

[56] AHP= Allied Health Professional

leadership (in the traditional role-focussed sense) as present. Time was discussed by other participants as a factor which influenced the leadership process when interacting informally (see quote (s) below).

Quote (s):

*"**Sandra:** in isolation a lot of it looks like disorganised chaos [laughter] and sometimes that's what it feels like you know there's so many different things going on*
***Sophie**: thing is so many things come up you know hour by hour, minute by minute*
***Sandra**: yes day to day*
***Sophie:** you can't really put a lid on it until you're in a meeting… you know 'this is the time for sharing information', it doesn't work like that"*
(Hospital Reflexivity Session 1)

Like Douglas, Sophie and Sandra see leadership happening as a result of immediate situational need (and thus emergent). Sandra also mentions the environment which she describes as 'disorganised chaos' many other's recognised the immediate environment to be affecting the leadership process. Some talked about having discussions 'on the move' (see Quotes (t) and (u) below), whilst others expressed that the surrounding noise levels (both human and non-human) had the potential to negatively affect leadership processes (see Quote (v) below).

Quotes (t) and (u), in particular Katie's, indicate there may be concern that undertaking conversations on the move may affect the leadership process negatively. Katie talked about how these mobile interactions in conjunction with the level of background distraction may have potential to affect important decision-making as it may be difficult to decipher from casual conversation. A concern shared by consultant 'Dr James' and physiotherapist 'Jenny' in a separate reflexivity session (see quote (v) below).

Quote (t):

*"**Douglas:** …conversations that happens round the corner...someone, like a nurse'll walk towards me they would ask me to do something and then they'll have to run off to see a patient and the conversation carry's on while they're running round the corner... it happens on a daily basis you just get used to it"* **(Hospital reflexivity session 5)**

Quote (u):

*"**Specialty trainee 'Katie':** ...there's a lot of toing and froing, there's a lot of talking going on when they're moving...you can see quite easily how something might not get done… it just always seems so noisy {laughs} I don't think you realise that at the time...a lot of those interactions just went on around that little square, you know the nurses station and the doctor desk and its true actually if you sit in that little area you can have umpteen conversations about different things and I suppose...you can be talking about very serious things and then just be having a casual conversation it's difficult to decipher out of all those interactions something that needs to be done there and then...…"***(Hospital reflexivity session 4)**

Quote (v):

*"**Consultant 'Dr James':** the buzzer is hellish... we're making decisions about whether people can go home or not whether they should go to a nursing home for the rest of their life… and we're making those decisions in this environment where the phone's going there are beeping noises people are answering the phone at the same time…*
***Jenny**:… it's easy to forget the magnitude of the decisions that are being made …and I think when it's in an environment like that I think sometimes more junior members of staff it does all seem quite casual I'd be concerned that they are losing the magnitude of you know the importance of that decision.*
(Hospital reflexivity session 3)

Wider systems were also seen to have an effect on the immediate working environment. In fact, Dr James discussed how decisions are made about the buzzer system (and other environmental factors: see quote (w) below).

Similar to the narrative shared in Chapter 5 by Carol (section 5.4.4) Dr James uses the pronoun 'they' to depict a separate group not within the immediate context of the

ward. Using the pronoun 'we' to describe the team within the ward environment creates the sense of separation between the two systems.

Quote (w):

*"**Dr James**: so many decisions are made that you know above us...the relative importance of a buzzer system but also the influences of the buzzers on decision making but also the patient's confusion*
***Me:** And where's that decision made?*
***Dr James:** We don't know they just make those decisions…"*
(Hospital reflexivity session 3)

Finally, good team working, communication and mutual support were identified to be facilitative of the emergent leadership processes depicted within the informal interactions. This was seen to be a particular strength of the team on the ward (see quote (x) below).

Quote (x):

*"**Gary**:...I think it's also...there's that expectation that you will work as a team...and more and more often now patients you get on [ward name] are very complex because the simple ones have been discharged from the medical ward….its complex rehab so you need that daily communication and a knowledge of everyone's roles and using them appropriately … it's always been a nice supportive place to work."*
(Hospital reflexivity session 6).

7.4 Reflexivity: an opportunity to lead change?

Finally within this chapter, I turn more specifically to the reflexivity sessions, to explore how they became a catalyst for change leadership. Most reflexive talk revolved around changing formal clinical activities. For example, the multidisciplinary meeting structure in site A (see quote (m) in section 8.3.4) or the ward round and the board rounds in site B (see quotes (y) and (z) below).

Quote (y):

*“**Consultant ‘Dr Martin’:** I was thinking just there gosh it’s brilliant when we've got the nurses [on the ward round] a lot of interaction goes on...I was just thinking a lot of the things I was interacting with them about there is really important...so I think I might insist {laughs}”*
(Hospital reflexivity session 3)

Quote (z):

*“**Rhoda:** [regarding the board round] the physio helper was over picking up notes, they weren't focused...they're all standing way back there*
***Marilyn**:…they're all back, yeah, we need them in a wee bit...*
***Rhoda** [to Marilyn]: at different times people are either inputting or they're not... that’s the whole point about the board round is that everybody inputs...there was so much going on...how can people concentrate*
***Marilyn**: I think it’s better just being the nurse that has that end [looks at Rhoda]*
***Rhoda**:... you could look at doing it in different ways...I don't think it helps [points out of senior charge nurse’s office towards the nurses’ station] that it’s out there…*
***Marilyn:** It’s a busy place to have the board round...but it’s the same in the other wards...[points to laptop where clips are being shown] gives you ideas for the board round doesn’t it...”*
(Hospital reflexivity session 7).

In quote (m), GP ‘Graham’ recognised how some conversations (that were regarded as important) were often tagged on to the end of MDT meetings when not everyone was around to discuss the issues. Through the discussion within this reflexivity session a need was identified for a forum in which these issues could be discussed. In quote (y), having watched the ward round clip in which she has a nurse present on her ward round, Dr Martin stated that she recognised the value of interdisciplinary communication within this context and decided that she would insist on nurse presence on ward rounds in the future. Finally, in quote (z) the two ward charge nurses spent time within the reflexivity session watching the board round clips (repeatedly) and through recognising that the current set up was not ideal for

discussion and decision-making about patients they discussed possible improvements.

Other reflexive talk included systems change as discussed previously within this chapter (in section 7.3.4). This data revealed the early stages of a systems change for the way in which the GPs inputted medically to the community hospital at site A. The reflexivity sessions provided opportunity to explore and discuss this potential of this change and make suggestions for improvement (for example, see quote (k) in section 7.3.4).

7.5 Conclusion

In conclusion, this chapter has provided a 'close-up' view of the video-data. As well description of the edited data and the reflexivity sessions, I provided an in-depth analysis of four different types of leadership interaction. To add a further layer to the analysis of leadership enactment, I included the discussions had within the reflexivity sessions about the clips. Finally, I explored in more detail how the reflexivity sessions acted as a catalyst for the consideration of change within participants' workplaces.

This concludes the results chapters of my thesis. In the following (and final) chapter within my thesis, I will bring together and discuss the preceding chapters.

CHAPTER 8: DISCUSSION

8.1 Introduction

In this final chapter of my thesis, I will bring together my research findings presented in Chapters 4-7 and discuss this in light of leadership theory, previous healthcare leadership research and leadership development in medical education. As discussed in Chapter 2, rather than searching for and depicting a single representation of leadership in healthcare, I have offered an assemblage of multiple 'leaderships' within this thesis (Mol and Law 2002). As such, within this chapter, rather than bringing together and articulating a neat account of what leadership in the healthcare workplace is, I continue to emphasise the multiple ways in which leadership is conceptualised, narrated and enacted. I also want to reiterate here that I draw on the concept of 'rhizomatic thinking', in that the conclusions within this chapter are grounded in my theoretical understandings and methodological choices (Deleuze and Guattari 1987). Thus, the readers of this thesis may come to different understandings and interpretations of the presented data.

In section 8.2, I summarise and discuss my research findings in relation to the three overarching research questions. In section 8.3, I reflect on the methodologies I used in my research. In section 8.4, I discuss the strengths and limitations of my research. In section 8.5, I discuss the educational implications of my research with specific focus on medical education. Finally in section 8.6, I discuss the implications for future research into leadership in healthcare.

8.2 Addressing the research questions

This section will explore each of the overarching research questions in turn. First, I summarise my research findings and then discuss them in relation to the theoretical

and research literature presented in Chapter 1. Throughout this section I will highlight the originality of my research and specify how my research adds to the current knowledge base.

8.2.1 RQ1 How do participants conceptualise leadership and followership?

The focus of this section is on the results reported in Chapter 4, which explored medical trainees' conceptualisations of leadership and followership in the interprofessional healthcare workplace. Box 8.1 below summarises the key findings I presented in Chapter 4.

Box 8.1 Summary of key findings from Chapter 4

- While definitions of leadership and followership were multidimensional, defining followership was difficult
- Whilst medical trainees drew on all four Discourses across the data, they were most likely to draw in an individualistic Discourse
- Trainees were more likely to use a relational Discourse in solicited talk. However, in unsolicited discussion, talk shifted to an individualistic Discourse
- Leadership was conceptualised differently according to training stage and different medical specialties

My research questions revealed multidimensional definitions of both leadership and followership, drawing on all four Discourses. However, the prevalence of the individualistic Discourse (particularly in unsolicited discussion) highlights that, similar to the research literature in healthcare, a focus on the leader's role dominates (for example, see Flin et al. 2006; Zelembo and Monterosso 2008; Palarca et al. 2010).

As mentioned in Box 8.1, trainees found followership more difficult to define. Use of the terms "follower" and "followership", although growing more common-place within contemporary leadership literature, are not widely utilised within healthcare

and healthcare educational spheres (Kean and Haycock-Stuart 2011; Uhl-Bien et al 2014). As discussed in Chapter 1 (see Section 1.3.1.3), I only found one study specifically related to followership in healthcare (Kean et al. 2011). However, the words are sometimes being substituted by "team" or "teamwork". For example, within the UK, the recently published "Healthcare Leadership Model" uses "team" and the promotion of "teamwork" when talking about leader-follower relationships (NHS Leadership Academy 2013).

The differences between solicited and unsolicited talk indicate that the relational Discourse found within the grey healthcare literature of a "shared" approach to leadership may influence how some medical trainees (in particular those at higher stages who have been exposed to compulsory formal leadership training) articulated their conceptualisations of leadership when directly asked (WHO 2009; NHS Education for Scotland 2013; The Kings Fund 2014). This was in contrast with unsolicited talk, which may reflect trainees' actual workplace experiences of leadership that seem to exemplify individualism. This finding echoes the work of Lingard et al. (2012) and Long et al. (2006), in which talk about a shared approaches to leadership were not necessarily enacted within the realities of the workplace. Similar influences have been found in medical students' understandings of professionalism and thus it highlights the importance of workplace experience in learning about leadership (Monrouxe et al. 2011).

A particularly original aspect of my study was the exploration of similarities and differences in conceptualisations of leadership between training stage and specialty. The differences between higher and early stage trainees may reflect the different foci in educational practices on trainees at different stages, although higher stage trainees

reflected concern about their transition certificate of completion of training (CCT: NHS Education for Scotland 2013). This transition is underexplored in medical education literature as the focus of medical transitions research has explored the phases of doctors at earlier stages of their training, most commonly the transition between medical school and first job (e.g. Roberts et al. 2009; Kilminster et al. 2011; Morrow et al. 2012; Illing et al. 2013; Monrouxe et al. 2014). My results would corroborate recent research that suggests that higher-stage trainees feel less able to take on non-clinical responsibilities including leadership and management issues (Brown et al 2009; Morrow et al. 2009; 2012; Westerman et al. 2013).

Highlighted by my research was the influence of context on conceptualisations of leadership. As Willcocks (2004) describes, many factors influence cultural context, thus it is perhaps unsurprising that differences in conceptualisations were identified between specialties. For example, surgery is notorious for its traditional hierarchical practices and the literature on surgical leadership (see section 1.3.1.1) describes using various tools to rate surgeons' leader behaviours including example setting and individual performance indicators (Yule et al 2008; Hendricksson-Parker et al. 2012; Bleakley et al. 2013). Educational practices within specialties may also influence conceptualisations of leadership and followership, for example, the focus on leadership as part of anaesthetic non-technical skills training (Flin et al. 2010).

