

# **Rethinking Leadership for Dentistry: A Critical, Exploratory Approach**

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The candidate confirms that the work submitted is her own, except where work which has formed part of jointly-authored publications has been included. The contribution of the candidate and the other authors to this work has been explicitly indicated below. The candidate confirms that appropriate credit has been given within the thesis where reference has been made to the work of others.

The Critical Literature Review and Discussion chapters contain content and lines of argument which are included in the in the jointly-authored publication:

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The published work is directly attributable to me. The joint authors; J Ford and M Manogue, are my PhD supervisors and acted in a supervisory capacity in relation to the published paper and did not contribute any written work within it.

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There are times in life when the question of knowing if one can think differently than one thinks, and perceive differently than one sees, is absolutely necessary if one is to go on looking and reflecting at all.

Foucault, M. 1990, p.8.

This work is dedicated to my late mother  
Rosemary Wardman



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## Abstract

The agenda for leadership in dentistry is growing and is now found throughout national policy, including education. Dentistry is effectively following the path taken in other areas of healthcare where leadership is seen as a solution to a diverse range of problems. Among this talk of leadership in dentistry, a critical voice to surface and challenge the assumptions made about it has been absent and there is a paucity of empirical research to inform a dentistry-specific understanding.

This thesis aims to provide an opportunity to rethink leadership for dentistry through four separate but interlinked dimensions:

**Leadership Theory:** to construct a theoretical framework of leadership for dentistry;

**Leadership Practice:** to understand leadership from within dentistry: where, when, how and why leadership takes place;

**Leadership Research Methodology:** to explore the use and value of innovative approaches to qualitative research to make sense of leadership in dentistry;

**Leadership Education:** to explore the needs of leadership education for dentistry, specifically in relation to what leadership development outcomes and approaches are relevant to dentistry.

A critical perspective is provided by situating the dentistry related leadership literature within the broader leadership studies literature. Exploratory empirical research then provides an alternative conceptualisation of leadership for dentistry through a 'practice and contextual' based theoretical approach using an interpretivist epistemology and qualitative methodology. This is situated within the General Dental Practice context and uses crafted multi-methods: semi-structured interviews, ethnographic observation and collaborative practitioner-academic working groups.

A 'practice and contextual' rethinking of leadership for dentistry is presented which takes into account the challenges, purposes, values, people and practices involved in dentistry specifically. The findings tell of the lived experiences of leadership in everyday dental practice and demonstrate the value of non-conventional research methodology and methods in making sense of leadership. Education to more meaningfully prepare students for practice is proposed.

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# 1. Introduction

This thesis aims to provide an opportunity to rethink leadership for dentistry. In doing this, it takes a critical perspective on leadership thinking as it is currently found in dentistry. This critical perspective is provided by the academic field of leadership studies where debates about the understanding and practice of leadership are well advanced. The thesis goes on to take an exploratory approach to finding an alternative thinking of leadership for dentistry through the use of practice-based empirical research.

## Why rethink leadership for dentistry?

In the UK, the dental profession recognises leadership as something that is worthy of attention. In doing so, it is effectively catching up with and following the agenda for leadership found in the wider healthcare context. Leadership is deemed as a solution to the challenges found in dentistry and the means by which the profession can develop and improve. Much is being expected of it.

In 2013, Morison and McMullan invited a number of developments to be made within UK dentistry in relation to leadership:

- A rethink of the role that leadership plays in dentistry;
- A need to outline the leadership requirements for the profession;
- A need to involve the whole dental team;
- The development of new approaches to leadership.

Brocklehurst et al. (2013a) also called for a better understanding of leadership in dentistry and for “ongoing academic support to develop an evidence base” (p.245).

Since then, few empirical papers have been published and there has been little progress towards this better understanding or rethinking of leadership.

Despite this, the agenda for leadership in dentistry has grown and is now found throughout national policy, including educational policy. The recent and ongoing (started in 2017) ‘Advancing Dental Care: Education and Training Review’, carried out by Health Education England (2018, 2019a) is a key driver for a focus on leadership, recognising a need for leadership development within the profession:

Leadership development aims to help shape people’s knowledge, skills and behaviours to help them become outstanding leaders, and for the NHS, it aims to develop inclusive and compassionate leaders



working at all levels across the NHS to improve patient care, people's health and their experiences of the NHS.  
Health Education England, 2019.

Already, the General Dental Council (the UK regulator for dentistry) includes 'Management and Leadership' as one of four main domains within its 'Preparing for Practice' (2015) learning outcomes for all undergraduate training programmes within the profession that lead to registration. The expectation to engage in leadership development continues after registration, into the early years of foundation training, specialist training and in continued professional development. In addition, there are calls to develop more defined leadership learning expectations in the form of a set of tailored competencies for dentistry, following the competency models found elsewhere in UK healthcare.

Among this talk of leadership, a critical voice to challenge the assumptions made about it has been absent. These assumptions relate to the way that leadership is theorised, practised, researched and developed.

#### For dentistry

This thesis is *for* dentistry: its purpose is to encourage the dental profession to think more deeply and critically about its agenda for leadership. The empirical research work is embedded within the dental profession; its context, its participants (and the researcher). Leadership is seen as a way to improve patient care and people's health, but it can also improve working lives. This thesis exposes the effect that leadership can have on members of the profession and how it can be experienced in different and contrasting ways. It gives a voice to those within the profession who might not be perceived as having a leadership role and tells their stories. This thesis is for them.

#### A critical approach

It is important to explain the approach this thesis takes and what is meant by a critical approach. A *critical* approach can take on different meanings (Mingers, 2000). It can, for example, be involved deeply within social theory (critical social theory, Habermas, 1978) or with fundamental and radical arguments in relation to power and control (Foucault, 1980). In this thesis, a critical *thinking* approach is used, and this incorporates a broad interpretation of this term. Here it means taking a sceptical and questioning approach to:

- rhetoric (the arguments made, and the language used);
- conventional wisdom (the traditions or culture found);
- the prevailing or dominant views;
- information and knowledge (how these are never objective)

Mingers, 2000, p.227.

The aim of a critical approach is to unsettle the current thinking in relation to leadership (Ford et al., 2008; Learmonth and Morrell, 2019); to challenge the assumptions that are made in relation to *who* does leadership to ask *where* leadership happens, *when* it happens, *how* it happens, and *why* it happens (Raelin, 2016a).

A critical approach can be perceived as being something that is negative and dismissive, and which offers no alternatives. In this way, it can be seen to be “paralysing” (Learmonth and Morrell, 2019, p.134) to progress. It is argued however, that meaningful progress in thinking can only be made by engaging in critical thinking (Learmonth and Morrell, 2019). Deeply held assumptions and ways of doing things need to be challenged to allow the emergence of more meaningful and useful approaches. Critical thinking is therefore crucial to “revitalising” (Wilson et al., 2018) leadership for dentistry.

#### An exploratory approach

In seeking to offer an alternative thinking on leadership for dentistry, the empirical work of this thesis takes an exploratory approach. It does not take the common path of positivist and objectivist research philosophy or use a quantitative methodology. Instead, it seeks to use approaches which aim to make sense of leadership more meaningfully: to provide deep and rich insight. This thesis uses an interpretivist epistemology, a subjectivist ontology and a qualitative methodology. The research takes an inductive path which involved a series of stages in which different research methods were used in order to gain increasingly rich and relevant findings. The stages and methods that were used resulted from a continual reflexive process of decision making as the research unfolded. In this sense, the research was exploratory and had no pre-determined path. A decision was made to embed the research within the ‘practice’ context, in this case, General Dental Practice and to engage with its participants. This was a key part of the Leadership-As-Practice-in-Context theoretical framework that was used to inform the research lens and perspective. Here the everyday practice of leadership was the focus of enquiry. Multi-methods were used as part of this enquiry: semi-structured

interviews, ethnographic observation and collaborative working groups. At each of these stages, General Dental Practice participants were involved. The findings or outcomes are not intended to be generalisable, instead the intention is to offer insight and resonance and to provide a way of rethinking leadership in relation to theory, practice, research methodology and education. This thesis does not promise or offer a new prescription of leadership for dentistry. It does not say, "do it this way". What it does offer is a different way of thinking about leadership for dentistry. In doing so, it offers encouragement for the profession to engage more deeply and critically in leadership to help to revitalise it, to make it useful and meaningful, in practice.

#### Thesis Aims:

The thesis takes a broad perspective on leadership, considering four separate but interlinked dimensions: theory, practice, research methodology and education. In doing this it exposes assumptions and offers opportunities for rethinking approaches across these dimensions.

#### **Overall aim:**

This thesis aims to provide an opportunity to rethink leadership for dentistry through the following four separate but interlinked dimensions:

**Leadership Theory:** to construct a theoretical framework of leadership for dentistry;

**Leadership Practice:** to understand leadership from within dentistry: where, when, how and why leadership takes place;

**Leadership Research Methodology:** to explore the use and value of innovative approaches to qualitative research to make sense of leadership in dentistry;

**Leadership Education:** to explore the needs of leadership education for dentistry, specifically in relation to what leadership development outcomes and approaches are relevant to dentistry.

### Thesis structure

This thesis is presented in a series of chapters:

**Critical Literature Review:** this chapter provides an understanding of the current thinking in relation to leadership in dentistry. A critical perspective is given by considering arguments made in the wider leadership studies literature. This identifies opportunities for dentistry to rethink its approach to leadership. The review uses the leadership dimensions outlined earlier: 'theory', 'practice', 'research methodology' and 'education' to provide a broad consideration of critical issues in leadership and how these apply to dentistry specifically.

**Methodology and Methods:** this chapter explains the exploratory and inductive journey that the empirical work of this thesis undertook. It provides an explanation and rationale for the methodology and methods used. Definitions and explanations are given to aid in the understanding of terminology and an introduction to research philosophy provides a basis for the chosen approaches taken in this thesis. This chapter also explains how a theoretical framework was adapted for use in this thesis.

**Findings:** this chapter presents the empirical work of the thesis. The chapter is presented in two parts.

**Part 1:** addresses the 'theory', 'practice' and 'research methodology' research aims. Here semi-structured interview, ethnographic observation and collaborative working group findings are presented and analysed together according to leadership themes based on an adapted model for theorising leadership which uses: 'challenges', 'purposes', 'values', 'people' and 'practices' to construct a contextually specific version of leadership. Incorporated within this is a reflexive account with the voice of the researcher (*my* voice) becoming involved.

**Part 2:** considers the 'education' dimension and the aim to rethink leadership education in dentistry.

**Discussion:** this chapter considers the thesis findings in relation to the published literature and how they represent an alternative 'practice and context' based thinking of leadership for dentistry. The chapter is structured around the leadership dimensions highlighted in the Critical Literature Review. The chapter also considers the limitations of this research as well as a reflexive insight into the researcher's experiences.