In summary, addressing this research question through asking "what is leadership" and "what is followership" rather than "what" or "who" makes a good leader within the interviews and by exploring the Discourses that participants used, revealed new understandings of what leadership and followership means to medical trainees. Thus,

this aspect of my research moves beyond traditional research, focusing on behaviours, traits and skills (Fairhurst and Uhl-Bien 2012).

8.2.2 RQ2 How do participants narrate their experiences as leaders and followers?

Narratives were used by participants as sense-making tools to explore their experiences of leadership and followership within the healthcare workplace (Riessman 2008). Within Chapter 5, I began by presenting an overview of the personal incident narratives (PINs) collected in the interviews and reflexivity sessions before focussing on three exemplar narratives to explore how narrators constructed their identities as leaders and followers within their stories. Box 8.2 below summarises the key findings from Chapter 5. To my knowledge, no other study has explored narratives of leadership and followership in this way.

Box 8.2 Summary of key findings from chapter 5

- Participants most commonly drew on their experiences of clinical leadership within hospitals
- The narratives were evenly split between positive and negative experiences and were most often narrated from the position of followership
- Narratives about static leadership relationships were most often recounted
- Narratives about emergent leadership relationships were less commonly recounted, but were complex and had many facilitating and inhibiting factors
- Abuse narratives were the third most common content subtheme
- Narrators constructed their leader and follower identities not only through *what* they said within their narratives but also *how* they narrated their stories

Participants most commonly drew on their experiences of clinical leadership within hospitals in their narratives, despite the traditional notion that leadership is focussed on organisational change (Northouse 2013). Thus ‘leadership’ within these narratives were about ‘influential acts of organising’ (IAOs) that happened day-to-day in the

healthcare workplace (Hosking 1988). This finding is different from previous research into leadership stories which have focussed on the broader narratives of an organisation or the life story of an individual leader (Boje 2008; Cuno 2005). This could be explained by the recruitment of participants from out with traditional positions of organisational leadership, which meant their focus was on 'everyday' leadership experiences. Again, this adds to the originality of my work.

The even split in evaluations between positive and negative experiences could be due to the subject of discussion (leadership) in which the narrator may have felt the need to project a positive image of their leadership (Clifton 2014). I also questioned trainees in a way that may have prompted the even split through asking them to recall experiences that they would describe as good leadership or not so good leadership. This is in contrast to narratives about professionalism dilemmas and feedback experiences in medical education in which most narratives were evaluated negatively as they were solicited that way (For example, Monrouxe et al. 2014; Urquhart et al. 2014).

Participants most often narrated stories from the position of followership with 'static leadership relationships' the dominant content-related theme. The static leader-follower relationships described were mostly hierarchical and often uni-professional (i.e. within medicine), suggesting a traditional picture of the healthcare workplace. However, because leader behaviours were embedded within a narrative, they became part of a process in which participants described how leaders and followers related to each other within context. Yet, the focus of these narratives was leaders, whether stories were being recounted from the position of leader or follower. Followers

within these narratives were constructed as recipients of, and reactants to, these leader behaviours.

From the position of follower, narrators would evaluate whether these were 'good' or 'bad' leaders. Schyns and Miendl (2005) suggest that leaders are evaluated through followers' ideas about leadership that have been formed through previous experiences as part of the processes of professional socialisation. Leaders are thus linked to pre-existing prototypes (Lord et al. 2001; Uhl-Bien et al. 2014). Therefore the importance of the influence of early professional experience of leadership is highlighted through my research. Also, a workplace that perpetuates an early relational leadership Discourse, embedded in static leader-follower positions has the potential to be prescriptive about the division of labour and may be inflexible to innovation (Gronn 2002; Uhl-Bien et al. 2007; Uhl- Bien et al. 2014).

Less than a quarter of narratives were identified as emergent leadership relationship narratives, most of which were complex patient scenarios. Relating this to the different contexts articulated by Osborn et al. (2002) and Grint (2005), it can be suggested that complex patient scenarios or acute emergency scenarios (also commonly recounted) could be seen as 'non-linear' or 'wicked'. Thus, these contexts require emergent leadership relationships that potentially happen outwith traditional hierarchies (Lichtenstein and Plowman 2009). Many emergent narratives were also interprofessional, in which doctors stepped back from what was perceived to be traditional leader roles. Experience or knowledge placed an individual in the position of leadership regardless of hierarchical position. Key to these emergent leadership relationships was the assumption that actions were in the best interests of the patient

(and thus potentially these relationships are seen to be patient-centred). These findings shed new light onto the importance of workplace experiences of leadership.

Similar to MacIntosh et al.'s (2012) study, closer exploration of talk revealed how leadership identity was constructed. To my knowledge, however, different from any previous study, my focus was on how participants constructed their leader and follower identities through their narratives of specific leadership and followership incidents.

'Scott' and 'Carol's' narratives (see Sections 5.4.2 and 5.4.4) revealed unpredictable situations in which change (and learning) was required in response (Uhl-Bien et al, 2008). Through their narratives, both Scott and Carol constructed their identities as leaders out with formal positions, and thus leadership was 'emergent' (Uhl-Bien et al. 2008). Exploration of Scott and Carol's narratives also revealed the 'enabling' identities of their consultants, acting as a bridge between the administrative leadership structures within the organisation and the adaptive leadership required to solve the issues faced (Uhl-Bien et al. 2008). My structural narrative analysis revealed that Fitzgerald et al.'s (2013) notion of a 'hybrid leader' is a key role of the consultant in an emergent leadership context and may warrant further exploration. Complexity leadership theory suggests the need to pay attention to the 'space between' agents (Lichtenstein et al 2008; Dooley and Lichtenstein 2008). My structural narrative analysis revealed the potential for 'disconnect' between the emergent leadership expectations of the immediate context and the expectations of traditional medical hierarchies within the wider organisation.

Closer exploration of 'Alice's' abuse narrative (see section 5.4.3) revealed the potential implications of destructive leadership (Krasikova et al. 2013). Through

constructing a vivid identity as the victim of abuse, Alice's narrative illustrated the negative emotional and physical impact the incident had. Indeed, this narrative was recounted some years following the experience and clearly left a strong emotional effect illustrating how memory and emotion are entangled (Rees et al. 2013b). Narrated experiences of destructive leadership are reflected in findings from undergraduate studies, in which abuse within the healthcare workplace has been narrated by medical students and students from other healthcare professional groups (Rees and Monrouxe. 2011; Rees et al. 2013b; Monrouxe et al. 2014; Rees et al. 2014). It would appear that abuse continues to be experienced in the postgraduate sphere. To date, I am unaware of other research that has revealed narratives of abusive leader-follower relationships.

What was particularly original within the field of leadership research was my exploration of the process-orientated themes and how they related to the content of the narratives, for example, the use of metaphoric linguistic expressions. In previous leadership literature, metaphors have been used to describe leadership as an overall phenomenon, or to describe particular aspects of leadership (Alvesson and Spicer 2010; Fairhurst and Grant 2010).To my knowledge, no-one has explored how metaphors are used *within* narratives about leadership. Although systematic metaphor analysis was out with the scope of my thesis, paying attention to the metaphoric linguistic expressions gave me insight into how participants evaluated the leadership relationships they had experienced. Similar conceptual metaphors have been found in narratives that describe the student/doctor-patient relationship and the student-doctor feedback relationship (Rees et al. 2007; Rees et al 2009; Urquhart et al. 2014).

In summary, collecting and analysing narrative data provided me with new understandings of the multiple ways in which leadership and followership is experienced in the workplace. Exploring the interplay between both what the narratives contained and how the narratives were told, provided unique insights into how narrators constructed their identities as leaders or followers against the backdrop of a complex healthcare workplace.

8.2.3 RQ3 How is the leadership process enacted in interprofessional healthcare workplaces?

This section focusses on the results presented in Chapters 6 and 7. In Chapter 6, I presented an overview of the video-observational data I captured within two clinical sites (a GP practice and an elderly rehabilitation ward). Chapter 7 explored in more detail, four excerpts of interactional footage alongside data from the video-reflexivity discussions. Through these analyses, I was able to explore in detail how leadership was enacted in interprofessional healthcare workplaces and what factors facilitated or inhibited these processes. Box 8.3 below summarises the key findings from Chapters 6 and 7.

These data showed the huge number of 'influential acts of organising' (IAOs) that occur interprofessionally at a micro-system level outwith traditional organisational leadership structures, so called informal patterns of leadership (Lichtenstein and Plowman 2009). Similar to the interview data, I most often identified clinical IAOs.

Box 8.3 Key findings from Chapters 6 and 7

- Video-observation revealed that leadership was operating within an interprofessional complex adaptive system (CAS) through: large numbers of interactions occurring out with formal organisational leadership positions; the interconnection of micro systems with wider organisational systems; and the unpredictability of the core business of the system (patient care)
- Within these CASs, complexity leadership was enacted both formally through hierarchies and informally through emergent leadership
- IAOs are negotiated through social interaction between leaders and followers acting in context and typical features of these interactions were identified
- Linguistic and paralinguistic features were used to negotiate power and thus leadership
- Facilitators and inhibitors for leadership emergence were identified including: individual; contextual; relational; and systemic factors

My research suggests that leadership in healthcare is enacted within complex adaptive systems (CASs), something that is often discussed within the healthcare literature but seldom researched (Pslek and Wilson 2001; Kernick 2011; Weberg 2012). Within these CASs, many routine issues were resolved through the traditional medical and interprofessional hierarchies, demonstrated within the formal clinical IAOs I captured on video (Park 2005). However, I also recorded informal clinical IAOs in which leadership was emergent and came from outwith the traditional hierarchies (Uhl-Bien et al. 2008; Lichtenstein and Plowman 2009). These IAOs were negotiated through social interaction between leaders (either designated or emergent) and followers acting within context (Fairhurst and Uhl-Bien 2012).

Another original aspect of my research was to identify some of the typical interactional features that occurred within the IAOs. These highlighted the importance of communication of all types, in all directions, between team members. Similar to research out with leadership I found non-verbal, linguistic and

paralinguistic features prominent in negotiating power and therefore leader-follower relationships (Rees et al. 2013a).

The four sets of edited video-excerpts presented in Chapter 7 afforded more detailed exploration of leadership enactment through human-human interactions (verbal, non-verbal, paralinguistic and embodied) and human-to-material interactions. By analysing the visual aspects, I extend the work on how power is constructed in audio recorded interactions (Van der Zwet et al. 2014; Arber 2008). In other healthcare educational research, similar interactional strategies have been found to construct power relationships. For example, verbal strategies such as pronouns and directives have been used to construct power in medical student-patient-clinical teacher interactions (Rees and Monrouxe 2010a; Rees et al. 2013a). Outwith healthcare, Norrick and Spitz (2008) found that humour and laughter was used as a way of mitigating conflict. My work extends and brings new knowledge to this research as it specifically explored interprofessional leadership interactions within healthcare.

The context of the interactions was also revealed to be important. Outwith healthcare, context has been found to play a crucial role. For example, in the way directives are used (in terms of frequency and the ways in which directives are expressed) by New Zealand government workers (Vine 2009). To my knowledge, no-one has explored context as an integral part of leadership interaction in the interprofessional healthcare workplace.

Another original aspect of my research, was including within my results, the discussion in the reflexivity sessions which revealed factors that facilitated and inhibited leadership emergence. These factors included individuals, contexts, relationships, time, materials, systems and the environment. Some of the discussion

revealed the deeply entrenched values, beliefs and practices in relation to healthcare leadership (Long et al. 2006; Lingard et al. 2012; Chriem et al. 2013). This was made overt through the process of participants viewing themselves in practice during video-reflexivity (Long et al. 2006). This was very evident, for example, in the third excerpt (section 7.3.4), which depicted the initial stages of a change process. I would suggest that the context that the community hospital found itself in at this point was at 'the edge of chaos' and there was therefore a requirement for new learning and ways of working (Uhl-Bien et al. 2008; Osborn et al. 2002). Thus, this 'perturbation' in the system was made visible, first through the videoed interaction; and second through viewing this interaction and the consequential discussion within the video-reflexivity sessions. This enabled the team in the GP practice to see beyond original concepts and known solutions, setting the wheels in motion for change (Lord 2008; Uhl-Bien et al. 2008).

From a complexity leadership theoretical perspective, I could identify within the interactional data all three integrated forms of complexity leadership proposed by Uhl-Bien et al. (2008). That is, administrative, enabling and adaptive forms of leadership (see section 1.2.4). First, a*dministrative leadership* was enacted through the local policies and procedures present within each site, through paperwork and IT systems to which participants continuously referred to within the video footage. Specific incidences of administrative leadership were also identified within the data. Second, *enabling leadership* was enacted through the GPs and the practice manager in the GP practice and the consultants and senior nurses in the hospital ward. Through my data, I saw examples of how these individuals acted as a link between the local system and the wider organisational structures. This was augmented by boundary work, for example, through the consultants and senior nurses ensuring

internal practices within the ward were embedded within the wider macro-environment (see Section 7.3.3 quote (f): Chriem et al. 2013). Third, *adaptive* leadership was particularly evident, for example, in the informal interactions depicted in section 7.3.5 in which leadership could be described as emergent and adaptive to each situation (Uhl-Bien et al. 2008).

In summary, my 'wide-angled' and 'close-up' analysis of leadership as it was enacted in the workplace revealed that many individual, contextual, relational and material factors affect leadership enactment. The reflexivity sessions allowed me to explore the video-data in more depth alongside participants (and produced leadership enactment in their own right: something that will be discussed in section 8.3). The following section discusses the methodological strengths and limitations of my research.

8.3 Methodological strengths and limitations

To my knowledge, this is the first study that has sought to explore the emergence of leadership in the interprofessional healthcare workplace through exploring conceptualisations, narratives and the enactment of leadership. More specifically, this was done using a multi-phase study employing multiple methodologies and methods of data collection and analysis. Use of multiple methodologies enabled me to provide both a 'wide-angled' and 'close-up' view of the leadership process. The team-based approach to data analysis (through regular discussion with my research supervisors) encouraged research rigour. Both phases of my study were multisite and drew participants from a wide range of specialties and professions (in Phase 2). Therefore, I suggest that my findings are transferable to other UK contexts.

Using narrative inquiry provided opportunity for participants to evaluate and make sense of their experiences of leadership and followership (Chase 2005). This could lead to better understandings for participants of the multiple, constructed realities of leadership and followership in different healthcare contexts. Through their narratives, participants had the opportunity to develop their own voice as they constructed their stories, others' voices and multiple realities (Chase 2005). This was particularly valuable when considering that some narratives described workplace abuse and others that were also evaluated negatively. I suggest these narratives at times became 'acts of resistance', which challenged the traditional hierarchical modes of leadership (Rees and Monrouxe 2010b). This 'resistance' was arguably a conscious act to 'subvert' asymmetrical power relationships that were constructed through traditional healthcare hierarchies (Rees and Monrouxe 2010b: p. 433). Similarly, I suggest that my own narrative, presented within this thesis, created a 'collective voice' for participants' experience and in its own way could be seen to challenge the norm.

However my research is not without its limitations. I acknowledge the lower proportion of foundation doctors and non-white trainees within the interview phase, which may mean that the data is not transferable to these medical trainee groups. While using interview methods revealed a complex picture of leadership within the interprofessional healthcare workplace it also exposed a limitation in the interview study, in that I sought only to interview medical professionals. Broadening my narrative interviews to take in the whole interprofessional team would have enriched this data and should be a consideration for future interview research. My cross-sectional data did not allow for an exploration into how conceptualisations of

leadership change over time as doctors move through training and would be an interesting topic for further study.

In Phase 2 of my research, my presence in the interprofessional healthcare workplace with a video-camera could be described as 'interventionist ethnography'. The in-depth insight into leadership enactment in the interprofessional healthcare workplace is an advantage of this methodology which allowed me to visibilise practice in the moment rather than behaviours that were simplified or reassembled through memory (Mesman 2007; Iedema et al. 2007; Carrol et al. 2008). Using video allowed me to look at minute-by-minute interactions (i.e. micro-level interactions) and to some extent get a sense of meso-level interactions (through observations of regular occurrences such as ward rounds, board rounds and team meetings) within each workplace. Exploring the data at this level through identifying influential acts of organising (IAOs) revealed the intricacies of leadership enactment within the healthcare workplace context (Hosking 1988). For example, I was able to identify the embodiment of leadership through clothing and the control and use of artefacts. Previous observational studies of leadership in healthcare have either not used video to record leadership interactions (Lingard et al. 2012; Chriem et al. 2013), or have purposively sampled contexts seen to be atypical (Long et al. 2006; Denis et al. 2010). To my knowledge, this is the first study that has explored the enactment of leadership using interactional analysis of video-footage of everyday healthcare workplaces.

Despite this, I was also mindful of the extent to which participants would actively construct the interactions I captured, even though they appeared to be ignoring the camera (Lomax and Casey 1998). Different participants afforded different

prominence to the experience of being videoed, thus the process was at all times fluid and unplanned (Forsyth 2009). I suggest, therefore, that the video-camera became more than a mere recording device, but was a presence in the research in its own right, allowing participants to generate their own understandings about their workplaces and the leadership processes within them (Forsyth 2009).

Viewing the video-footage of their everyday workplace activities within the video-reflexivity sessions provided opportunity for participants not only to re-experience the complexities of their healthcare workplace, but also view it from a different aspect (Iedema et al. 2013). Through this, participants were 'confronted by the deeply familiar in a way that rendered it strange', empowering participants to explore possibilities for improvement and change that were contextually relevant (Iedema et al. 2007; Iedema et al. 2013: p. 8). Despite editing and compressing multiple interactions in time into short edited clips, a small piece of footage would elicit long discussion within the video-reflexivity sessions and lively description of their working lives (Iedema et al. 2013). Thus, participants would 'fill in the gaps' through their own experiences and familiarity of the contexts (Carrol 2009; Iedema et al. 2013). These multiple realities were co-constructed in discussion with me, who had spent time within their workplace contexts (Carrol 2009; Iedema et al. 2013). Thus, video-reflexivity also served to deepen my understandings of participants working practices and the processes that occurred during leadership interactions (Forsyth, 2009).

In addition, using video-reflexivity provided formal accountability for my own analysis and the framing of leadership interactions within the workplaces (Carrol 2009). To be captured on film alongside my participants put me in a new position as

researcher, blurring the distinction of the traditional researcher role (Forsyth 2009). As discussed in Chapter 2, I allowed myself to ‘boundary ride’ and embrace this new and uncertain position (Horsfall and Higgs 2011; Carrol 2009). By allowing this to happen I argue that the data collected provided opportunity for co-construction of meaning and significance of the video footage and as such served to enrich the results presented in Chapters 6 and 7 of my thesis (Iedema et al 2006; Carrol et al 2008).

Finally, I suggest that the video-reflexivity sessions facilitated leadership emergence. By viewing their own or their team’s working practices on video, video-reflexivity facilitated participants’ abilities to explore their work and revealed previously “unseen” habits and leadership processes that may not normally have been revealed (Iedema et al. 2006; Iedema et al. 2013). Through watching themselves and their colleagues on video, participants became both the “subject” and the “object”, in other words participants were able to detach themselves and consider how they may be seen by others (Iedema et al. 2013). Thus, using reflexivity within these sessions, allowed those in non-formal positions of leadership (for example, the GP trainee ‘Elaine’ in section 7.3.4) to explore change and innovation out with traditional hierarchical settings. In summary, the use of VRE allowed for engagement with leadership complexity, enabling the exploration of the whole workplace as a dynamic learning system (Iedema et al. 2009).

Although phase two of my study involved prolonged engagement with the workplaces I studied, I did not return to the workplace following the reflexivity sessions to explore whether participants’ experiences of VRE had changed practice

in any way. This would be an interesting adjunct to my research and would have added a longitudinal element.

8.4 Educational implications

In section 1.3.1.4 of this thesis, I explored the medical education literature on leadership development and found that leadership was typically seen as a skill to be learned or a set of behaviours to develop. This was done through, for the most part, courses which require individuals to come out of their workplaces in order to participate. Through my thesis, I suggest that this focus on leadership roles does not fully take into account the complexities of leadership as a process occurring within the context of the interprofessional healthcare workplace. This section will discuss the implications of my research on these traditional educational approaches to leadership development.

Key to the argument against these traditional approaches are two premises: first, the current theoretical premise that leadership is a fluid process that is relational and contextual would suggest that the focus only on individuals and the process of *leader* development rather than *leadership* development is not addressing the full picture of leadership. Second, my research shows that leadership is contextually bound and therefore I argue that a one-size-fits-all approach to leadership development fails to account for the wide ranging contexts in which people work.

Addressing RQ1 in the initial phase of my research showed that although conceptualisations of leadership were multidimensional, they were generally unsophisticated. I suggest that improvements in these conceptualisations could be made through sharing my research in an educational context to help learners develop more sophisticated understandings of leadership and help them recognise its

multidimensional nature. I also suggest that the concept of followership and its fluidity in context should be introduced within any educational development. My research also suggested that leadership development is relevant at all stages of a career and as such should be offered to early-stage trainees.

My research also highlighted a potential mismatch between the grey literature on leadership, which advocates a shared approach and actual workplace experiences (for example, The Kings Fund 2011-2014). Thus, leadership development should focus on the workplace as an educational setting with open discussion (for example, in small group situations) about this potential mismatch which could expose traditional individualistic leadership practices and serve to diminish them (Fraser and Greenhalgh 2001; Spilg et al. 2012). Exploration and reflection of similarities and differences between groups could also be discussed in such an educational context.

Addressing RQ2 highlighted the potential use of narratives for educational purposes. Use of narratives as part of the educational process through sharing of stories between learners would also provide opportunities for learners to evaluate and make sense of their leadership experiences and explore opportunities for ongoing development and build on their understandings of the leadership process (Fraser and Greenhalgh 2001).

Focussing on RQ3 in Phase 2 of my research highlighted the interprofessional nature of leadership in the healthcare workplace. Thus, I argue that my research emphasises the need for leadership development to be an interprofessional rather than uniprofessional activity. Providing interprofessional leadership education that is contextually relevant will encourage open discussion about professional boundaries and changing leadership processes which may break down traditional

interprofessional hierarchies. For example, leadership education situated in the workplace with the whole interprofessional team should be considered. From a complexity perspective, focusing on developing learners' understandings of the systems in which leadership works and emerges would help them move away from the notion that leadership is all about position within a hierarchy (Hernadez and Varkey 2008). In addition, this focus could help early-stage clinicians recognise the leadership processes in which they a*re* involved and pinpoint opportunities for leadership emergence.

In particular, I suggest that as well as a research methodology, VRE should be explored as having great potential for educational use. By viewing themselves in practice as part of the VRE stage of my research, participants explored opportunities for change and improvement through open discussion about their everyday work. This provided the ability for the teams to learn their way out of problems through reflexive discussion. Table 8.1 below summarises the key educational implications of my research.

Table 8.1 Educational implications

Relevant research question	Educational Implications
RQ1	1. Sharing the multi-dimensional nature of leadership and followership definitions 2. Leadership development is essential at all stages of a career
RQ 2	3. Small group teaching to share leadership experiences through Communities of Practice 4. Non-linear methods of learning through story-telling
RQ 3	5. Leadership education should be an interprofessional activity 6. Training in complexity leadership theory and lateral thinking 7. Consider the use of VRE as an educational strategy

8.5 Research implications

Finally within this chapter, I will articulate some recommendations for future research into leadership in the interprofessional healthcare workplace. My research demonstrated the value of undertaking a process-focussed approach to leadership research through insight into the multiple realities of leadership and followership (Uhl-Bien et al. 2014). My research illustrated the interprofessional nature of leadership processes in the healthcare workplace and as such, I would suggest that any future research should continue to be interprofessional.