**Conclusions and Contributions:** this brief chapter presents the conclusions and core contributions of the thesis including an overall rethinking of leadership for dentistry and makes recommendations for further research and policy.

This thesis engages with two main academic fields: dentistry and leadership studies. Readers who are based within one of these fields will not necessarily be familiar with the other. This thesis has therefore taken the approach of providing a full explanation of terms, organisations, policy and theory with this dual readership in mind. Throughout the thesis, footnotes are used and there is sign-posting to indicate where explanations are given elsewhere.

## **2. Critical Literature Review**

### **2.1 Critical Literature Review - Opening Notes**

This chapter provides an understanding of the current thinking in relation to leadership in the dental profession. A focus on the dental profession alone however risks acceptance of the prevailing views and assumptions found. A wider, critical perspective is therefore needed, hence this chapter turns to debates found within the leadership studies field to offer opportunities for a rethinking of leadership for dentistry.

A critical approach, beginning with dentistry and then using the leadership studies literature provides a frame for analytic review. To structure this, the dimensions already set out in the Introduction: 'theory', 'practice', research methodology' and 'education' are used. These allow a broad exploration of the dentistry leadership literature, situated within the wider leadership studies literature.

## 2.2 Leadership Theory

This section explains how leadership theory has been introduced to dentistry, what approaches have been advocated and the call for a dentistry-specific construction of leadership. The generic leadership studies literature then explains the main developments in leadership thinking: from mainstream, heroic theories to post-heroic, collective and critical theories. A 'practice' theory of leadership is introduced, and this is recognised as a concept which could be both relevant and meaningful to dentistry.

### 2.2.1 Leadership theory in dentistry

Dentistry is beginning to make sense of leadership theory. In the UK, a handful of papers have been published, aimed mainly at the practitioner audience. This literature raises leadership as a concept that is worth paying attention to, as a way to keep pace with the modern demands of a healthcare profession.

A starting point was attention to the various theories, definitions and meanings of leadership drawn from the popular leadership literature. In a series of four short papers in *Dental Update* (a practitioner-focused journal), Busby (2012a) presents a range of popular leadership theories: 'management is doing things right; leadership is doing the right things' (Drucker, 1999.), 'Leadership is influence – nothing more, nothing less' (Maxwell, 1998), 'Management is efficiency in climbing the ladder of success. Leadership determines whether the ladder is leaning against the right wall' (Covey, 1992), Kotter (1990) 'more change always demands more leadership' and Lewin's three principal styles of leadership: autocratic, democratic, delegative (Lewin et al., 1939).

Busby (2012a,b,c,d) goes on to outline and describe 'three pillars' of leadership: 'vision', 'motivation' and 'delivering the key outcomes'. A definition of leadership as it applies in the context of a dental practice is proposed: "the ability to continuously define a future practice vision which inspires you and your dental team towards success." (Busby, 2012a, p.437). The behaviour of an ideal leader is described: "walk the talk, not be afraid to show your tough side, be visible, feel the fear, live a vital life, listen" (Busby, 2012d, p.592).

Willcocks, an academic outside of dentistry and from within the leadership studies and management field, presents a more formal and scholarly account of the general, mainstream leadership theories for the dental audience in the British

Dental Journal (Willcocks, 2011). Leadership is described as “the ‘glue’ that will hold dental practices together, making them coherent and purposeful and linking the clinical and non-clinical together” (Willcocks, 2011, p.107). Personality traits, behavioural style, situational/ contingency and transformational theories (including mention of charisma and inspiration) of leadership are explained. Willcocks (2016) also presents to a wider, non-dental specific audience. It is argued that the dental profession needs to engage in leadership, as other healthcare professions have done, so that it does not fall behind in being able to respond to increasing challenges and demands. Willcocks suggests that it is appropriate for dentistry to use a mix of leadership theory such that it formulates its own, tailored theory or model of leadership.

Brocklehurst et al. (2013a) (dental public health and dental postgraduate education background) explore clinical leadership in dentistry and outline their interpretation of developments in leadership theory: from what might be considered the traits of a ‘good leader’ (charisma, intelligence, self-confidence) to processual leadership and a description of transformational leadership. They call for dentistry-specific leadership traits and behaviours to be defined (Brocklehurst et al., 2013a, p.245) and for:

On-going academic support to develop an evidence base for the assessment and development of leadership skills and for the evaluation of the impact of clinical-leadership in the dental context.

Brocklehurst et al., 2013, p.246.

An interesting opinion-based paper asks the question “do dentists make poor leaders?” (Nalliah, 2016). This paper (written by a US dental academic and published in the British Dental Journal) claims that the skills and attributes that make dentists successful do not necessarily translate well into becoming successful leaders. For example:



| <b>Good dentist</b>                              | <b>Good leader</b>                                  |
|--|---|
| Transactional leadership that leads by authority | Transformational leadership that utilises influence |
| Autonomy and self-reliance                       | Inter-dependence                                    |
| Detail orientated                                | Creative and 'big picture' orientated               |
| Controlling                                      | Delegating and collaborating                        |
| Patience, endurance and tolerance                | Impatience  |
| Pessimism  | Optimism  |

**Table 1.** Comparison of attributes of a good dentist and of a good leader. From Nalliah, 2016, p.391.

The intention is to provoke discussion and to stimulate debate and is not academically evidence based. Again, the supporting leadership literature comes from popular sources such as the Harvard Business Review, McKenzie Management and Forbes.

A focus on leadership is also promoted by a group of new Fellows in Clinical Leadership (Health Education England). In a paper published by this group (Stagnell et al., 2017), they identify leadership as having many different definitions and allude to the concept of 'post-heroic' leadership as a 'revisioning' (Fletcher, 2004) of leadership as collective endeavour.

Moving on from the opinion-based literature, there have been some empirical UK based studies which explore leadership in dentistry. Morison and McMullan (2013), present the findings in relation to the characteristics and behaviours of dental leaders. They found that "being approachable, inspiring, fair, firm, unbiased, good listener, good knowledge and broadminded" (p.2) were characteristic of good leadership. In relation to behaviours, "encourage, enthuse, take decisions with confidence, have clear vision, communicate this vision, delegate, consult" (p.2) were ideal. The findings, it is argued support a future focus on shared leadership theories for the dental team and the transformative theory of leadership which is suggested as being congruent with the needs of dentistry. There is a call for further exploration in relation to leadership for dentistry and the development of new approaches.

Brocklehurst et al. (2013b) explore cultural differences in clinical leadership – between General Dental Practitioners (GDPs) in Greater Manchester and Tokyo.

Differences in approaches to leadership were found: the UK based GDPs identified more with collaborative styles leadership while the Tokyo GDPs identified more with hierarchy and power alongside a transactional style.

### Summary

In relation to leadership theory in dentistry, the literature reveals the following:

- There is early engagement in leadership theory which is drawn from the popular literature as well as more scholarly and academically based mainstream literature;
- There is a call for shared and transformative theories of leadership to be developed in dentistry;
- There are some examples of empirically based studies which provide early insight into the approaches to leadership found in the dental profession;
- There is a call for academic support to develop an evidence base and to construct a leadership theory which is specific to dentistry.

### **2.2.2 Perspectives on leadership theory from the leadership studies literature**

The first point of consideration in this view from the leadership studies field relates to the conceptualisation of leadership itself: how it can be defined and theorised. Definitions can help to delineate a concept, to aid in a common understanding and to provide a theoretical basis to models of application in relation to practice, research methodology and education. The academic leadership studies literature however demonstrates that leadership is a 'highly contested phenomenon' (Grint, 2005b) with fundamental differences about the philosophical and theoretical underpinnings and construction of the concept being argued. Stogdill's (1950) definition includes the ideas of process, influence, group action and the achievement of goals. Definitions can consider leadership as being the attributes of a person: the leader, others considering it as a relationship, or as a process (Bolden et al., 2011), or, more recently as a practice (Raelin, 2016b). This variation in focus reflects the many leadership theories that over the years have been proposed and developed. It is perhaps important to reflect on Stogdill's report that "there are almost as many definitions of leadership as there are persons who have attempted to define the concept" (Stogdill, 1974, p.259).

One way to consider leadership theories is to use the headings 'heroic', 'post-heroic' and 'critical'. These groups of leadership theories share common, underpinning notions of leadership.

Heroic leadership theories

Examples of some of the main heroic leadership theories are outlined in table 2.

| Leadership Theory | Description   |
|-------------------|---|
| Trait leadership  | <p>This approach to leadership assumes that there are a set of 'traits' or attributes that an individual possesses which makes them suited to be a leader. Traits might include physical, personality, social and skill attributes for example: height, enthusiasm, dominance, tact, intelligence, judgement (Jago, 1982). This builds on the 'great man' theory of leadership which singles out individuals who have been thought of as being successful and influential leaders and looks to identify their attributes. Taylor (2015) describes three components of trait theory:</p> <ol style="list-style-type: none"> <li>1) Some people have them, some don't</li> <li>2) They can't be given or taken away from someone</li> <li>3) They are in place at birth</li> </ol> <p>Taylor, 2015, p.29.</p> <p>A set of definitive or applicable traits for leadership has not been established. Stogdill (1948, 1974) conducted a review of the available evidence. In relation to the identification of traits and effective leadership, only weak correlations were found, with varying research methods used and a lack of clarity in the reporting of results. The importance of context (social, cultural and organisational factors) in relation to the effect of traits was highlighted as part of this review.</p> |
| Style leadership  | <p>This considers the behaviours leaders adopt in 'doing' leadership. Styles or behaviours used may depend on the needs of followers in certain situations. An example is illustrated by Blake and Mouton's Managerial or Leadership Grid (1964). The grid is formed by two axis: concern for production on one axis and concern for people on the other. Plotted at various points against these axes are a set of styles:</p> <p><b>'Impoverished management'</b> – low concern for production and low concern for people</p> <p><b>'Country club management'</b> – low concern for production, high concern for people</p> <p><b>'Authority obedience'</b> – high concern for production, low concern for people</p> <p><b>'Team Management'</b> – high concern for production and high concern for people</p> <p><b>'Organisation and management'</b> or 'middle of the road management' – moderate levels of concern for production and for people (a compromise position)</p>   |