The possibilities for longitudinal research should be explored as this type of research would provide insight into how leadership changes over time[57]. For example, a longitudinal VRE study would provide the potential to explore the impact of video-reflexivity on leadership practices within healthcare. Longitudinal work would also allow exploration of how macro-, meso- and micro-systems interrelate and interact within the healthcare organisational context and how the different leadership activities described in complexity leadership theory (administrative, enabling and adaptive) are enacted (Uhl-Bien et al. 2008).

8.7 Conclusion

To conclude, my thesis has explored leadership in the interprofessional healthcare workplace through the theoretical lens of complexity and multiplicity. Through my research, I have identified that leadership is not a single thing 'possessed' by individuals but involves many processes. My research has shown that the ways in which leadership is conceptualised, narrated and enacted is affected by many

[57] Following completion of this PhD, I will be undertaking a 2-year longitudinal study which will explore the transition of higher-stage medical trainees into trained positions (e.g. consultant or GP). As co-investigator, a large research grant has been secured through SMERC (funded by NES) to undertake this work.

aspects, including individuals, context, relationships and systems. I argue that my thesis calls for a redefinition of the way that we, as medical educators, facilitate leadership development education and for new approaches to research in this field, shifting the focus away from *leaders* to instead focusing on *leadership*.

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APPENDICES

Appendix A: Letters of ethical approval and institutional consents

Phase 1*:

<u>University of Dundee Ethical approval received by email 30/05/12:</u>

Dear Lisi,
Again, my sincerest apologies for taking so long to respond to your application.
The good news is that your study is approved. Many thanks for the very clear documentation.
The very best of luck with your research!
Best regards,
Astrid

Dr. Astrid Schloerscheidt
Chair, University of Dundee Ethics Committee

*Please note that this email was confirmed as formal ethical approval notification.

<u>Letter of approval NHS Highland received 27/09/12 (overleaf)</u>**

**Please note that all other organisations were happy to accept formal approval from University of Dundee.

Professor Angus Watson
Research & Development Director
NHS Highland Research & Development Office
Room S101
Centre for Health Science
Old Perth Road
Inverness
IV2 3JH

Tel: 01463 255822
Fax: 01463 255838
E-mail: angus.watson@nhs.net

24 September 2012 NHS Highland R&D ID: **873**

Mrs Lisi Gordon
Centre for medical Education
University fo Dundee
Taypark House,
484 perth Road
Dundee
DD2 1LR

Dear Mrs Gordon,

Management Approval for Non-Commercial Research

I am pleased to tell you that you now have Management Approval for the research project entitled: **'Exploring emergence of leadership involving medical trainees with an interprofesional workplace (Protocol V1, April 2012)**

I acknowledge that:

- The project is co-sponsored by University of Dundee.
- The project is funded by NHS Education for Scotland.
- Research Ethics Committee approval is not required for the project as it involves staff only.
- The Site-Specific Information form for this site has been reviewed (completed on 15/08/2012) and there is no objection to NHS Highland being included as a site for this project

The following conditions apply:

Headquarters:
NHS Highland, Assynt House, Beechwood Park, Inverness, IV2 3HG

Chairman: Mr Garry Coutts
Chief Executive: Elaine Mead
Highland NHS Board is the common name of Highland Health Board

- The responsibility for monitoring and auditing this project lies with university of Dundee.
- This study will be subject to ongoing monitoring for Research Governance purposes and may be audited to ensure compliance with the Research Governance Framework for Health and Community Care in Scotland (2006, 2nd Edition), however prior written notice of audit will be given.
- All amendments (minor or substantial) to the protocol should be copied to the NHS Highland Research and Development Office together with a copy of the corresponding approval letter.
- The paperwork concerning all incidents, adverse events and serious adverse events, thought to be attributable to participant's involvement in this project should be copied to the NHS Highland R&D Office.
- Monthly recruitment rates should be notified to the NHS Highland Research and Development Office, detailing date of recruitment and the participant trial ID number. This should be done by e-mail on the first week of the following month.

Please report the information detailed above, or any other changes in resources used, or staff involved in the project, to the NHS Highland Research and Development Manager, Frances Hines (01463 255822, frances.hines@nhs.net).

Yours sincerely,

Professor Angus Watson
NHS Highland Research and Development Director

cc Frances Hines, R&D Manager, NHS Highland Research & Development Office, Room S101, The Centre for Health Science, Old Perth Road, Inverness, IV2 3JH

Phase 2:

University of Dundee Ethical Approval email received 16/09/13***

Dear Lisi,

Many thanks for the clarification and the amended protocol. That is all fine and your study is approved.

Given that the places where you want to conduct the study are aware of the scope I will not need any further confirmation that you can go ahead. Usually we ask for this if research is to be conducted during participants' work time as we want to be sure that the individuals managing a place are aware that this is going on. The TASC letter simply confirms that you do not need REC approval but TASC cannot determine whether you should be allowed to use participants' work time to carry out your research.

Best regards,

Astrid

***Please note that this email was confirmed as formal ethical approval notification

Appendix B: Introductory email for Phase 1

Dear Doctor

I am undertaking a PhD research project which seeks to explore how leadership emerges within a workplace learning environment. You have been identified by the [North/East/West] deanery as a possible participant for a focus group discussion. I have enclosed further information about the study. If you wish to participate then please email me at l.j.gordon@dundee.ac.uk by [date]. I will then contact you further to arrange a date and time for focus group attendance.

Thank you for your time

Lisi Gordon

University of Dundee

Appendix C: Phase 1 flyer

Exploring the emergence of Leadership in the workplace involving medical trainees

Recruiting NOW!

This study aims to establish what leadership means to medical trainees and what their lived experience of leadership is. The findings from the study will help us understand how leadership emerges in the workplace.

We need doctors at all stages in their medical careers and training to participate in focus groups or individual interviews to tell us about their experiences of leadership and leadership development.

Sessions are taking place on [date.........] at [venue...........]

What's in it for You?

- You will get the chance to describe and share your experiences with peers.
- Participation in this research will provide unique insight into how leadership emerges within the inter-professional workplace learning environment
- Through better understanding of the workplace, improvements can be made and ultimately medical training practices can be improved
- Refreshment will be provided.
- You will get a Certificate of Participation.

We hope you will come and support our project. If you are interested in taking part, please contact: Lisi Gordon at l.j.gordon@dundee.ac.uk

Thanking you in anticipation and looking forward to meeting with you in the near future.

This project has been reviewed and approved by the University of Dundee Human Research Ethics Committee

Appendix D: Phase 1 participant information sheet

PARTICIPANT INFORMATION SHEET

(Version 1: April 2012)

Study title: Exploring the emergence of leadership involving medical trainees in the workplace

INVITATION TO TAKE PART IN A RESEARCH STUDY

You are invited to participate in a research study which aims to explore how leadership emerges within an interprofessional workplace learning environment. This research is being undertaken by me, Lisi Gordon as part of my PhD study which is being supervised by Professor Charlotte Rees (University of Dundee), Professor Jean Ker (University of Dundee) and Professor Jennifer Cleland (University of Aberdeen). This study is funded by NHS Education for Scotland as part of the Scottish Medical Education Research Consortium (SMERC).

What is the aim of the study?

This study aims to establish what leadership means to medical trainees and what their lived experience of leadership is. The findings from the study will help us understand how leadership emerges in the workplace and will inform the second part of my research project which aims to understand the processes that occur in the workplace which affect leadership emergence.

Who are we inviting to participate?

We are inviting doctors at all stages in their medical careers and training to participate.

What will participants be asked to do?

If you consent to participate in this study, you will be invited to attend a group discussion within your geographical area, which will include other doctors at different stages in their training and from different specialties.

If, for logistical reasons (for example geographical), you cannot attend the group discussion, you will have the opportunity to attend using video-conferencing or Skype. If this is not possible, you may be invited to individual interview.

On attendance and completion of written consent, you will be asked to complete an anonymous questionnaire which gives some details about yourself and asks you 3 questions regarding leadership for which you are asked to provide short written answers; a focus group schedule will also be provided at this point. The focus group will then be undertaken by me, Lisi Gordon, along with one of my supervisors. The discussion will be audio-recorded and analysed by the research team along with your short written responses and the researcher's notes.

Everything you say within the group discussion (or interview) will be kept anonymous and whilst we will be reporting on findings from the study in general, personal confidentiality will be maintained, with the exception of circumstances where it is likely to cause harm to you or others. In this case we will contact the appropriate authorities, but we will discuss this with you first. Please be aware that you may decide not to take part in this project without explanations and without any disadvantage to yourself of any kind.

Can participants change their mind or withdraw from the project?

You may withdraw from participation in the project at any time without explanation and without any disadvantage to yourself. If you choose to withdraw after participation, your data will be excluded in the final analysis.

How will data be used?

Audio-data will be transcribed and along with the written data from the questions you answered will be analysed by the research team (Lisi Gordon, Professor Charlotte Rees, Professor Jean Ker, University of Dundee and Professor Jennifer Cleland, University of Aberdeen).

Once data has been analysed, we will send a preliminary report to every participant, you will be given the opportunity to comment on these results before they are submitted for publication in any way. Data will be kept for 7 years following publication. Data will be stored under lock and key, or if electronic, password protected.

The whole data will be seen only by the research team. On publication, through my PhD thesis, in academic journals or through presentation at conferences, the data will be presented in a way that no-one will be able to link the data provided to your identity and name.

Are there any advantages or disadvantages to participation in this study?

Participation in this research will provide unique insight into how leadership emerges within the interprofessional workplace learning environment. We anticipate that some people will benefit personally from the opportunity to discuss information with others. However, others might find the issues discussed within the group upsetting. Through better understanding of the workplace, improvements can be made and ultimately patient care benefits.

How long will it take, what will I have to commit?

This study will require you to commit approximately one and a half hours plus travel time to attend the focus group session.

Your participation in this study is voluntary, refreshments will be provided and you will receive a certificate of attendance which may be useful for your portfolio or appraisal file.

What if participants have any questions?

I, Lisi Gordon, would be very happy to answer any questions you may have about this study. You can contact me by email at: l.j.gordon@dundee.ac.uk or by telephone 01382 381974

The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study.

Thank you for your time

Lisi Gordon
PhD Student
Centre for Medical Education
University of Dundee
Taypark House
484 Perth Rd
Dundee
DD2 1LR

e-mail: l.j.gordon@dundee.ac.uk
Tel: 01382 381974

Appendix E: Phase 1 consent form and Participant Details Questionnaire

CONSENT FORM

(Version 1: April 2012)

Exploring the emergence of leadership involving medical trainees in the interprofessional workplace

I have read the information sheet concerning this project and understand what it is all about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1. My participation in this project is entirely voluntary Y/N
2. I am free to withdraw from the project at any time without explanation and without any disadvantage Y/N
3. The discussions will be audio-recorded Y/N
4. Any raw data on which the results of the project depend will be retained in secure storage. Audiotapes will be kept in accordance with the research governance policies and destroyed 7 years after the study has been published Y/N
5. The project involves open-questioning technique and I have the right to decline to answer particular questions Y/N
6. My participation should not lead to any significant harm/discomfort or any benefit Y/N
7. The results of the project may be used for educational purposes but my anonymity and that of my Deanery will be preserved Y/N

I agree to take part in this study Y/N

______________________________ ________________

Participant's signature Date

Participant's name Participants e-mail

Signature of person obtaining consent Date

Name Date

This study has been approved by the University of Dundee Human Research Ethics Committee

Exploring the emergence of leadership involving medical trainees in the interprofessional workplace

Written Data Sheet

(Verson 2: August 2012)

Thank you for consenting to take part in this research project. Before our focus group discussion begins, please can you take some time to complete the following written data sheet?

If you do not wish to answer a question then please leave blank.

Thank you once again.

1. Are you a Foundation Year doctor (FY)? **Yes** **No**
   If yes, what year **FY1** **FY2**
   Which programme are you on?____
   (Please now move to question 4)
2. Are you a Specialty trainee? **Yes** **No**

   If yes, what speciality do you work in and which year are you?_______________

3. Do you hold a national training number? Yes No

4. Are you currently out of programme? Yes No

   If yes, what are you currently doing?____

   At which level did you come out of programme?______________________________

5. What hours do you work? (please circle) **Full-time** **Part-time**

6. What is your gender? (please circle) **Male** **Female**

7. What do you consider to be your ethnic origin?

8. Where did you receive your medical degree?(please circle)

   In UK **Outside UK**

9. Do you hold any other qualifications (e.g. intercalated degree or degree prior to medicine
10. What is your age? (please circle) **20-29 30-39 40-49 50-59 60-69 70+**
11. Have you had any formal leadership training? **Yes** **No**

    If yes, can you provide details

    ---

12. Do you have any needs in relation to leadership development?
13. Do you hold any roles or positions that you consider a "leadership position"? If so, can you please specify what these roles are and what they entail?
14. What is your understanding of the term 'leadership'?
15. What is your understanding of the term 'followership'?

Please use this space to provide any additional comments:

Thank you

Lisi Gordon, PhD Student, University of Dundee

This study has been approved by the University of Dundee Human Research Ethics Committee

Appendix F: Structure of Medical Education Research Executive 2011-2014

SMERC is a consortium between NHS Education for Scotland (NES), the University of Dundee (Centre for Medical Education and the Health Informatics Centre), and the Universities of Aberdeen, Glasgow, Edinburgh and St Andrews. Although the consortium began its groundwork in September 2011, we were officially launched at NES' Second Medical Education Conference in Edinburgh in May 2012. It aims to produce internationally excellent research that has local, national and international impact on medical education through two main objectives:

1. To facilitate the data collection, analysis and reporting of routinely collected medical education data such as the national training surveys.
2. To develop, conduct and disseminate a programme of original, significant, and rigorous medical education research on two themes: workforce and workplace.

Ultimately, these two objectives should help understand the workplace learning environment better and inform understanding about how best to improve the quality of doctors' training. SMERC should also act as a catalyst to build bridges across the medical education continuum including undergraduate, Foundation and specialty training.

Key achievements for Phase 1 of SMERC (September 2011 – August 2014) include the successful:

- Building of relationships, governance structures, communication and education research capacity.
- Completion of four nationwide medical education research projects: (1) Online surveys with multiple stakeholders to identify priorities for medical education research in Scotland for the next five years; (2) Understanding push-pull factors in medical careers decision-making in Scotland and England (funded by NHS Education for Scotland); (3) A qualitative evaluation of the new supervised learning events in the UK Foundation Programme (funded by the AoMRC); (4) Exploring UK stakeholders' views and experiences about graduates' preparedness for practice to inform Tomorrow's Doctors (funded by the GMC).
- Progress of two PhD studentships: (1) Exploring the emergence of leadership in inter-professional teams involving medical trainees; (2) Exploring support for newly qualified doctors through placement transitions in the Foundation programme.

The medical education research executive (MERE) is part of SMERC and in Phase 1 its purpose was to support and develop collaborative medical education research projects. It consisted of representation from each of the 5 medical schools, the Director (Professor Charlotte Rees), representation from NES, and the researchers funded by SMERC (including post-doctoral research fellows and PhD students).

Appendix G: Phase 2 Initial site information

Understanding leadership in the interprofessional workplace

Researcher Details: My name is Lisi Gordon and I have 20 years of experience within healthcare, initially as a physiotherapist and then moving into healthcare education. I am currently a full-time PhD student in medical education at the Centre for Medical Education at the University of Dundee.

Project background: This study is the second of two phases and is funded by NHS Education for Scotland (NES) through the Scottish Medical Education Research Consortium (SMERC). The aim of my work is to better understand how leadership emerges in the interprofessional workplace and how medical trainees learn about and develop leadership. Within the first study, I undertook a series of group and individual interviews with medical trainees discussing with them their understandings, experiences and development needs in relation to leadership in the interprofessional workplace. It became clear that trainees experience and interpret leadership differently in different contexts.

Proposal: On the basis of my first study, I would like to observe a range of interprofessional workplace environments to which medical trainees belong with a focus on leadership within the interprofessional team. I plan to use a range of data collection methods, all of which will be negotiated between myself and the interprofessional teams who participate. These may include observation and fieldnotes, audio-recorded interviewing, video and/or audio-recorded observation (of non-patient contact e.g. meetings or teaching sessions) and team reflexivity sessions (using the video and audio-recorded materials as triggers for discussion). Please note that the focus of my work is not on the clinical practice of the team members but on the environment in which team members work.

The benefits of taking part: Literature suggests that this type of research within the healthcare workplace provides opportunity for interprofessional healthcare teams to reflect on their working practices that can lead to improved systems that ultimately have a positive impact on patient care.

What now: I would like to come and discuss with you the possibility of your workplace taking part in my study and discuss any questions/concerns you may have. Please note that this in no way obliges you to take part. If in the meantime, you wanted to contact me, please email at: l.j.gordon@dundee.ac.uk or phone me on **07515 702709.**

Appendix H: Phase 2 participant information sheet

PARTICIPANT INFORMATION SHEET
(Version 1: August 2013)

Study title: Exploring the emergence of leadership involving medical trainees in the workplace

Researcher Details: My name is Lisi Gordon and I have 20 years of experience within healthcare, initially as a physiotherapist and then moving into healthcare education. I am currently a full-time PhD student in medical education at the Centre for Medical Education at the University of Dundee.

INVITATION TO TAKE PART IN A RESEARCH STUDY

You are invited to participate in my research study which aims to explore how leadership emerges within an interprofessional workplace learning environment. This research is being undertaken by me, Lisi Gordon as part of my PhD study which is being supervised by Professor Charlotte Rees (University of Dundee), Professor Jean Ker (University of Dundee) and Professor Jennifer Cleland (University of Aberdeen). This study is funded by NHS Education for Scotland as part of the Scottish Medical Education Research Consortium (SMERC).

What is the aim of the study?

This study aims to explore leadership in the interprofessional workplace and what factors affect how leadership is developed. The findings from the study will inform healthcare educators about how leadership can be developed.

Who are we inviting to participate?

We are inviting all members of the interdisciplinary team within your workplace to participate.

What will participants be asked to do?

- The study will involve Lisi observing and filming within your workplace.
- At first, Lisi will spend time within your workplace at various times during the working week (including out of hours) in an observational role. Lisi will be making field notes.
- Please note that the focus of Lisi's research is not on your clinical performance but is on interactions between staff.
- Following this initial observation phase, filming will occur of planned interdisciplinary interactions during times of **non-patient contact**, for example, multidisciplinary meetings, handover or teaching sessions. Lisi will discuss and agree with the interdisciplinary team what should be filmed and everyone will be

consented prior to filming. Lisi will use a "handy-cam" and filming will take place in a "fly on the wall style" in that Lisi will not speak during the filming session.
- No patient contact will be filmed
- The video observation footage will then be edited into a shorter film and you will be invited to attend either a group or individual discussion to view this film and share your experiences and feelings about the footage. This is known as video reflexivity.
- The video reflexivity session will also be video-recorded.
- Prior to any observation, filming or reflexivity session, consent will be revisited verbally and at this point you can refuse to take part.

Can participants change their mind or withdraw from the project?
You may withdraw from participation in the project at any time without explanation and without any disadvantage to yourself. If this is prior to the reflexivity film being shown in a reflexivity session, your footage will be removed or where this is not reasonably practicable every effort will be made to de-identify the footage. However, if your workplace video footage has already formed part of the reflexivity film it will be impossible to remove you from this footage.

How will data be used?
The edited observation footage for the video reflexivity sessions and the video recording of the reflexivity session will be analysed along with the transcribed observational notes. This will be done by the research team (Lisi Gordon, Professor Charlotte Rees, Professor Jean Ker, University of Dundee and Professor Jennifer Cleland, University of Aberdeen). Data will be kept for 7 years following publication. Data will be stored under lock and key, or if electronic, password protected.
The whole data will be seen only by the research team. On publication, through my PhD thesis, in academic journals or through presentation at conferences, transcriptions of the data will be presented in a way that no-one will be able to link the data provided to your identity and name. In the case of video footage, if you consent to the video footage being used for educational and dissemination purposes then you will be identifiable. Prior to the first time I use this footage for these purposes, I will seek your permission either verbally of by email.

Are there any advantages or disadvantages to participation in this study?
Participation in this research will provide unique insight into how leadership emerges within the interprofessional workplace learning environment. We anticipate that some people will benefit personally from the opportunity to discuss information with others. However, others might find the issues discussed within the group unsettling. If this is the case we can discuss any further actions you wish to take.

It is hoped that through a better understanding of the workplace, we will be able to derive educational implications from the study that improve leadership development.

What if participants have any questions?
I, Lisi Gordon, would be very happy to answer any questions you may have about this study. You can contact me by email at: l.j.gordon@dundee.ac.uk or by telephone 01382 381974

The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study.

Thank you for your time.

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This study has been approved by the University of Dundee Human Research Ethics Committee

Appendix I: Phase 2 consent form and participant details questionnaire

CONSENT FORM

(Version 1: August 2013)

Exploring the emergence of leadership involving medical trainees in the interprofessional workplace

I have read the information sheet concerning this project and understand what it is all about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage. **Y/N**

I know that:

1. My participation in this project is entirely voluntary **Y/N**
2. I am free to withdraw from the project at any time without explanation and without any disadvantage **Y/N**
3. If I withdraw consent, before the reflexivity session any video footage taken of me will not be retained by the researcher. **Y/N**
4. If I withdraw consent, after the reflexivity session, any video footage that has already been utilised as part of a reflexivity film it cannot be withdrawn and will still be used. **Y/N**

I understand that:

5. I may be observed in the clinical workplace by the researcher who will be taking field notes **Y/N**
6. The focus of the workplace observation is leadership in the interprofessional workplace **Y/N**
7. Specific interactions for example multidisciplinary meetings or teaching sessions will be video-recorded **Y/N**
8. As well as this written consent form, on-going verbal consent will be sought by the researcher before any video recording takes place **Y/N**

9. Video footage will be used within group reflexivity sessions in order to stimulate group discussion **Y/N**
10. The group reflexivity sessions will also be video-recorded, with permission **Y/N**
11. Any raw data on which the results of the project depend will be retained in secure storage. Data will be kept in accordance with the research governance policies and destroyed 7 years after the study has been published **Y/N**
12. The group discussion will involve open-questioning technique and I have the right to decline to answer particular questions **Y/N**
13. My participation should not lead to any significant harm/discomfort or any benefit **Y/N**

Please Initial

I agree to take part in this study ☐

I agree to being observed without video in the workplace ☐

I agree to being observed with video in the workplace ☐

I agree to participate in a video-recorded-reflexivity session ☐

I agree to my video/audio being used for reflexivity sessions ☐

I agree to my video/audio being used for educational purposes ☐

I agree to my video/audio or still images being used for research dissemination including conferences and publications ☐

______________________________	________________
Participant's signature	Date
______________________________	________________
Participant's name	Participants e-mail
______________________________	________________
Signature of person obtaining consent	Date

This study has been approved by the University of Dundee Human Research Ethics Committee

Exploring the emergence of leadership involving medical trainees in the interprofessional workplace
Personal Details Questionaire
(Verson 1: August 2013)

Thank you for consenting to take part in this research project. Please can you take some time to complete the following personal details questionaire? This helps us define the characteristics of our participants.If you do not wish to answer a question then please leave blank.Thank you once again.

1. What is your job title? ____
2. What is your professional background?______________________________
3. How many years' experience do you have in this profession?_____________
4. What hours do you work? (please circle) **Full-time** **Part-time**
5. What is your gender? (please circle) **Male** **Female**
6. What do you consider to be your ethnic origin?

   ____

7. What is your age? (please circle) **20-29** **30-39** **40-49** **50-59** **60-69** **70+**
8. Have you had any formal leadership training (this could be either within or outwith your workplace)? **Yes** **No**

   If yes, can you provide details____

9. Do you hold any roles or positions that you consider a "leadership position"? If so, can you please specify what these roles are and what they entail? **Please use this space to provide any additional comments:**

Thank you
Lisi Gordon, PhD Student, University of Dundee

Appendix J: Phase 1 interview schedule

Exploring the emergence of leadership involving medical trainees in the interprofessional workplace

Focus group schedule

(Version 1: April 2012)

Welcome:

Welcome and thank you for volunteering for this study. We acknowledge how busy you are and really appreciate the time you have taken.