|                                    |   |
|------------------------------------|---|
| <p>Situational leadership</p>      | <p>Situational leadership considers an adapted approach to leadership depending on the situation it is involved in. The situation may be determined for example by the people involved or the nature of an event or circumstances.</p> <p>One of the first examples of this approach was proposed by Fiedler (1964). This considers how a leader's style (e.g. task orientated, or relationship orientated) and the situation involved (e.g. the level of task structure) can determine the level of influence they may have on followers, in effect, how well they do.</p> <p>Another, later and well-known example, Hersey and Blanchard's situational model (1969,1977,1988) considers the developmental levels of followers and four adapted leadership styles which suit different levels: directing, coaching, supporting, delegating. For example, a follower who is 'low' in terms of development, according to the model would be best lead by using a 'directing' style (high directive and low supportive behaviour).</p> <p>The leader-participation style model (Vroom and Jago, 1988) considers decision making and the level of participation of followers in making decisions. There are five approaches or levels of decision making, with increasing level of follower or group participation. For example:<br/> Autocratic: decision is made by the leader and communicated to the group.<br/> Consultative: the group is brought together, and input collected. The leader then makes the decision.<br/> Group based: the group makes the decision. The leader is effectively a facilitator at this level.</p> <p>In deciding which of these approaches will be used, the leader needs to consider various factors: the significance of the decision, the level of expertise of the group and the commitment of the group to the end-goal (Cullen, 2015).</p> |
| <p>Transformational leadership</p> | <p>Transformational leadership has become popular over the last 40 years having been developed by Burns (1978). It is often compared to 'transactional' leadership to demonstrate the inspirational, motivational and empowering approach it aims to promote.</p> <p>Transformational and transactional leadership are both based on the relationship between leaders and followers. Whereas transactional leadership uses a functional, exchange of directed work and reward, transformational leadership appeals to hearts and minds through reference to values, purposes, insights and vision (Bass and Avolio, 1994) - and perhaps to the fundamental, moral and ethical 'why' questions (Delaney and Spoelstra, 2015).</p>  |
| <p>Charismatic leadership</p>      | <p>Charismatic leadership takes ideas from trait leadership theory and transformational leadership. As in trait theory, the focus is on the characteristics of the individual leader- in particular, "personality (dominance</p>  |

|                    |   |
|--------------------|---|
|                    | and self-confidence, being a strong role model, communication of goals and having high expectations)" (Northouse, 2013, p.188). Here leaders may demonstrate extraordinary qualities to rouse and inspire their followers to do 'great things' (Delany and Spoelstra, 2015). This approach was suggested by House (1976) and was popular as part of the 1980s and 90s trend for a reinvigoration of leadership within organisations (Bolden, 2004).   |
| Servant leadership | Servant leadership is based on the idea that leaders act firstly to 'serve' their people and organisation, putting their own needs and 'power' ambitions aside. This theory was first suggested by Greenleaf (1977). Key characteristics of servant leadership include: developing people, modelling integrity and authenticity, altruistic calling, wisdom, trust, transforming influence, stewardship (Northouse, 2013, p.224). There is also an ethical and moral aspect to this approach and the focus on a higher purpose. |

**Table 2.** Examples of heroic leadership theories. Based on descriptions of leadership theories from Northouse, 2013; Carroll et al., 2015 and Bolden, 2004.

Criticisms of heroic leadership theories

In considering these examples, the focus is very much on the leader as an individual and are based on psychological perspectives of leadership. One of the main issues in looking at these theories, is that, fundamentally, each considers a different aspect of what it takes to be an effective leader (Collinson, 2011). The focus is on the traits, behaviours and styles that individuals can use to demonstrate effective leadership. Much of the focus within the academic literature and the leadership development industry is based, fundamentally around these theories (Ford, 2015b). There is, however, growing criticism of this mainstream approach to leadership and the inherent assumptions made. Fundamental criticisms of mainstream leadership theory have been argued and it is useful to consider them under the headings proposed by Collinson (2011): essentialism, romanticism and dualism.

Essentialism assumes that leadership can be reduced to a core, definitive set of features that constitute its essence. Leadership therefore becomes an entity. There is certainty to the concept, it becomes concrete and something that everyone accepts: it is therefore a universal concept. This entity can be measured, and objectively so, using positivist, quantitative methodology<sup>1</sup>. Leadership also

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<sup>1</sup> Explanation of the terms objectivism, positivism and research methodology are given in the Methodology and Methods Chapter (3.1).

becomes universal because it applies in the same way in all contexts: it is decontextualised (Ford, 2015b). Leadership therefore becomes predictable, prescriptive and functional (Wilson et al., 2018).

Romanticism relates to the notion that there are such individuals who can demonstrate extra-ordinary abilities in leadership such that they become almost heroic. This has been described as a mythological or idealised view of leadership (Sinclair, 2007). The focus is on these ideal individuals and the search for them. When asked as part of leadership development sessions, to describe leadership, participants will often describe a well-known, popular or historical leader for example, in politics or sport. This is an example of romanticising leadership. Charismatic leadership is based on this idea that a leader is able to inspire followers to do extraordinary things.

Dualism relates to the assumption that polar opposites, or dichotomies exist within leadership concepts. For example, the most prominent leadership dichotomy, as argued by, Fairhurst (2001) is that of leaders and followers or the individual and collective. Leaders and followers are separated such that leaders do leadership and followers (the others) do followership. There is one, or the other; they are mutually exclusive (Bennis, 1989). This relates to the formal hierarchy and power, or 'position power' (Northouse, 2013, p.10) that leadership is thought to involve. Often, the focus of research will be on those who are designated as leaders and those designated as followers will be ignored. Another example is the concept of transactional and transformational leadership and how these might be interpreted as being management and leadership.

The effect of dualism is to simplify concepts, removing complexity and ambiguity (Collinson, 2014). The criticism is that this over-simplification is naïve and can result in the exclusion of many individuals or aspects involved in leadership.

#### Thinking beyond heroic leadership approaches

A re-thinking of leadership considers alternatives to the mainstream, conventional approaches that traditionally have been prominent in the literature. Firstly, in relation to essentialism, it is argued that the fundamental assumption of leadership as an objective entity should be questioned. Barge and Fairhurst (2008, p.228)

argue for a constructionist<sup>2</sup> approach to be applied where leadership is seen as a “lived, experienced social activity”. Carroll et al. (2008) calls for leadership to broaden its epistemological approaches: to move away from objective ‘detachment’ to interpretive ‘engagement’. Leadership, it is also argued, cannot be universal in its application to context. It is context dependent and therefore what will apply in one context will not necessarily translate to another. There are multiple factors within contexts which interact: identities, values and cultures (Ford et al., 2008). Leadership is therefore a complex phenomenon: it changes and is dynamic. Because of this alternative epistemological view of leadership, the way in which it is researched needs to fundamentally change (Raelin, 2007).

In relation to romanticism, it is argued that there is a need to “go beyond the hero” (Ford, 2015a): (‘post-heroic’), and accept that there is no such thing as an ideal leader (Ford et al., 2008). In addition, the ‘dark side’ of those heroic leaders who might be considered as transformational has been discussed by Tourish (2013). Here it is proposed that leaders using transformational approaches can be used in coercive or even abusive relationships.

There are moves away from leadership being seen as something that happens only at the top of an organisational hierarchy, making the big decisions and setting strategic policy. Leadership can also be mundane and involve the ordinary, everyday aspects of working in organisations (Carroll et al., 2008). This does not fit with a romantic notion of leadership.

Another way to ‘deromanticise’ leadership has been to remove the notion of leadership altogether. Carroll et al. (2019) in their book ‘After Leadership’ consider this an exercise in conceptual thinking. They argue that a romantic focus on leadership neglects what leadership actually needs to achieve if it is to be a concept that is meaningful and useful in modern society.

The dualisms set up within leadership such as leaders/ followers, need to be replaced with dialectic analyses of leadership (Collinson, 2014). This means accepting that leadership is a complex phenomenon, not a simplistic one. Often there are tensions and ambiguities and the ‘interdependency’ between factors needs to be exposed. For example, in relation to the separation between leaders and followers, removing this separation can allow collective and co-productive

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<sup>2</sup> An explanation of social constructionism is given in the Methodology and Methods Chapter (3.1).

approaches to be encouraged (Raelin, 2016a). An influential paper by Smircich and Morgan (1982, p.259) raised the issue of “dependency” which traditional approaches encourage. The dependency of followers on leaders was described as a “surrender” (Smircich and Morgan, 1982, p.259) - of followers’ ability to think for themselves and to influence others. This form of traditional leader/ follower relationship can be replaced, it is argued with a “leaderless” (p.272) working approach.

#### Post-heroic leadership theories

Post-heroic theories move away from the previously considered heroic approaches. In general terms, post-heroic theories offer a more collective, inclusive and dispersed version of leadership which de-centres the notion of a single, controlling leader who achieves leadership by themselves (Crevani et al., 2007; Ospina et al., 2020). There is overlap in how these theories are constituted. Examples of post-heroic leadership theories are explained in table 3.



|                        |  |
|------------------------|--|
| Collective leadership  | Collective leadership theory recognises that leadership is achieved collectively – not just through a designated leader but by the co-ordinated activity of team members in an inter-exchange of activity (Friedrich et al., 2009; Ospina et al., 2020).   |
| Distributed leadership | Distributed leadership considers that leadership is not solely the domain of a designated leader at the top of the hierarchy of an organisation, rather leadership responsibility can be shared and demonstrated at all levels. It encompasses ‘informal’, ‘emergent’ and ‘dispersed’ leadership (Bolden, 2004) and denotes a movement away from the clear separation of the roles of leader and follower towards a more expanded (Gronn, 2002), shared and collective approach.   |
| Relational leadership  | Relational leadership considers leadership as being engaged in and experienced through relationships (Cunliffe and Eriksen, 2011). Uhl-Bien (2006, p.654) discusses the idea of a “social influence process” as part of the relational process. This therefore brings in the notion of the socially constructed nature of leadership; how leadership is shaped by and emerges through interpersonal relationships. What follows is that context becomes important and the idea that leadership can be applied in a generalised or universal fashion is questioned.   |
| Shared leadership      | Shared leadership focuses on how the work of leadership can be taken on by members of a team, rather than being retained by a single leader (Carson et al., 2007; Crevani et al., 2007).   |
| Leadership-As-Practice | <p>The focus of Leadership-As-Practice is on the following:</p> <ul style="list-style-type: none"> <li>• Everyday practice – ordinary, routine occurrences (Carroll et al., 2008)</li> <li>• The ‘unfolding’ or emergent (Raelin, 2016b) nature of leadership</li> <li>• Lived experiences and reflections of participants (Fisher and Robbins, 2015) (all participants regardless of position within an organisation, Raelin, 2016b)</li> <li>• Collective and collaborative involvement of all participants (Raelin, 2016a)</li> <li>• Relational aspects (Carroll et al., 2008)</li> <li>• Moral and ethical dimensions, including compassion (Raelin, 2011, 2014)</li> </ul> <p>How leadership is interconnected within the ‘whole’ of a situation</p> |

**Table 3.** Examples of post-heroic leadership theories.

### A 'practice' theory of leadership: Leadership-As-Practice

One of the post-heroic movements away from mainstream theory has been to consider leadership as a practice. This is based fundamentally on the notion of a theory of practice; practice being used as a defining, holistic, philosophical term (Miettinen et al., 2009). This practice perspective has been developed across different areas of the social sciences: philosophy (Heidegger, Wittgenstein), sociology (Bourdieu, Schatzki) and education (Dewey) (as examples) and there has been what has been described as a 'practice turn' (Schatzki, et al., 2001; Raelin, 2007); a movement towards this kind of approach within the social sciences. In relation to leadership, one of the attractions of a practice approach is that it seeks to deal with and move beyond issues of essentialism, romanticism and dualism inherent within heroic approaches. Within leadership studies, the use of a 'practice lens' has been recognised as an opportunity to rethink how leadership is viewed in relation to its conceptualisation and this has implications as to how it is researched and how it is developed (to be considered later in the Leadership Research Methodology and Leadership Education sections of this chapter).