You have been invited to participate in this study which constitutes part of my PhD in which I want to explore how leadership emerges in the interprofessional workplace. I am interested in finding out what your understanding of leadership is and what your experiences of leadership and followership have been.

I am keen to encourage you to respond to other people's comments and stories with comments thoughts and stories of your own. I hope that we can do this in a manner in which everyone feels they have had the opportunity to be heard without being judged.

Introductions

Turn on audio-tape (make sure everyone is aware this is happening)

First I would like to go round the group to give the opportunity for everyone to introduce themselves. If you could tell us who you are and where you work, I will start...[researcher will give a brief introduction about herself].

Anonymity and right to withdraw

- The discussion will be audio-recorded, but I would like to assure you that the discussion will be anonymous.
- Following the discussion, the tapes will be transcribed and you will each be assigned a participant number and so will remain anonymous.
- The files will be kept securely and I would like to remind you that you have the right to withdraw at any time.
- If you do not wish to answer a question then you do not have to. If you find anything that we have discussed upsetting we can discuss further how this can be addressed (for example, a discussion with your supervisor).

Ground rules

Before we begin, I wonder if we could take a few minutes to set some ground rules (may want to write them up on a flip chart). Does anyone want to begin with suggestions? **Allow participants to take the lead. What we wish to include are:**

- Ensure focus is on the subject at hand (leadership in the workplace)
- Care should be taken not to disclose names/patients names/identifiable characteristics of other people involved in any situations described
- Confidentiality between participants i.e. not to be discussed outside the group
- Only one person speaks at a time
- You do not have to speak in a particular order
- Please do speak up when you have something to say, it is important that I get the views of all of you
- There are no right or wrong answers, all ponts are valid
- You may not agree with the views of others in the group, however we wish to avoid direct challenges.

Does anyone have any further questions before we start?

What do participants define as leadership and followership?

To kick the discussion off, I would like you all to think about leadership in the workplace and what this means to you. I have given you the opportunity to write down some thoughts at the beginning of this session. I wonder if we could expand on these a little. Who would like to get the ball rolling?

Facilitative questions may include:

- Is leadership/followership within your workplace necessary?
- Who do you think the leaders/followers are in your workplace?
- Can leadership/followership be learned?

What are medical trainees' experiences of leadership and followership?

Focus in this section will be on getting participants to provide examples of their experiences of leadership and followership. Some example questions to facilitate discussion may include:

- I wonder if we could expand this discussion a little by asking you to give me some memorable examples of experiences of leadership and followership you might have had since starting this training year?
- Who was there?
- What was your role?
- Who was the leader in this situation and who was/were the followers?
- What was good or bad about this experience?
- How did you respond to this experience?
- Can anyone comment on this experience and/or provide similar examples?

- How do these experiences affect your understanding of what leadership is and how you develop leadership? What did you learn about leadership from this experience?

What do medical trainees perceive they need in terms of leadership development?

This section will aim to elicit understanding from participants about perceived need in terms of leadership development. Examples of questions include:

- Do you perceive that you have any training needs in terms of leadership development?
- How do you think these needs should be met?
- How should a formal leadership curriculum be taught?
- How can your leadership development be assessed/supervised?

Conclusion

Thank you for participating. I think that this discussion has been very successful. Does anyone have anything they wish to add to the discussion before I conclude?

Appendix K: Overall coding framework

Section A: Understandings of leadership and followership. The themes in this section describe what medical trainees and other healthcare professionals say leadership and followership is through data obtained within 4 contexts: when directly asked what leadership and followership is within the interviews, group discussions and reflexive sessions; what they wrote on pre-interview data sheets in response to the same direct questions; how respondents specifically describe leadership and followership within general discussion; and specific definitions of leadership and followership within personal and general incident narratives.
Theme 1: Leadership Dimensions
Leadership as:
1.1 Behaviour: Leadership is described as a set of behaviours.
1.2 Role: Leadership is described as being part of the role of doctor i.e. ‘doctor as leader’
1.3 Hierarchy: Leadership was talked about as something that is part of the medical or interprofessional hierarchy.
1.4 Group process: This dimension is focussed on team working both uni-professional and inter-professional.
1.5 Personality: Examples of this are participants talk about dominant personalities or individuals being “natural” leaders.
1.6 Principles and values: Participants talk about a leader being fair, approachable, coaching and supportive, and allowing followers to develop and learn.
1.7 Responsibility: The person who has ultimate clinical responsibility within a given situation was perceived to be the leader.
1.8 Skills: Participants describe that a leader or leadership requires skills e.g. negotiation skills, delegation skills. This differs from behaviours in that there is explicit mention of skills.
1.9 Emergent: The focus of this dimension is the dynamic nature of leadership as a process; trainees talk about “stepping forward” or “stepping back” as a leader according to context and team present.
1.10 Management: Participants will talk about management roles being part of leadership. The two terms can be conflated.
1.11 Knowledge: Participants describe a leader or leadership as being in the possession of specific knowledge, often clinical knowledge.
1.12 Gender: In the data participants talked about issues such as workplace culture and gender or specifically talked about gender issues or used he/she when talking about leadership in the abstract. In these situations, leadership was seen as male and followership as female.
1.13 Exclusive: Participants describe leadership as something that is not for everybody.
1.14 Not management: Participants specifically identify that leadership and management are not necessarily the same but are instead, separate entities.
1.15 Followership: Participants talked about those they perceived to be leaders in name taking a followership role
Theme 2: Followership Dimensions
Followership as:
2.1 Behaviour: This dimension is focussed on followership being a set of behaviours of an individual which participants perceive to be typical within the healthcare workplace.
2.2 Active participant: This is concerned with followers being active participants in the leadership process.
2.3 Group process: This dimension describes participants’ understandings of the role that followers have to play within a team.
2.4 Unknown term: Here, trainees explicitly state that “followership” is an unknown term
2.5 Passive: In contrast to active participant, participants see followership as passive.

2.6 Hierarchy: Participants link followership to the medical hierarchy.
2.7 Personality: Participants talk about followership as something relating to someone's personality, often seen to be lacking leadership traits and therefore by default a follower.
2.8 Role: Participants are talking about interprofessional roles and expectations of who should lead and who should follow e.g. doctors as leaders and nurses as followers.
2.9 Non-leadership: This dimension is concerned with participants describing followership as the default position when someone is not a leader, also described as the "opposite" of leadership.
2.10 Negative: Participants describe followership and being a follower as having negative connotations.
2.11 Emergent: This dimension is concerned with the dynamic nature of followership. Within this participants describe "stepping back" into a followership role in a context or situation where it is more appropriate for someone else within the team to take the lead.
2.12 Responsibility: Within this dimension, participants talk about the responsibilities of the follower.
2.13 Responsibility free: Within this dimension participants describe followers as people who have no responsibility.
Theme 3: Discourses of leadership and followership Coding the Discourses of leadership and followership allows me to compare whether certain groups of participants (e.g. GP vs surgical, medical vs non-medical early vs higher stage) conceptualise leadership and followership in similar or different ways. It also allows us to compare the participants' Discourses within the interviews and group discussions with the Discourses of leadership and followership that are presented in the academic and non-academic leadership literature.
3.1 Individualistic Discourse: This code aligns itself with individualistic theories of leadership. The focus here is on the leadership traits, skills, behaviours etc of the individual.
3.2 Contextual Discourse: The focus of the contextual Discourse of leadership and followership is the context or situation that the participant describes.
3.3 Relational Discourse: The focus of the relationship Discourse of leadership and followership is on the interpersonal relationship and social interaction between leader and follower.
3.4 Complexity Discourse: Within the complexity discourse, it is not the individual, the relationships, the context or the team that defines what leadership is but a complex interplay between all that make leadership and followership dynamic entities that shift across time and emerge or are negotiated according to a situation that can change from minute to minute, hour to hour or day to day.
Theme 4: The context within the discussion in which leadership and followership is conceptualised The final theme within this section is concerned with when within the discussion, leadership and followership is conceptualised. As described in themes 1 and 2, there are 4 contexts in which data were gathered which pertained to specific definitions of leadership and followership: when directly asked what leadership and followership is within the interviews, group discussions and reflexive sessions; what they wrote in the data sheets in response to the same direct questions; how respondents describe leadership and followership within the general discussion; and how leadership and followership is defined within personal and general incident narratives. By identifying when these definitions occur allows us to analyse whether there are differences between conceptualisations of leadership and followership when participants are directly asked compared to how they define leadership and followership within their lived experiences etc.
4.1 Solicited conceptualisations of leadership: This theme concerns how participants conceptualise leadership when directly asked what their understanding of leadership is during the discussion and what they have written on the data sheets in response to the same direct question.

4.2 Solicited conceptualisations of followership: This theme concerns how medical trainees conceptualise followership when directly asked what their understanding of followership is during the discussion and what they have written on the data sheets in response to the same direct question.
4.3 Unsolicited conceptualisations of leadership: This theme concerns data which pertains to how leadership is specifically defined within the context of personal and general incident narratives and through general discussion.
4.4 Unsolicited conceptualisations of followership: This theme concerns data which pertains to how followership is specifically defined within the context of personal and general incident narratives and through general discussion.
Section C: Narrative codes This section of the coding framework is concerned with the overarching research questions "What are participants' experiences of leadership and followership?" and "How does leadership emerge in the interprofessional workplace and what factors influence that emergence?" Data relevant to this section is obtained through narrative interviewing techniques in which participants were asked for stories of leadership and followership and narratives offered spontaneously within the reflexivity sessions.
Theme 5: Overall narrative codes
5.1. Personal Incident Narrative (PIN): This relates to one (or more) participants telling a story of a specific event. Each PIN will be coded in its entirety and all codes related to the PIN will be allocated to the entire PIN.
Theme 6: Contextual codes (for both narratives and video observation) These contextual themes provide opportunity for the leadership and followership events (both narrative and Influential Acts of Organising (IAOs) from video data) to be quantified.
Theme 6.1: Setting
Subthemes
6.1.1 Hospital: This includes all aspects of secondary care e.g. surgical, medical, theatre, laboratories, accident and emergency, radiology etc. All narratives and IAOs should be coded to one of these higher order themes as well as the themes below (if possible to identify context in more detail)
6.1.1.1 Hospital: Nurses' station
6.1.1.2 Hospital: White board
6.1.1.3 Hospital: Corridor Corridor interactions outside bays, outside hospital ward etc
6.1.1.4 Hospital: Doctors' desk
6.1.1.5 Hospital: Charge Nurse's office
6.1.1.6 Hospital: Storage room off ward Interactions occur off ward in a room used for storage and also multidisciplinary meetings
6.1.2 GP practice: The primary setting is a GP practice. *All narratives and IAOs should be coded to one of these higher order themes as well as the themes below (if possible to identify context in more detail)*
6.1.2.1 GP practice: Meeting room
6.1.2.2 GP practice: Reception
6.1.2.3 GP Practice: consultation room
6.1.2.4 GP Practice: Practice manager's office
6.1.3 Community hospital: The setting is within a community hospital. This is different from the hospital setting in that community hospitals are part of the primary care setting and are often medically staffed by GP practices. *All narratives and IAOs should be coded to one of these higher order themes as well as the themes below (if possible to identify context in more detail).*
6.1.3.1 Community hospital: Ward office
6.1.3.2 Community hospital: Treatment room.
6.1.4 Outwith healthcare: This refers to PINs that have occurred out with the healthcare

workplace, although they may be directly relevant to healthcare or include healthcare professionals, e.g. a story told at a surgical dinner. *All narratives and IAOs should be coded to one of these higher order themes as well as the themes below (if possible to identify context in more detail).*
6.1.5 Exact venue not stated: This is where it is not clear where the narrative took place. *All narratives and IAOs should be coded to one of these higher order themes as well as the themes below (if possible to identify context in more detail).*
Theme 6.2: Who the leaders and followers are within the narratives
Subthemes
6.2.1 Narrator position in story: Primary narrator as follower.
6.2.2 Narrator position in story: Primary narrator as leader
6.2.3 Narrator position in story: Primary narrator as both leader and follower
6.2.4 Narrator position in story: Primary narrator as observer
6.2.5 Narrator position in story: Primary narrator recounting someone else's story
Theme 6.3: Primary narrator job role at time of story
Subtheme
6.3.1 Medical: Higher stage specialty trainee
6.3.2 Medical: Early stage trainee
6.3.3 Medical: Unclear training stage
6.3.4 Medical: CCT
6.3.5 Medical: Out of programme
6.3.6 Medical: Student
6.3.7 Non-medical: Nursing
6.3.8 Non-medical: Allied Health Professional (AHP) Including physiotherapy, occupational therapy, pharmacy etc.
6.3.9 Non-clinical: support staff Including GP receptionists, practice manager, ward clerk etc.
6.3.10 Non-medical: Social work
6.3.11 Narrator as patient
Theme 6.4: Activity type This theme describes the primary activity that is occurring during the narratives or observed interactions. Observed interactions can be either formal (or planned) or informal (unplanned).
Subthemes
6.4.1 Primary Activity: Complex patient scenario A patient care scenario which is deemed to be out of the ordinary. An example may be, a junior doctor describing the management of a patient with an unusual diagnosis not normally seen in the specific specialty context. *However, this does not include an acute emergency scenario which would be coded separately to the acute emergency scenario code.*
6.4.2 Primary Activity: Acute emergency scenario Examples of this include cardiac arrest scenario, obstetric emergencies, patient management within A and E.
6.4.3 Primary Activity: Routine patient care This is when participants narrate situations in which routine patient care is being undertaken.
6.4.4 Primary Activity: Management This is when trainees describe leadership within the context of a management activity for example, rota management, holiday planning, and audit. Trainees in these circumstances can be conflating leadership and management.
6.4.5 Primary Activity: Formal clinical activity This refers to: (1) planned multidisciplinary (MDT) meetings in which more than one professional group are present to discuss patient care, (2)handover meetings in which patient care is "handed over" between professionals for example at the end of a shift (at this point information tends to be passed between professionals either uni- or interprofessionally

regarding patient status and ongoing care), (3) Ward rounds which are the formal processes of medical professionals going round visiting each patient's bedside and discussing care. This can take a range of different forms from the traditional "grand round" style in which the consultant leads a group of doctors including students and nurses around the ward to less formal situations.

6.4.6 Primary Activity: Educational
This covers both formal and informal teaching activities. This includes teaching sessions, ward-based teaching sessions, bedside teaching, specific workshops/courses/training programmes.

6.4.7 Primary Activity: Teamworking
Within this code, the primary activity is teamworking e.g. this would involve communication practices between team members or a specific incident.

6.4.8 Primary Activity: change project
This refers to PINs in which participants describe leadership in relation to a specific change project.

6.4.9 Primary Activity: Patient transfer
This refers to PINs that are recounted or interactions that are observed in which the discussion is focussed around patient transfer. This could include transfer between specialties e.g. A and E to medicine, from hospital to hospital, or from primary to secondary care.

6.4.10 Primary Activity: Feeding back about leader
This refers to PINs when the primary activity is about providing feedback about a leader. This could be in the form of a paper exercise, an informal meeting etc.

6.4.11 Primary Activity: Research supervision
This refers to scenarios in which participants describe the leader-follower relationship as a research supervisor-researcher relationship.

6.4.12 Primary Activity: Disciplinary procedure
This refers to specific incidences in which participants describe a disciplinary procedure being undertaken.

6.4.13 Primary activity: Laboratory work:
The primary activity is laboratory work that is not research work (this would be coded as research supervision above).

Theme 6.5: Timing of experience within working week.

Subtheme

6.5.1 Timing of experience: Normal working hours
This is typically during the day between the hours of 8 and 6, Monday to Friday.

6.5.2 Timing of experience: Out of hours
This includes evenings, nights, weekends and bank holidays.

6.5.3 Timing of experience: timing unclear
The timing of the incident is not specifically stated by the narrator.

Theme 6.6: Evaluation of event by primary narrator

Subtheme

6.6.1 Evaluation: Positive
The PIN is evaluated by the narrator as a positive experience, usually through use of positive language within the PIN

6.6.2 Evaluation: Negative
The PIN is evaluated by the narrator as a negative experience, usually through use of negative language within the PIN.

6.6.3 Evaluation: Contradictory, both positive and negative
The narrator uses both positive and negative language at different points within the PIN as the PIN unfolds.

6.6.4 Evaluation: Neutral
The PIN is evaluated as neutral in that the narrator uses neither strongly positive or negative

language.
6.6.5 Evaluation: Unclear It is unclear within the PIN how the narrator has evaluated this experience.
Theme 7: Content of narratives Within this section we identify codes for the nub of the narrative that the participants are conveying through recounting a PIN.
Theme 7.1 Static leadership relationships Leader-follower relationships were a dominant subject of participant narratives. Participants describe within their narratives how relationships with others in the workplace affect the process of leadership. Who the leaders are and who the followers are seen as static, often based on traditional roles and hierarchies within the healthcare workplace. The codes below describe key features within the narratives that trainees perceive to be facilitative and inhibitive to good leadership relationships.
Subtheme
7.1.1 Static leadership relationships: fostering constructive team-working Uni- and interprofessional team working that is collaborative and perceived to be conducive to good patient care.
7.1.2 Static leadership relationships: inhibiting team working Participants describe instances of poor team working: Uni and inter professional, often conflict/disagreement described or lack of inclusivity
7.1.3 Static leadership relationships: collective decision-making Decision-making is done through sharing group goals, all team members working towards the same goal, and appropriate allocation of tasks.
7.1.4 Static leadership relationships: conflictive decision-making Trainees describe those perceived to be leaders in conflict/disagreement with each other about patient care.
7.1.5 Static leadership relationships: supportive dialogue or behaviours In this subtheme, leaders are perceived to take part in supportive behaviours or dialogue through revealing fallibility, listening, accommodating, being fair, responsive, or showing empathy.
7.1.6 Static leadership relationships: unsupportive behaviours or lack of dialogue Leaders are perceived to be unsupportive and lack dialogue between leaders and followers. This is done through being unfair, not admitting fallibility, not listening, unresponsive or not showing empathy
7.1.7 Static leadership relationships: identified through traditional clinical roles For example, Doctor as leader, nurse as follower
7.1.8 Static leadership relationships: identified through traditional hierarchies The most senior person present was seen to automatically take the lead. This was assumes through traditional medical or inter professional hierarchies.
7.1.9 Static leadership relationships: effective, based on clearly defined roles Where roles within a situation are defined often as a result of having time to prepare for the situation For example,a multiple trauma coming into Accident and Emergency.
7.1.10 Static leadership relationships: ineffective due to unclear role definition Described in situations when there is a perceived lack of leadership or when too many people are trying to take on the leadership role.
7.1.11 Static leadership relationships: effective, based on practiced protocols Often related to cardiac arrest scenarios in which protocols are practiced and the scenario is seen to “run” “smoothly” due to repeated practice of these scenarios.
7.1.12 Static leadership relationships: abusive Abuse was constructes through actions of the leaders including, undermining, verbal abuse, physical abuse, humiliation and/or criticism

Theme 7.2 Emergent leadership relationships
Theme 7.2 Emergent leadership relationships This set of codes describe leadership as an emergent process in which participants recount how a combination of individuals, context, relationships, time, space and systems affect who emerges as the leader in the narrative. Often trainees will describe themselves and/or others within a narrative as both a leader and a follower. Although leadership emergence can be seen as a product of a range of factors, the codes below describe the most dominant factor which has led to leadership emergence.
Subtheme
7.2.1 Emergent leadership relationships: facilitated by individual knowledge or experience An individual will "step into" leadership based on previous experience or knowledge. Leadership can sometimes come from unexpected sources and does not necessarily follow traditional hierarchies.
7.2.2 Emergent leadership relationships: inhibited by lack of knowledge or experience Trainees describe an individual who "steps into" the leadership role but is unable to take on that role due to lack of experience or knowledge.
7.2.3 Emergent leadership relationships: facilitated by lack of engagement of expected leader. Trainees describe being "pushed into" a leadership role due to lack of engagement of a perceived leader. The perceived leader can "hand leadership back to the junior". In contrast to the previous codes, trainees are not actively seeking to take on leadership but circumstances require them to.
7.2.4 Emergent leadership relationships: facilitated by timing Due to timing of incident trainees will take on leadership e.g. at night.
7.2.5 Emergent leadership relationships: facilitated by systems and protocols For example, trainees use protocols to support a change in clinical care and take on leadership.
7.2.6 Emergent leadership relationships: inhibited by systems and protocols Where systems do not allow leadership to emerge e.g. consultant to consultant referral systems. Often linked to perceptions of traditional medical hierarchies.
Section D: Video observation codes/reflexivity session codes This section is concerned with the overarching research question "How does leadership emerge in the interprofessional workplace and what factors influence that emergence?" Data coded within this section comes from the video observational data and the video reflexivity sessions (also video data) when participants are talking specifically about the clips they observe or discussing their workplace. This allows us to compare researcher analysis with participant analysis of the video observation data.
Theme 8: Influential Acts of Organising (IAO) This theme identifies within the video data points at which the process of "leadership" occurs in context. This term is based on the premise that leadership is a complex relational process that occurs between leaders and followers in context with any actor undertaking the process of leadership at any one time (Fairhurst and Uhl-Bien, 2012). Within this theme codes will also identify different types of influential acts. Similar to coding narratives, these codes will be coded to a wider piece of video which take in the moments leading up to the "influential act" and the moments following. Within this theme, the IAO will be further coded (using the codes above and below) in more detail to take in who is involved, what activity is being undertaken, the process that is undertaken, the context and the way in which actors interact with each other. This theme will also be coded to a whole narrative in which an IAO occurs.
8.1 IAO: Clinical leadership Within this subtheme the IAO is occurring during clinical activities.
8.2 IAO: Educational leadership Within this subtheme the IAO is occurring during educational activities.
8.3 IAO: Administrative leadership

Within this subtheme the IAO is occurring during administrative/managerial activities e.g. appointment management in GP practice or bed planning in a ward.
8.4 IAO: change leadership Within this subtheme the IAO is occurring in response to a proposed change.
Theme 9: Observed or narrated Leader/s This theme identifies who the leader/s are within the interaction involving an IAO. This is coded to the whole IAO or narrative. These codes can also be used within the reflexivity sessions to identify who participants see as the leaders in the clips. This allows us to compare researcher analysis with participant analysis. We will be able to identify which data this theme and the following theme are related to through the primary documents.
9.1 CCT as leader
9.2 Specialty trainee as leader
9.3 Foundation trainee as leader
9.4 Nurse as leader
9.5 AHP as leader
9.6 Clinical support staff as leader This could include Health Care Assistants, physio assistants etc.
9.7 Administrative staff as leader This includes practice manager, GP receptionists, ward clerk etc.
9.8 More than one leader
Theme 10: Observed or narrated Follower/s This theme identifies who the follower/s are within the interaction involving an IAO. This is coded to the whole IAO or narrative. This code may also be used in reflexivity session when participants are discussing the clips. This allows us to compare researcher analysis with participant analysis.
10.1 CCT as follower
10.2 Specialty trainee as follower
10.3 Foundation trainee as follower
10.4 Medical student as follower
10.5 Nurse/s as follower/s
10.6 Health Care Assistant as follower
10.7 Multidisciplinary Team as followers
10.8 Medical trainees as followers
10.9 Allied Health Professionals as follower/s
10.10 Administrative staff as follower/s
10.11 Nursing student/s as follower/s
Theme 11: Specific leadership process codes This theme aims breaks down the processes that occur during leadership. Within an IAO there may be a range of processes that are occurring. This theme should only be coded to the relevant parts WITHIN the IAO. This will allow for a picture to be built up of the process of leadership. This theme can also be coded to discussion within the reflexivity sessions about the video. Participants may offer these codes as part of their analysis of the clips and will allow us to compare researcher analysis with participant analysis.
11.1 Information exchange Within the observation video. An exchange of information between actors will be observed, for example, clinical information about patients.
11.2 Leadership negotiation Negotiation of who will lead often follows information exchange. In this subtheme, leaders and followers negotiate and then "grant" leadership to the most appropriate team member to take on the leadership role. This may be due to what information is exchanged prior to this. This granting may happen overtly through direct designation of role or covertly through questioning or non-verbal interactions (coded below).
11.3 Non-negotiation of leadership: hierarchy