It is common to think about theory and practice separately; another example of dualistic thinking. How then, can a theory of practice be reconciled? For example, traditionally, theory is learned and then put it into practice. It is expected that the application of theory will help us in the real (everyday, experienced) world to navigate the various challenges that arise in the course of our work. There is however often a disconnect (Simpson, 2009) and what is found is that learned theory does not necessarily prepare us for the actualities of the practice world. Practice approaches offer to address this with what has been described as a 'bridge' (Fisher and Robbins, 2014) between the practical and the theoretical. This brings with it an opportunity for a 'scholarship of integration' (Bartunek, 2007) between practitioners and theorists to resolve the traditional disconnect between the two domains.

One of the ways practice approaches address the disconnect, is to engage in the everyday, experienced, real world of practitioners; to focus on what actually happens (Carroll et al., 2008). There is an opportunity to understand how things happen and why. Often this is at a very detailed, 'on the ground level' – what has been described as the "nitty-gritty" (Chia, 2004, p.29) of the real world (Fisher and Robbins, 2015); the "scene of everyday action" (Chia, 2004, p.30) where events 'unfold' (Carroll et al., 2008); the "real time doings" (Simpson et al., 2018, p.648) of ordinary working life. What is attractive is the focus on everyday organisational life;

what has been termed the “extra-ordinarisation of the mundane” (Alvesson and Sveningsson, 2003, p.1435). Practice theory means focussing on the experienced ‘actual’, rather than the theorised ‘abstract’. It involves three aspects: praxis, practices and practitioner. Praxis is a Greek word meaning the process of enactment or application (of a theory) and can be thought of as “what people do” (Whittington, 2006, p.619). Practices refers to routines and patterns of activity including “traditions, norms and procedures for thinking and acting” (Whittington, 2006, p.619). Practitioners refer to those who undertake to enact and demonstrate these practices. Rather than focusing on individual practitioners or individual practices, however, the ‘Logic of Practice’ as proposed by Bourdieu (1990) deals with the socially constructed, collective nature of practices. According to Schatzki (2005, p.480), practices should be considered as “social sites in which events, entities, and meaning help to compose one another.”

Practice theory also draws on the philosophy of Heidegger (1971) to deal with the issue of the nature of action: deliberate, conscious, intentional action versus unplanned, unconscious, improvised action. Heidegger termed these ‘building’ and ‘dwelling’ modes of action. It is argued that in everyday practice, much of the work involves the latter ‘dwelling’ type. Actions carried out in ‘dwelling mode’ are unplanned and unconscious as they are a result of one’s disposition, embodied skills and habits which form a “modus operandi” (Chia and MacKay, 2007, p.236). This is what is of interest in a ‘practice’ based approach.

The following descriptions can be used to describe a ‘practice’ approach:

- Practices represent the means by which work gets done and give meaning to this work;
- Practices are context and time dependent (they are specific to certain situations);
- Practices are brought about socially; they are created, shared, maintained and developed through interaction and interdependency between practitioners;
- Practices are interconnected and should not be seen in isolation. Practices should be viewed as part of the ‘totality’ or the ‘whole’ of a situation and context.

Based on Nicolini, 2012, p.214.

In addition, a useful summary can be found in the following quote:

Practice is a rich polysemic word that, in addition to denoting organised arrays of action, also highlights the necessary embeddedness of human activity in social and material contexts and the relentlessly unfolding character of action and sequences of performances.

Hui et al., 2017, p.2.

Practice approaches can be applied to leadership. This is the basis of the concept of Leadership-As-Practice (L-A-P). One of the main proponents of L-A-P, Raelin, argues that leadership “occurs as a practice rather than from the traits or behaviours of individuals” (Raelin, 2016b, p.3). Leadership is found within and through practices. Raelin (2011, p.196) defines ‘practice’ as “a co-operative effort among participants to choose through their own rules to achieve a distinctive outcome”. As Carroll et al. (2008) describe, Leadership-As-Practice approaches focus on the routine and mundane occurrences of everyday organisational life – “the where, when, how and why leadership is done” (Raelin, 2016a, p.134). Leadership is therefore a socially constructed phenomenon where inter-relations between actors shape the actions, reflections and adjustments that take place within organisational life (Raelin, 2007). In addition to this, Raelin (2011; 2014) highlights the moral and ethical dimensions that Leadership-As-Practice draws out. This is in contrast to the rational, objectivism found in mainstream leadership approaches (Raelin, 2007).

#### Leadership-Practice-In-Context

Recently, another development in ‘practice’ thinking has emphasised the importance of context in relation to how leadership can be theorised: this is termed ‘Leadership-Practice-In-Context’ and has been proposed by Wilson et al. (2018). It suggests that leadership theory is developed in such a way that it is tailored to specific contexts: ‘contextualised theorising’. This is in contrast to the application of universal theories of leadership which aim to be a ‘one size fits all’ solution. The proponents offer this new approach as a way to ‘revitalise’ leadership; to move it away from universalist and prescriptive mainstream conceptualisations to theories of leadership that are shaped by the specific needs of real, lived and experienced contexts. Revitalised leadership therefore becomes more relevant, meaningful – and useful. Leadership, it is argued, should be informed by the challenges, purposes and values that it seeks to work with. “Context is the starting point for

thinking about what approach to leadership is likely to be of value” (Wilson et al., 2018, p.5).

A framework or ‘meta-theoretical methodology’ (Wilson et al., 2018, p.47) is offered (figure 1). This aims to inform the development of contextualised, tailored theory. The framework identifies areas which the proponents suggest are of fundamental importance in capturing context specific issues which should inform leadership theory. These areas are:

- Challenges

This area aims to recognise and acknowledge the specific challenges which leadership needs to deal with within a particular context. These might be “tasks, issues, opportunities and difficulties” (Wilson et al., 2018, p.47). Identification of these allows leadership to be ‘targeted’ at their ‘resolution’. Examples: International and highly mobile workforces, emerging technologies;

- Purpose

This area centres on the issue of aims and goals within particular contexts. This is a fundamental consideration and can provide clarity to the work of leadership as it can help to set up ‘boundaries’ in relation to what should be achieved. This means “working through competing and conflicting goals” (Wilson et al., 2018, p.48). Examples: to build engagement, to support creativity that drives innovation;

- Values and norms

This area brings in an ethical and moral dimension. These aspects can help to guide what should and should not be done, and what is deemed acceptable within a context. In this model, leadership is not considered to be a value-neutral concept, rather it is inherently guided by deeply held moral and ethical values. Examples: trust, mutual obligation;

- Domains of leadership activity

This area aims to delineate boundaries in relation to the scope of leadership. It essentially aims to outline the remit of leadership, dependent on the context involved.

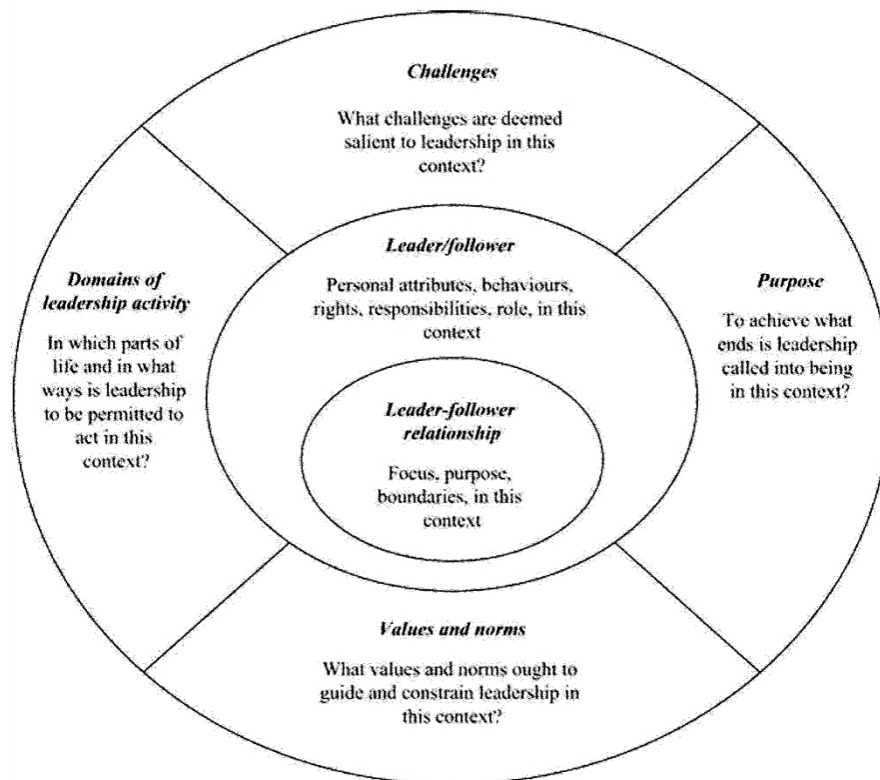
Examples: internally within the organisation; restricted to the work domain but with care for quality of life, inside and outside the organisation;

- Leader / Follower

This area focuses on the individuals involved in leadership. It considers the ways in which leaders and followers conduct themselves (e.g. their behaviours, scope of action) in particular contexts. Examples: can cope with ambiguity, complexity and paradox, defines organizational reality;

- Leader / Follower relationship

This area considers how leaders and followers interact within specific contexts. It considers issues such as the balance of power and the needs of the relationship in relation to purpose. Again, this is context dependent. Examples: collaborative and participatory, transformative not transactional.



**Figure 1.** A meta-theoretical methodology for theorising leadership. Wilson et al., 2018, p. 47.<sup>3</sup>

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<sup>3</sup> Republished with permission of Taylor & Francis Group LLC- Books, from *Revitalising Leadership: Putting Theory and Practice into Context*. Wilson, S., Cummings, S., Proctor-Thomson, S. and Jackson, B. eds. 2017; permission conveyed through Copyright Clearance Center Inc.

It is suggested that this framework be used to guide the development of tailored leadership theory to particular contexts. It is in effect, a 'theory-building process' (Wilson et al., 2018, p.53). The authors are not prescriptive in relation to how the framework is used. For example, the inner rings which include the leader/ follower and leader/ follower relationship are not essential and can, if deemed appropriate, be removed or reduced in emphasis. The danger, they suggest, is that if considered first, a leadership theory which focuses on the individual attributes of leaders, a separation with followers and a weak consideration of contextual needs will result (akin to early mainstream theories of leadership).

The authors do emphasise that the areas included in the outer ring are more important: challenges, purpose, values and norms and domains of leadership activity. They also suggest that the framework can be used in different ways. For example, it can be used in a structured manner by starting with challenges and then working round the ring in sequence. Alternatively, the framework can be used in a more flexible and 'fluid' manner. Ultimately, it is important to keep in mind the importance of context and how this informs both the process and outcome of the contextualised theorising approach. The aim is to produce approaches to leadership which actually embrace the needs of different organisations so that leadership becomes useful, effective and meaningful. In this way, leadership can be brought to life in everyday work.

#### Critical leadership studies

Critical leadership studies represent a third main group of leadership theories (in addition to heroic and post-heroic groups). Critical leadership studies (CLS) represent not a specific theory of leadership, but a body of thought which seeks to radically question, and rethink assumptions made by mainstream theories of leadership. This thinking is relatively new and emergent and had its early beginnings with Smircich and Morgan's (1982) call for the "dependency" (p.259) of the traditional leader-follower relationship to be replaced with a "leaderless" (p.272) working approach. The main proponents of CLS (Ford et al., 2008; Ford, 2010; Collinson, 2011; Harding et al., 2011; Sutherland, 2015; Learmonth and Morrell, 2019) have taken on this call to challenge the dominance of mainstream approaches to leadership and have established a range of more critical perspectives dedicated to this aim. CLS has been defined as:

The broad, diverse and heterogenous perspectives that share a concern to critique the power relations and identity constructions

through which leadership dynamics are often produced, frequently rationalised, sometimes resisted and occasionally transformed. Collinson, 2011, p.181.

This definition identifies the issues of power and identity. Examples of the assumptions that CLS seeks to challenge in relation to this include:

- The 'hierarchical' – 'command and control', leader-centric nature of leadership (Ford, 2015a, p.235, p.236);
- The notion of a 'perfect' (Ford and Collinson, 2011) or transcendental, homogenous, heroic leader (Ford, 2015a, p.238);
- That there is only one legitimate source of power and authority – the leader (Learmonth and Morrell, 2019, p.44);
- That other actors in that setting are necessarily subordinate to that so-called leader (Learmonth and Morrell, 2019, p.44).

CLS also challenges the way in which leadership research and leadership education has been shaped in relation to mainstream perspectives: research which is based on an objective view of leadership as a discrete entity and education approaches which encourage the development of certain leadership traits and behaviours. These themes will be explored further in the 'Leadership Research Methodology' and 'Leadership Education' sections of this chapter.

CLS offers a "re-framing" (Collinson, 2014, p.36) of leadership as a collectively constructed, emergent process much removed from the mainstream, individualistic, heroic theories. Here, the importance of context, specific situations, events and practices involved in how leadership 'happens' are emphasised (Ford, 2015b; Learmonth and Morrell, 2019). Leadership is recognised as a highly complex concept which cannot be reduced into a neat, generalisable or specific theory. As Sutherland (2018, p.281) argues, there is no "magic recipe applicable to leadership everywhere."



### Summary

In relation to leadership theory, the leadership studies literature reveals the following:

- Differences in leadership theory reflect differences in the way leadership is thought about as a concept;
- Heroic theories of leadership of leadership focus on the individual leader: what traits and behaviours are needed to be a successful leader. These theories are criticised as essentialist, romanticist and dualist;
- Post-heroic theories move away from individualistic versions of leadership to offer a view of leadership which is more collective, inclusive and dispersed;
- A 'practice' theory of leadership is one example of a move away from heroic, mainstream theory;
- Leadership-As-Practice theory pays attention to the everyday, in-situ, mundane and routine practice of leadership and asks: where, when, how and why leadership happens;
- Leadership-Practice-in-Context extends 'practice' thinking and pays attention to the importance of context in building leadership theory;
- Critical Leadership Studies offer a more radical challenge to the taken for granted assumptions in relation to leadership and particularly focuses on power and control relationships in leadership, between leaders and followers.

### **2.2.3 Situating leadership theory in dentistry within the wider leadership studies literature**

Seen through the lens of the leadership studies literature, the leadership theories advocated in dentistry are based mainly on heroic and some post-heroic types. They are drawn from the popular and mainstream leadership literature and have not yet engaged in a critical questioning of the assumptions that these theories make. For example, the leadership approaches advocated by Busby (2012a,b,c,d) are characteristic of an individualistic and heroic version of leadership which is essentialist, romanticist and dualist. These privilege the role of a designated leader and exclude others from being involved in leadership. There is an interest in trait and behaviour approaches as well as an indication that transformative leadership may be ideal to dentistry alongside a shared leadership approach (Morison and McMullan, 2013). There is a call for academic support to develop an evidence base

for leadership in dentistry (Brocklehurst et al., 2013a) and the development of a leadership theory which is specific to dentistry (Morison and McMullan, 2013). One of the criticisms made by the leadership studies literature is that most mainstream leadership theories do not engage deeply enough or meaningfully enough in the needs of specific contexts and the everyday and routine, socially constructed practice of leadership. The use of a Leadership-As-Practice (Raelin, 2016b) together with a Leadership-Practice-In-Context (Wilson et al., 2018) approach to leadership offers dentistry an opportunity to move away from mainstream approaches to understand how leadership emerges in practice and to construct a theory which takes into account the challenges, purposes, values and relationships involved in leadership within its own context.

## **2.3 Leadership Practice**

Grint (2005a) makes the point that leadership should not only exist in theoretical terms, it must do something, in practice; to be useful in the real world.

This section situates dentistry within the wider healthcare context in order to understand the agenda for leadership. It explains the specific issues that inform and influence a dentistry-specific leadership agenda. The leadership studies literature offers a critical perspective on this agenda, demonstrating a sceptical view on the ubiquity of leadership and its promotion as a 'simple solution' to complex challenges.

### **2.3.1 Leadership practice in dentistry**

The dental profession is becoming involved in leadership. This has been stimulated by the focus on and recognised importance of leadership in the wider healthcare field, particularly in medicine and nursing, so Dentistry is effectively catching-up. There is seen to be a need to recognise how leadership specifically applies to dentistry and the implications in relation to the quality of individual care and the planning and contracting of dental services.

#### Leadership in the UK Health Service

In the UK, a key driver for a focus on leadership in healthcare has been the publication, over the past 20 years, of a series of high-profile government commissioned reports and policy initiatives. These have recognised leadership as being an important factor in the development, governance and quality assurance of healthcare services:

- The NHS Plan: a plan for investment, a plan for reform (Department of Health, 2000) led to an initiative within the Health service to develop leadership capabilities. This was part of a new NHS Institute for Innovation and Improvement;
- The Darzi Report– High Quality Care for All: NHS The Next Stage Review (Professor the Lord Darzi of Denham, 2008) introduced the approach of “fostering leadership for quality” (p.61). It called for stronger clinical leadership across the NHS and recommended a focus on training and development for staff. It specifically referred to the need to include

leadership in medical and nursing undergraduate curricula as well as outlining series of proposals for postgraduate training and development. This involved the establishment of Clinical Leadership Fellows (a training scheme for early career healthcare professionals, specifically focused on the work of leadership) and a call for schemes to allow clinicians to develop their leadership skills;

- The establishment of an NHS Leadership Academy, in 2012, dedicated to leadership in the NHS.

The aims of this organisation are to:

- 1) Define and promote good leadership (through the use of a developed Leadership Framework)
  - 2) Set national standards for leadership development and talent management
  - 3) Reward and recognise outstanding leadership
- NHS Leadership Academy, 2013a;

- A series of healthcare 'scandals', reported heavily in the media have raised public awareness of failings in the health service. For example, the Bristol Royal Infirmary children's heart surgery (1984- 1995) case. A public inquiry led by Professor Ian Kennedy QC reported poor organisation, failure of communication, paternalism and a 'club culture' resulting in a failure to put patients at the centre of care (Kennedy, 2001). More recently, was the case of a single surgeon, Mr Ian Paterson who was allowed to continue carrying out surgery which did not adhere to evidence-based practice putting patients at risk. Again, a Review, carried out by the same Professor Sir Ian Kennedy, found challenges in managing difficult and powerful members of staff, dysfunctional organisation, failures of communication, lack of openness, a particular style of leadership and a lack of engagement at Board level in the quality and safety of care (Kennedy, 2013);
- The publication in 2013 of The Francis Report – Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2012), was perhaps the most crucial influencer in relation to the recognition of leadership as being a key factor in healthcare. This report told of significant lapses in the quality of basic care provided to patients at the Mid-Staffordshire NHS trust. Patient and family transcripts included in Francis'

earlier 2010 report had illustrated an “appalling lack of care and respect” (Bagg and Welbury, 2015, p.206) for patients. There was widespread shock that such poor standards could be found in a UK NHS hospital trust. In relation to the Trust Board, the report stated:

It failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.

Francis Report, 2013, p.3.

A “re-emphasis of what is truly important” was proposed regarding:

- A commitment to values;
- Standards and no tolerance of non-compliance;
- Openness, transparency and candour;
- Strong leadership and support for leadership roles;
- Accountability.

Francis Report, 2013, p.66.

The significant failures in the quality of patient care have raised the stakes in relation to accountability and responsibility in healthcare. Common themes emerge, with failures in leadership being recognised as being key. These developments have also demonstrated a commitment to leadership as a solution for improving leadership across the healthcare system.

#### Leadership contexts in healthcare and clinical leadership

It is recognised that leadership is needed across all layers of healthcare, from the national political and policy level through to the front-line of direct patient care (Hartley and Benington, 2010). At this front-line level, the issue of clinical, as opposed to non-clinical leadership becomes pertinent. Jonas et al. (2011) define clinical leadership as:

The concept of clinical healthcare staff undertaking the roles of leadership: setting, inspiring and promoting values and vision, and

using their clinical experience and skills to ensure the needs of the patient are the central focus in the organisation's aims and delivery. Jonas et al., 2011, p.1.

Daly et al. (2014) also consider the issue of defining clinical leadership. They argue that clinical leadership, like other forms of leadership can be defined or 'framed' in multiple ways; "as situational, as skill driven, as value driven, as vision driven, as collective, co-produced involving exchange relationships and boundary spanning" (Daly et al., 2014, p.77). Facilitators and barriers to effective clinical leadership are also recognised. Facilitators include the need to engage staff in leadership. Barriers include:

Lack of incentives, lack of confidence, cynicism, poor communication, curriculum deficiencies at undergraduate level in health professional courses, role conflict, resistance to change, poor team work. Daly et al., 2014, p.81.