In this subtheme, there is no leadership negotiation and leadership is assumed through professional or inter professional hierarchies. This granting may happen overtly through designation of role or covertly through questioning.
11.4 Volunteering to take on leadership In this subtheme, a participant will volunteer to be leader.
11.5 Agreement of plan In this subtheme, followers and leaders will agree a plan of action of what is needed to carry out the IAO decision for example ongoing treatment of a complex patient. Followers will actively contribute to the planning this could be through questioning, confirmation by verbally repeating their understanding of the required tasks or contribution to final decision.
11.6 Passive compliance with plan In this theme, followers can be seen to passively comply with the IAO, without offering opinion, planning, or any discussion. This could be related to hierarchy themes.
Theme 12: Interactional observations This theme allows us to make note of the interactional data within the video observation. Codes within this theme should be coded to only to the relevant part within the IAO. Codes within this theme will be added to during analysis.
12.1 Eye contact
12.2 Lack of eye contact Often this will be because participants are looking at notes.
12.3 Physical Positioning
12.4 Directives
12.5 Challenging others/disagreeing
12.6 Questioning
12.7 Lack of engagement with IAO
12.8 Engaging whilst others interact
12.9 Active listening
12.10 Eating during IAO
12.11 Not face to face via information technology (IT)
Theme 13: Material Aspects within video observation
13.1 Background noise Background noise noted within observations but also discussed within the reflexivity session.
13.2 Control and use of Artefacts For example who has the notes, who sits at the computer, using a pen to point.
Section E: Reflexivity sessions The codes within this section specifically relate to discussion within the reflexivity sessions which cannot be coded above. This is due to the discussion that occurs that is not directly related to what participants observe in the clips, definitions of leadership and followership or specific narratives which will be coded using the themes previously described. It is however related to leadership in their workplaces.
Theme 14: Phasal codes Phasal codes pay attention to the rhythm of the discussion (O'Halloran, 2011). Within the reflexivity sessions talk moved through different phases, some related to the videos, some related to leadership etc. Coding the different phases within the discussion will allow us to identify which "phases" of the complex reflexivity sessions relate directly to the research questions. Within these phasal codes the reflexive sessions will be coded using the codes above and below.
14.1 On-clip talk: on leadership/followership This will be coded to sections of discussion within reflexivity sessions that are directly related to the clips shown within the video sessions AND discussion is focussed on leadership/followership.
14.2 On-clip talk: off leadership/followership

This will be coded to sections of discussion within reflexivity sessions that are directly related to the clips shown within the video sessions BUT not focussed on leadership (e.g. wider teamworking issues are being discussed).
14.3 Off-clip talk: on leadership/followership This will be coded to sections of discussion that are NOT directly about the video clips shown BUT ARE about leadership/followership (e.g. when participants offer leadership definitions, or leadership narratives coded using previous sections of the framework)
14.4 Off-clip talk: off leadership/followership This will be coded to sections of the reflexivity sessions that are neither related to the clips shown nor leadership/followership.
Theme 15: Discussed facilitating factors These subthemes relate to factors that facilitate leadership that are discussed within the both the medical trainee interviews and the interprofessional reflexivity sessions that cannot be coded to any of the codes above..
15.1 Individual factors facilitating leadership
15.2 Contextual factors facilitating leadership
15.3 Relational factors facilitating leadership
15.4 Material factors facilitating leadership
Theme 16: Discussed inhibiting Factors These subthemes relate to factors that inhibit leadership that are that are discussed within the both the medical trainee interviews and the interprofessional reflexivity sessions that cannot be coded to any of the codes above.
16.1 Individual factors inhibiting leadership
16.2 Contextual factors inhibiting leadership
16.3 Relational factors inhibiting leadership
16.4 Material factors inhibiting leadership
Theme 17: Reflexive talk Sections of talk within the reflexivity session related to ways in which participants express commitment to change practice/develop etc.
17.1 Reflexive talk: Improving formal clinical activities
17.2 Reflexive talk: Improving personal behaviours
17.3 Reflexive talk: Appreciative
17.4 Reflexive talk: Improving systems
Section F: Linguistic features This theme identifies notable linguistic features across the data set. This theme will aid, in particular, structural analysis of the narratives and analysis of interactions. This theme will also form the basis for possible secondary analysis etc.
Theme 18: Linguistic features
18.1 Metaphoric talk
18.2 Pronoun use and collocates
18.3 Emotional talk
18.4 Hedging
Theme 19: Paralinguistic features
19.3 Over talk
19.4 Interruptions
19.5 Laughter
19.6 Pauses and hesitations

Appendix L: Detailed summary of edited clips

Site A					
Clip title	**Context**	**Clip length min:secs**	**Type of filming**	**Featured participants**	**Summary of edited clip**
Communication Meetings (CM) 1	Meeting room	00:45	Fly-on-the-wall	GPs x 5; Medical Student (MStud); Practice Manager; Community Hospital Senior Charge Nurse; Health Visitor; Pharmacist, MacMillan Nurse; District Nurse; GPST3; GPST1	Pharmacist providing prescribing advice to GP
CM 2	Meeting room	01:00	Fly-on-the-wall	As above	Patient discussion between MacMillan Nurse and GP
CM 3	Meeting room	00:40	Fly-on-the-wall	As above	Hospital Charge Nurse (SCN) asking about bringing discharge notes to meeting
CM 4	Meeting room	01:10	Fly-on-the-wall	GPs x 3; practice manager; Community Hospital Senior Charge Nurse (SCN)	At end of MDT meeting: discussion between GPs and SCN about changing GP input into hospital
Community Hospital	Community Hospital	02:00	Fly-on the-wall	Community Hospital senior charge nurse and GP	SCN makes phone call from ward office requesting GP attendance at hospital; discussion in ward office with GP about patient; discussion in treatment room after patient is seen
Educational. meeting 1	Meeting room	01:10	Fly-on the-wall	Practice Nurse; GPs x 3; pharmacist; GPST3; MStud	Discussion about introduction of new pharmacy paperwork for hospital patients
Educational. meeting 2	Meeting room	02:00	Fly-on the-wall	GPs x 6; GPST1; Practice Nurse, Health Visitor; MStud	Significant Event analysis of GP's patient about adverse effects of a particular drug
Educational. meeting 3	Meeting room	02:20	Fly-on the-wall	GPST1; MStud; GPs 6; GPST3; Practice Nurse	Summary of presentation given by ST1 about sexual health, (edited to include the points where she suggests change)
GPST3	Various	02:10	Expert-apprentice	GPST3	Edited from a morning spent shadowing GP ST3
Trainee Tutorial	Consult room	02:45	Fly-on-the-wall	GPST1 and GP	Tutorial about eye examination
Admin 1	Reception area	01:00	Fly-on-the-wall	Receptionist and GP	Receptionist asking GP to take something over to another GP's house

Admin 2	Reception area	00:30	Fly-on-the-wall	Receptionist x 2 and assistant practice manager	Discussion about taking leave
Practice Manager	Practice manager's office	01:00	Expert-apprentice	Practice manager	Practice manager on phone to reception discussing appointment delays
Diabetic Meeting	Practice nurse's room	01:40	Fly-on-the-wall	GP and practice nurse	Diabetes meeting patient discussion
GPST 1 shadowing	GP's room	02:30	Fly-on-the-wall	GP and GPST1	Complex patient discussion
Total time		22:40			
Site B					
Clip Title	**Context**	**Clip length mins:secs**	**Type of Filming**	**Featured participants**	**Summary of edited clip**
Board round 1	Nurses' station	01:20	Fly-on-the-wall	Senior Charge Nurse (SCN); Occupational Therapist (OT); Social Worker (SW); Medical Consultants x 2; Staff nurses (SN) x 2; Physiotherapist (PT); Physiotherapy assistant (PTA)	Board rounds held every Mon and Thursday, go through patients and discuss D/c planning.
Board round 2.	As above	01:20	Fly-on-the-wall	SN x 2; Foundation trainee (FY); Medical Consultant x 2; SW; PT; OT.	As above
Board round 3	As above	01:10	Fly-on-the-wall	OT; PT; Mental health OT; SW; medical consultant; at board Charge Nurse (CN)	As above
Ward round 1	Outside patient bays/rooms	01:50	Fly-on-the-wall	Consultant; FY	Ward round consultant and FY present only
Ward round 2	White board	00:40	Fly-on-the-wall	SN; Consultant; SW [difficult to hear]	Ward round moves to board- discussion about pt overheard by SW and she joins in discussion
Ward round 3	Outside patient bays/rooms	00:25	Fly-on-the-wall	SN; Consultant	Ward round discussion about patient
Ward round 4	Outside patient	02:35	Fly-on-the-wall	SN; Consultant; joined by FY and MStud	Ward round, discussion about patients x 2

	bays/rooms				
Ward round 5	Outside patient bays/rooms	01:05	Fly-on-the-wall	FY; MStud; Consultant; Nursing student (NSstud)	Ward round discussion about patient
MDT meeting 1: Patient A.	Storage room off ward	01:05	Fly-on-the-wall	Consultant; CN; SW;OT; PT; SN; NSstud	Patient discussion
MDT meeting 1: Patient B	As above	00:40	Fly-on-the-wall	Consultant; CN; SW; OT; PT; SN; NSstud	Patient discussion
After MDT meeting 1	Corridor	00:25	Fly-on-the-wall	CN; Nsstud x 3	Discussing the benefit of attending MDT meeting in an observational role.
MDT meeting 2: Patient C,	Storage room off ward	00:45	Fly-on-the-wall	Consultant; CN; OT; SW; MStud; PT x 2; SN	Patient discussion
MDT meeting 2: Patient D	As above	01:15	Fly-on-the-wall	Consultant; CN; OT; SW; MStud; PT x 2; SN	Patientt discussion
MDT meeting 2: Patient E	As above	00:50	Fly-on-the-wall	Consultant; CN; OT; SW; MStud; PT x 2; SN	Pt discussion
Informal Interactions 1	Doctors desk	00:25	Fly-on-the-wall	PT; FY; Consultant; Pharmacist (Pharm)	Discussion about patient’s chest condition (hard to hear)
Informal Interactions 2	Doctors desk	00:24	Fly-on-the-wall	Pharm and FY	Discussion about pts prescription
Informal Interactions 3	Nurses station	00:10	Fly-on-the-wall	CSN; Psychiatric NS; SN	Discussion about bed planning
Informal Interaction 4	As above	00:20	Fly-on-the-wall	SN; CN; SCN	Staffing discussion

Informal Interaction 5	As above	00:30	Fly-on-the-wall	CN; Consultant; SCN	Discussing where to put a patient
Informal Interaction 6	As above	00:30	Fly-on-the-wall	CN; SCN; Consultant	Bed planning
Informal interaction 7	Doctors desk	00:30	Fly-on-the-wall	Pharm; SN	Discussing discharge prescription
Informal interaction 8	Nurses station	00:10	Fly-on-the-wall	SN x 2; CN; SCN	Bed planning
Informal Interaction 9	Outside patient bay	00:10	Fly-on-the-wall	FY and SN	Pt discussion (prescription)
Informal Interaction 10	Outside SCN office	00:15	Fly-on-the-wall	FY; SCN; Consultant; SN	Discussion about unsettled patient
Informal Interaction 11	Outside patient side room	00:20	Fly-on-the-wall	NSstud and Health Care Assistant (HCA)	HCA checking documentation correct
Informal Interaction 12	Outside SCN office	00:25	Fly-on-the-wall	Consultant and FY	Consultant advising about prescribing for a pt
Informal Interaction 13	Outside patient side-room	00:20	Fly-on-the-wall	OT; Community OT; PT	Discussion about pts mobility
Total Time		20:10			