#### Leadership in dentistry

Developments in leadership in UK dentistry are following the leadership agenda found within the wider UK health service. There is also attention to the specific dental context and the challenges that dentistry particularly needs to address.

Dentistry faces specific challenges. These relate to

- the different modes of dental care provision: NHS, private and mixed primary dental care, community dental care, specialist and secondary care;
- the business of dentistry in general and specialist dental practices and the rise of corporate dental companies;
- the funding of dental care (NHS contracts, private payment plans);
- a high level of accountability in relation to quality (NHS regulations and inspections by the Care Quality Commission);
- increased patient expectations and litigation;
- increased complexity of patient care;
- human resources (self-employment, employment of staff);
- high levels of occupational stress.

(Willcocks, 2016; O'Reilly and Jacobs, 2015; Stagnell et al., 2017; Collin et al., 2019)

### Involvement of the dental profession in leadership

The majority of dental care provision is still carried out in General Dental Practice (Health Education England, 2018) and the majority of the dental professional workforce practice in this setting. It is suggested that currently dental professionals are not able to get involved in meaningful leadership activities and therefore not able to develop leadership experience. The fact that most dentists work in General Dental Practice is considered a barrier. This environment is apparently too isolated (Brocklehurst et al., 2013a). “Therefore, the vast bulk of our profession don’t really get exposed to the opportunity to become a leader” (Morison and McMullen, 2013, p.3). Walsh et al. (2015) describe practitioners feeling isolated within the “practice bubble” (p.192) and their need to step outside of this in order to see a strategic view. A self-reflective opinion paper published in the British Dental Journal (Ford, 2014, p.222) describes the need for dental professionals to “get out of the surgery and into the Leadership Academy.” A remark by Morison and McMullen (2013, p.5) states that “there is a need to help future dentists to deal effectively with everyday challenges occurring in a dental practice.” There is therefore uncertainty as to whether the vast majority of the profession are or can be engaged in leadership.

A drive for the interest in leadership is the need for dental professionals to be more directly involved in the local commissioning and governance of dental care provision. This is a result of National Health Service re-organisation of primary dental care which has promoted localism and clinician led services (Brocklehurst et al., 2013a). The Steele Report (2009), a major review of UK dental care provision, recommended that there should be representation from dental clinicians at this level: “we recommend that clinical leadership in NHS dentistry is promoted actively and included in other NHS leadership initiatives, as well as in local engagement.” (Professor Jimmy Steele, 2009, p.77). The introduction of Local Professional Networks (LPNs) in dentistry, similar to the Clinical Care Groups (CCGs) found in medicine, has given the opportunity for general dental practitioners to become involved in the local commissioning of dental services. This has prompted an interest in the need to develop leadership skills as, it is argued, the needs of leadership at the commissioning level are “quite different” (Brocklehurst et al., 2013a, p.246) from those needed within a dental practice environment.

Another development in dentistry, has been the appointment in 2016 of the first Dental Clinical Leadership Fellows within Health Education England. This has mirrored the Fellowships offered to clinicians in medicine. These new fellows

published an opinion paper which promoted the value of leadership to the profession (Stagnell et al., 2017). The Chief Dental Officer's Clinical Fellow Scheme also supports members of the dental profession to engage in leadership learning and is provided in collaboration with the Faculty of Medical Leadership and Management:

The Scheme provides a unique opportunity to spend 12 months in a national healthcare-affiliated organisation outside of dental practice, to develop their skills in leadership, management, strategy, project management, and health policy.

NHS England, 2020.

#### Advancing dental care review

In 2017 a review, titled the 'Advancing Dental Care: Education and Training Review' was commissioned by Health Education England. This is ongoing, with a second phase being undertaken. The aim of this review was "to identify a future dental workforce model and the training required to deliver it" (Health Education England, 2018, p.4).

The outcome of the first phase called for:

- Flexible training pathways;
- More career development opportunities;
- Flexibility in the workforce such that it has the capacity to respond to changes in demand;
- A workforce with the appropriate skills and competencies;
- Multi-professional and multi-disciplinary models of working.

Health Education England, 2018.

As part of this review, leadership in dentistry was identified as being a key part of the agenda in relation to developing the dental workforce. The need for training in leadership at all levels was called for. This is a statement from the review report:

The Review found that more leadership and management skills should be taught at the undergraduate level, to address the resilience issues that have been identified in recent registrants. Dental school faculties would require up-skilling in this subject area in the first instance.

HEE, 2018, p.19.



This raises two issues; that the resilience of new graduates (their ability to cope with pressure and to be flexible in relation to change) can be improved by being taught leadership skills and secondly that there is seen to be a need for university teaching to improve its expertise in the subject of leadership.

The review made two recommendations in relation to leadership and these involved the NHS Leadership Academy:

D4. To develop and pilot a self-help, team-building pack specifically designed to help dental teams assess their current level of efficient and effective working practices and support the design of development plans for further strengthening team performance.

HEE, 2018, p.34.

D5. To develop system leadership from within primary care, identifying and supporting high-calibre individuals to maximise their potential.

HEE, 2018, p.34.

Phase II of the Review has involved establishing of a series of workstreams to further investigate the findings and recommendations made in Phase I. One of these workstreams is 'Leadership and Development' and is led by Professor John Darby, a Postgraduate Dental Dean within Health Education England. The first action of this workstream was to survey members of the dental profession in relation to their views on "leadership roles and abilities and the need for further development." (HEE, 2019, p.6). This survey will be further considered as part of the 'Leadership Education' section of this chapter (2.4.1).

There have therefore been a series of recent developments in relation to leadership in dentistry.

### Summary

In relation to leadership practice in dentistry, the literature reveals the following:

- Dentistry is effectively catching up with the focus and commitment to leadership found within the wider healthcare field;
- Within the UK health service there is seen to be a need for better accountability and responsibility. Leadership is recognised as a means by which this can be brought about;

- It is recognised that clinical leadership is needed at the front-line of patient care. This involves setting, inspiring and promoting values and vision;
- Dentistry has mirrored some initiatives found in medicine: the appointment of leadership fellows and the involvement of dentists in the local commissioning of services;
- There is uncertainty as to whether the vast majority of the profession (those who work in general dental practice) are or can be actively engaged in leadership;
- A recent national UK review of dental care provision has recognised leadership as a key theme for development within the profession.

### **2.3.2 Perspectives on leadership practice from the leadership studies literature**

Within the leadership studies literature, a different perspective on leadership practice can be found. Here there is strong scepticism with what has been described as the “growing fascination or perhaps emerging cult of leadership” (Ford, 2015a, p.261). Across the public sector, including healthcare, it is argued, leadership is seen as an all-encompassing, “simplistic solution to complex problems” (McDonald, 2014, p.227). Leadership is seen as something different, something that is more attractive to the bureaucratic and mundane work of management (Ford and Harding, 2007; Bresnen et al., 2015). As McDonald (2014) describes, leadership is promoted as something that has a proven positive effect on performance (NHS Leadership Academy, 2013b), when this is disputed (Ovretveit, 2009). The trend towards the ubiquity of leadership has been termed “leaderism” (O’Reilly and Reed, 2010; Bresnen et al., 2015) and there is a call for this to be challenged critically, to question the assumptions and motives that lay behind it (McDonald, 2014).

#### The growth of ‘leaderism’

Since the late 1990s, leadership has been advocated as a means by which the public sector can address the many and diverse challenges that it faces, for example:

- A rapid pace of change including the introduction of new technology;
- Greater organisational complexity;
- Increased expectations of the public.

Adapted from O’Reilly and Reed, 2010, p.966.

In this time there has been significant reform and reorganisation of the public services in the UK in what has been termed the “new public governance era” (O’Reilly and Reed, 2010, p.961). This era has been characterised by attention to:

- Standards and accountability;
- Devolution and delegation;
- Flexibility and incentives;
- Expanding choice.

O’Reilly and Reed, 2010, p.965.

O’Reilly and Reed (2010) illustrate the involvement of leadership in this ‘new era’ by investigating the number of UK public administration documents which include ‘leadership’ in the title. From 1988 to 1997 there were 124 such documents; from 1997 to 2008 there were 1428. This represents a huge increase in expectations for leadership.

This is also happening in the healthcare sector. Here there has been a move away from talk of management towards talk of leadership. Management was seen to be failing and many of the problems found in the UK National Health Service were blamed on this (O’Reilly and Reed, 2010). Leadership has been seen as something different, something that surpasses management (Ford and Harding, 2007) and something that can overcome the challenges that management could not. Bresnen et al. (2015) outline a series of contrasting “portrayals” (p.459) of management and leadership:

| <b>Management</b>                         | <b>Leadership</b>                           |
|---|---|
| Nuts and bolts                            | Visionary                                   |
| Following policies, procedures, processes | Make decisions                              |
| Day to day                                | Long term                                   |
| Getting people to do their jobs           | Helping people see why they do what they do |
| Bureaucratic                              | Heroic                                      |
| Unpleasant                                | Dynamic                                     |

**Table 4.** Portrayals of Management and Leadership. Adapted from Bresnen et al., 2015.

According to this portrayal, leadership appears to be far more attractive. This separation between leadership and management (described as dualist) however is argued to be false (Bresnen et al., 2015; Ford and Harding, 2007; McDonald, 2014). These are not mutually exclusive terms and there is significant overlap and interplay between them. Leadership is therefore not something far removed from management despite the status that it is perceived to have. Martin and Learmonth (2012) call leadership a 'relabelling' of management. They both involve people and relationships and depend on context and the navigation of complexity (Ford, 2015a).

There is also scepticism that there may be a 'dark side' to the rise of leaderism and the 'ideology' it has assumed (Ford, 2010; O'Reilly and Reed, 2010). It is a means by which individuals are singled out to take leadership training courses (in the UK health service this is delivered by the NHS Leadership Academy, including specific Leadership Fellow training posts). It is argued that this is just a "covert means of perpetuating elite domination" (Bresnen et al. 2015, p.454), Blackler (2006, p.5) terms these individuals as "little more than conduits for national policy." In effect, leadership becomes a "fig leaf to hide the more oppressive aspects of life in healthcare provision" (Martin and Learmonth, 2012, p.287). The motives behind the policy and purpose of leadership promotion therefore need to be questioned, critically.

Whether or not the motivation behind the rise in leaderism is to control and indoctrinate the workforce, the need to take a step back and think critically about why a focus on leadership has emerged is important. If this is not done, the danger may be that, in time, if 'leadership' fails and a replacement 'simplistic solution' comes along, critical lessons will not have been learned.

### Summary

In relation to leadership practice, the leadership studies literature reveals the following:

- There is strong scepticism about the ubiquity of leadership as a simplistic solution to complex problems across the public sector services;
- The 'growing fascination with leadership' as been described as 'leaderism';

- Leadership is assumed as something that can overcome the challenges that management could not. This assumption, and the dualist separation between them is questioned. Leadership is in effect, a positive relabeling of management;
- A sceptical view of leaderism is it that can perpetuate the ideas of elitism and control;
- A critical perspective is seen as important in challenging the assumptions made about the merit of leadership.

### **2.3.3 Situating leadership practice in dentistry within the wider leadership studies literature**

There is much talk about the role that leadership is expected to play within healthcare and in dentistry. Many of the main UK health policy documents identify leadership as key to the development to the future workforce and to the future of effective and high-quality healthcare provision. Dentistry has followed the rest of the UK health sector in recognising this; NHS leadership fellows have been appointed and there is a plan to identify 'high calibre individuals' to take on the challenge of leadership. The enhancement of leadership education at all levels is advised and this will be considered further in the 'Leadership Education' (2.4.1) section of this chapter.

Seen from the perspective of the leadership studies literature, these developments can be viewed sceptically, as examples of leaderism. Much is being expected of leadership to address the many and complex challenges found within dentistry. What is needed is a more critical and meaningful understanding of the way that leadership is found within the profession – where, when, how and why it happens (a Leadership-As-Practice-In Context perspective). In this way leadership might better engage the whole profession.

## **2.4 Leadership Research Methodology**

This section explores the status of leadership research methodology within dentistry. This raises questions as to the very nature of research philosophy and what methodological approaches can be used to discover and understand leadership, meaningfully. Within the leadership studies literature, approaches, based on opposing philosophical views, are found. It encourages innovative and practice-based research.

### **2.4.1 Leadership research methodology in dentistry**

In the UK, there are few examples of empirically based, published research papers in relation to leadership in dentistry. The methodology used in these examples is explored.

Firstly, Morison and McMullen (2013) used a 'qualitative, key informant' approach to exploring perceptions of leadership in the dental profession. Key informants were "professional leaders within the dental services" with "specialist knowledge of dental leadership and dental services and had knowledge of dental services policy" (p.2). They used a semi-structured interview method. The interviewer was not a healthcare professional therefore able to remain neutral and this was reported as an advantage in encouraging participants to speak freely. A thematic approach was used in analysis.

Brocklehurst et al. (2013b) also used a semi-structured method in their paper on cultural differences in attitudes to leadership. In this study, participants were selected purposefully – General Dental Practitioners who were involved in leadership roles. Participants came from cohorts in Greater Manchester and Tokyo. A series of questions were derived *a priori*, and the interviews conducted until saturation. 12 participants took part. A coding frame was developed for thematic analysis.

Hill and Brocklehurst (2015) used a questionnaire method to determine important leadership qualities for dentists. They then went on to use a data reduction analysis method to produce a tool to measure leadership. A 61-item questionnaire, with a 7-point Likert scale to allow rating against each item was used. All General Dental Practitioners in the North West of England (number: 998) were asked to

complete the questionnaire. The response rate was 22.9% (number: 237). Detailed statistical analysis was used as part of the data reduction analysis method. This is illustrated in the following quotes:

The dataset was initially evaluated for appropriateness for factor analysis by utilizing the Kaiser–Meyer–Olkin (KMO) measure to test whether the partial correlations among the items were small. The KMO measure ranges from 0 to 1 and factor analysis is considered appropriate when it lies at or above 0.5. Bartlett’s test of sphericity was then undertaken to determine whether the correlation matrix was an identify matrix, i.e., whether the diagonal elements were equal to unity and whether off-diagonal elements were equal to zero. Hill and Brocklehurst, 2015, p.14.

Several fit indices were then used to test which factor model best represented the data: chi-square ( $\chi^2$ ), chi-square statistic to degrees of freedom ( $\chi^2/df$ ), root mean square error of approximation (RMSEA), Tucker–Lewis index (TLI), comparative t index (CFI), or the parsimony-adjusted CFI (PCFI). The  $\chi^2$  statistic tests whether a model’s covariance structure is statistically significantly different from the observed covariance structure in the data. A P-value above 0.05 was considered to indicate a good fit. Hill and Brocklehurst, 2015, p.15.

The results indicate items that are ‘good leadership’ and ‘bad leadership’:

Examples:

|                 | Item   | Rotated factor pattern coefficient | Rotated factor structure coefficient | Item communalities |
|-----------------|--|------------------------------------|--------------------------------------|--------------------|
| Good leadership | I generate respect among my team               | 0.88                               | 0.88                                 | 0.77               |
| Bad leadership  | I find it difficult to adapt to new situations | 0.77                               | 0.75                                 | 0.59               |

**Table 5.** Example of statistical data within quantitative leadership research in dentistry. Data taken from Hill and Brocklehurst, 2015.

### Summary

These examples of leadership research in dentistry give an indication of the following:

- Semi-structured interviews and questionnaire methods are used;
- There is purposeful sampling of those who are considered as being involved in leadership in dentistry (General Dental Practitioners, Professional leaders within dental services), other members of the profession are not included;
- There are examples of qualitative approaches using thematic analysis;
- There is emphasis on objectivity (including the neutrality of an interviewer);
- The example of a quantitative approach illustrates a detailed attention to statistical analysis in determining important leadership properties for dentists. In this example, the response rate is poor.

### **2.4.2 Perspectives on leadership research methodology from the leadership studies literature**

Within the leadership studies field, questionnaire and semi-structured interview methods are also used as well as a growing diversity of alternative method types. This diversification has resulted from a questioning of assumptions in relation to the nature of research and inquiry and the meaning of leadership.

#### The nature of research

Traditionally, leadership research has been adherent to the scientific paradigm<sup>4</sup> (Bolden, 2011; Sutherland, 2018; Wilson et al., 2018). This means it follows approaches used within the natural sciences and is based on a set of underpinning principles and characteristics: “objectivity, neutrality, procedure, technique, quantification, replicability, generalisation, discovery of laws” (Alvesson, 1996, p. 455), “concern with precision and measurement”, “hypothetico-deductive logic”, “timeless and universal” and “decontextual” (Wilson et al., 2018, p.10-14). The scientific paradigm is based on a positivist epistemology. Epistemology can be thought of as what can be considered as truth. A positivist epistemology values

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<sup>4</sup> A more detailed consideration of research philosophy and methodology is given in the Methodology and Methods Chapter (3.1).



objective fact as being true. In relation to the trait (a focus on a “singular, heroic individual”, Sutherland et al., 2020, p.133) and behavioural theories of leadership this approach has seen to fit as aspects of trait and behaviour have been objectively measured and reported. In the leadership and organisation studies field there are academic journals which favour this approach, ‘The Leadership Quarterly’ (a north American based journal) being one example (Bryman, 2011). In the past decade, 69.4% of published papers in this journal have been quantitative and transformational leadership was the most prominent theory to be covered (Gardner et al., 2020). As the thinking behind leadership has progressed away from essentialist theory, there has been growing dissatisfaction with this approach to research and its “dominance” (Alvesson, 1996, p.455) within the literature, as illustrated by the critical description by Tourish (2015): the “ongoing fetishisation of positivist methodologies and functionalist perspectives which has become institutionalised by a deference to supposedly leading US journals” (Tourish, citing Wilkinson and Durden, 2015, p.138). Bryman (2004, p.749) argues that leadership is a “methodologically conservative field that is slow to innovate,” and this dominance of positivism could be an illustration of this conservatism.

This dissatisfaction relates to the changing way in which leadership is conceptualised and theorised, and the need to fundamentally change the way it is researched. Rather than being an objective, neutral and universal concept, leadership is now being seen as a subjective, socially constructed and contextual concept (Smircich and Morgan, 1982; Grint, 2005a; Barge and Fairhurst, 2008; Wilson et al., 2018). It therefore relies on an entirely different epistemology and ontology: interpretivism and subjectivism. Research which uses qualitative methodology to allow the exploration and elucidation of interpretive and subjective meaning is considered to be more congruous (Cunliffe, 2008). Academic journals which recognise and accept a variety of different qualitative approaches are found, mainly in Europe. The ‘Leadership’ journal is one example. This reflects a geographic, cultural contrast in approaches to leadership research.

As considered previously in the ‘Theory’ section of this chapter, a re-thinking of leadership theory has highlighted the following issues:

- The complexity of leadership;
- The contextual nature of leadership;
- The inter-relational and co-constructed, collective nature of leadership;
- The diversity of agents (participants) involved in leadership;

- The dynamic, unpredictable, unfolding nature of leadership.

Qualitative, exploratory methods are needed to allow these issues to be illuminated and described within the academic literature. There is a need for deeper engagement within research contexts and situations; a need for greater engagement with a more diverse range of practitioners as research participants; a need for flexibility and better receptivity to events as they unfold and there is a need for better engagement in the everyday activities of leadership (Conger, 1998; Bryman, 1988; Alvesson, 1996; Raelin, 2019; Kempster et al., 2016; Sutherland et al., 2020). In summary, there is a greater need for “practical engagement” as opposed to “scientific detachment” (Whittington, 2004, p.62). Carroll et al. (2008, p.372) call for leadership “to throw off the ‘epistemological straightjacket’” of the positivist science paradigm and a search for “richer versions of leadership.”

#### Research methods

Qualitative methods based on an interpretive epistemology, it is argued, allow for a more nuanced and contextually specific investigation of the complex nature of leadership than positivist quantitative methods (Sutherland, 2018). The advantages of qualitative research as applied to leadership studies include:

- Flexibility to follow unexpected ideas during the research process;
- Sensitivity to contextual factors;
- Ability to study social meaning and constructions;
- Increased opportunities for the development of new theory, in-depth exploration, more relevance and interest for practitioners.

Parry et al., 2014, p.133.

A specific focus on three main method types: questionnaire, interview and ethnographic observation is used here to illustrate various advantages and disadvantages in researching leadership.

- Questionnaire / survey studies

This method is used extensively in leadership research (Bryman, 2004). In the Leadership Quarterly journal, 46.8% of papers published in the last 10 years used this method (Gardner et al., 2020). One of its main advantages is that is relatively easy to apply (with a low financial cost and researcher time cost) and can be used to survey many participants within a short, defined time (it is therefore cross-

sectional). As in a quantitative methodology, responses can be controlled, with options being given to defined questions. Often Likert scales are used to provide a quantitative result which can be statistically analysed (Alvesson, 1996).

Questionnaires are therefore mainly positivist in epistemology.

Some of the main criticisms in relation to the use of questionnaires in leadership research are:

- Low response rates (Bryman, 2011);
- A lack of connection to activity and events (they are distanced from these) (Alvesson, 1996);
- The use of collated data in the form of statistical averages does not give detailed or rich insights into experience or meaning (Alvesson, 1996);
- They struggle to deal with the complexity of issues where multiple, interconnected factors are at play (Alvesson, 1996);
- They produce “abstract” and “standardised” results (Alvesson, 1996);
- Questions contained in the survey are written by the researcher and therefore may contain *a priori* assumptions in relation to areas of importance or significance, and they can be written in ways that can influence interpretation by participants.

#### - Interviews

Interviews are the most commonly used research method in management and organisational research; “it has been estimated that 90% of all social science investigations involve interviews” (Holstein and Gubrium, 2011). Interviews, in general terms, tend to align with a qualitative methodological approach. This is not always the case however, as the structure of the interview can be designed and analysed along quantitative principles (Alvesson and Ashcraft, 2012). Crucially, interviews provide an opportunity for social interaction (between participant and researcher) (Kvale and Brinkmann, 2009). They can therefore allow scope for a detailed and rich exploration of a participant’s knowledge, opinions and experiences, and the meanings generated can be negotiated between participant and researcher (Alvesson, 1996). This means that the interview is less likely (in comparison to the questionnaire method) to be based on the *a priori* assumptions of the researcher who can set and define the scope of enquiry. Interviews are also flexible and adaptable to different research strategies (Bryman, 2011). In relation to analysis, transcribed text is amenable to a variety of forms of analysis, for example,

content analyses such as coding, thematic and more discursive analytic approaches.

Some of the main disadvantages of interviews are as follows:

- Time and financial cost including the interview and transcription processes;
- Positive bias – this is the effect of participants feeling that they need to make a good impression (perform) in relation to the researcher. They will therefore say one thing and do another (Alvesson, 1996);
- Subjects may deliberately lie, conceal, or manipulate the interviewer;
- Subjects may be honestly mistaken/ misinformed;
- Many situations have “multiple truths” (Alvesson and Ashcraft, 2012);
- The interview situation is asymmetric in respect to power (Gubrium and Holstein, 2001; Kvale and Brinkmann, 2009);
- Each interviewer/ interviewee interaction is unique so another interviewer with the same participant may elicit different responses.

- Ethnography<sup>5</sup>

Ethnography is a method which involves a researcher or researchers going into real and specific research settings or contexts, to immerse themselves in the events and ‘lived experiences’ within it (Hammersely and Atkinson, 2007; White et al., 2004; Cunliffe, 2010; Sutherland, 2018). Immersion within the setting usually takes place over a long period of time (longitudinal) so that an understanding of events over time can be gained. The researcher sees things as they unfold in the setting (Van Maanen, 1988; Czarniawska, 2014). As such it does not take an experimental logic of enquiry. Researchers can take the role of participants and/ or observers within the setting (McDonald and Simpson, 2014). The gathered data is written up by the researcher (a process of translation) to create an account of the findings. This method is highly characteristic of a qualitative methodology and is based on an interpretivist epistemology. An example comes from Samra-Fredericks (2003). Here ethnography was used to reveal the work of a group of strategists in the planning of a new manufacturing facility. The ethnography lasted for 12 months and the researcher was able to follow events and attend meetings. The findings revealed that even small fragments of “everyday” recorded talk and interaction

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<sup>5</sup> A detailed consideration of ethnography is given in the Methodology Chapter (3.6). It is considered here to briefly allow comparison with questionnaire and interview methods in researching leadership specifically.

(Samra-Fredericks, 2003, p.159) were enough to reveal the way that the strategists constructed their reality and their future vision. Here there was opportunity to understand (through first-hand accounts) what really happened, rather than relying on participants' own accounts – what they said they did.

This method allows rich and thick (Geertz, 1973) data to be gathered. Insights gained by the researcher may not have been apparent to participants and therefore tacit issues can be illuminated and revealed by the observer (Kempster et al., 2016, p.253). This method has the flexibility and spontaneity to adapt to situations as they arise because the researcher can follow a stream of activity.

Some of the main advantages of ethnography include:

- Enables rich insights into a given context;
- Enables access to situations where the researcher is traditionally excluded from (Samra-Fredericks, 2003);
- Flexible in terms of following up new leads and research questions.

Sutherland (2018, p.263) argues that “investigating leadership ethnographically” presents opportunities to move away from quantitative type research which considers leadership as an objective and universal concept, to ‘make sense of’ leadership in a more meaningful way. In order to reveal and to gain an understanding of the complexity, contextual, inter-relational and unpredictable nature of leadership, methods which involve “a commitment to deep engagement” (Kempster et al., 2016, p.246) in contexts and participants are required. In particular, the Leadership-As-Practice lens (as described in the Theory section of this chapter) involves a focus on “interpersonal relationships and intercultural relationships”, “the language, the emotions, the stories, the physical arrangements of work, the rituals” and the “cultural, historical and political conditions” (Raelin, 2011, p.201). Sutherland (2018, p.281) also refers to the ability to gain an understanding of “underlying values and beliefs; to hear stories that people tell to get their point across...to see ‘influence’ happening.” These are the routine, mundane features of everyday organisational life. Proponents of the practice lens advocate for the use of methods which are aimed at “understanding the system from within” (Raelin, 2011, p.202); methods which allow the “where, when, how and why” questions to be answered (Raelin, 2016a, p.134). Gherardi (2008) highlights the need for a focus on ‘situated action’ and the need for ‘practice-based studies’. In relation to research findings, resonant (Tracy, 2010) accounts which offer insight and understanding are called for (Kempster et al., 2016).

Despite the many theoretical arguments made in favour of ethnography as a method suited to leadership research, it is infrequently used and there are few examples. It is argued that this is because of the practical challenges involved in actually conducting this type of research (Sutherland, 2018).

Some of the main disadvantages of ethnography include:

- Gaining (and maintaining) access to research settings and people (Bryman, 2004);
- Resource heavy time commitment for field work and analysis of a large amount of data (Alvesson, 1996);
- The intrusion on participants and their time commitment (Gill, 2011).

These challenges need to be overcome by researchers in order for the theoretical benefits of ethnographic enquiry to be revealed in practice.

### Summary

In relation to leadership research methodology, the leadership studies literature reveals the following:

- The nature of leadership research is closely related to the meanings and theories of leadership as a concept itself;
- Quantitative research methodology which considers leadership as an objective and universal concept dominates the leadership studies literature;
- Many involved in leadership studies are rethinking leadership as a complex, subjective, interpretive, co-constructed, collective and contextually specific concept;
- Methods, such as ethnography, are being promoted as having potential and opportunity to discover and reveal this rethinking of leadership in practice;
- There are challenges to ethnographic approaches which need to be overcome if it is to be used as a viable research method.

### **2.4.3 Situating leadership research methodology within the wider leadership studies literature**

Dentistry has only a handful of examples of leadership research and these take different approaches; key informant interviews and questionnaires. There is an assumption that those who 'do' leadership because of their position (designated leaders) should be chosen as the most appropriate research participants. The Hill and Brocklehurst (2015) example demonstrates the use of a quantitative approach using detailed statistical analysis of questionnaire data. The leadership studies literature demonstrates a dominance of this type of positivist approach but there is growing dissatisfaction with it, particularly as a result of a rethinking of leadership as a complex, co-constructed, collective and contextually specific concept. If dentistry can embrace this way of thinking about leadership, there is opportunity for a greater diversity of qualitative type research methods (and participants) to be used. It may be however that in order for dentistry to understand how leadership actually happens within the profession, research which immerses itself within its everyday practice, needs to come first.

## **2.5 Leadership Education**

This section explores how leadership is developed within the dental profession together with the current thinking in relation to learning outcomes and educational approaches. The leadership studies literature identifies differing educational philosophy and approaches and fundamental assumptions about the purpose and practice (Bolden, 2005) of leadership education are questioned.

### **2.5.1 Leadership education in dentistry**

There is recognition that having effective leaders is essential for the future success of the dental profession. The development and education of future leaders is seen as key. The 'key informant' research participants within Morison and McMullen's (2013) study call for a need to identify potential leaders through education and training. There is seen to be a deficit of leaders within the profession and talk surrounds the need to identify and 'grow' (Morison and McMullen, 2013, p.4) leaders from an early stage. In the UK, leadership development is already a requirement of undergraduate, postgraduate and continuing professional development stages in dentistry.

#### Undergraduate Leadership Education in Dentistry

A study which evaluated a pilot leadership programme for qualified general dentists (Walsh et al., 2015) recommended that leadership development should begin at undergraduate level. Action has been slow to follow however, with no examples of UK undergraduate leadership programmes being reported in the literature. Most of the literature in relation to undergraduate leadership education comes from the US, starting in 2008 (Victoroff et al., 2008). There are however recent examples from Finland (Taipale et al., 2018) and from Australia (Hayes and Ingram, 2019). The repetition of references indicates the limited number of authors and papers published in this area.

The call to action in the US emphasises the need to develop leadership capacity within the profession to deal with increasing challenges and demands (Taichman et al., 2012). It is reported that while dental education trains students well in the knowledge, skills and attitudes needed for the profession, leadership capabilities have been neglected (Taichman et al., 2012). A survey of dentists found that between 37-65% of respondents reported that their undergraduate training had not



prepared them well for leadership in dental practice (Taichman et al., 2014). Undergraduate education, it is argued, is therefore key in addressing the preparation need (Victoroff et al., 2008).

The call to action raises a series of questions in relation to leadership education for dentistry:

- 1) Do students value education in this area?
- 2) What approaches to curriculum design could be taken?
- 3) What content would be included?
- 4) Who will provide the content?

Taichman et al., 2012, p.189.

### Student views

In considering the first of these questions, several dental student surveys have been reported. Students responded positively to the opportunity to undertake leadership development (two thirds of respondents, Victoroff et al., 2008 and 84% respondents, Hammer and Nadershaki, 2011). There was recognition that leadership would form a significant part of their future practising careers (Victoroff et al., 2008; Taipale et al., 2018). The limitations are that these surveys were conducted within single dental schools and it was reported that 'social desirability bias' (Victoroff et al., 2008) may have affected student responses. An opinion paper written by a group of US dental students (Aljadeff et al., 2013) recognised the need to start leadership education at the early stages of the curriculum and that students should be allowed some 'structured freedom' to allow them to explore areas of interest and potential. They recognised that leadership would be important in their practising careers: "practising dentists employ leadership on a regular basis: the challenge of leading an office staff and influencing patient behaviour requires daily leadership" (Aljadeff et al., 2013, p.392).

Kalenderian et al. (2010) and Victoroff et al. (2008) reported on student evaluation surveys of experiences of leadership education programmes. These evaluations were generally positive with improvements in confidence, communication, organisational and influencing skills being reported.

Approaches to curriculum design

Kalenderian et al. (2013, p.1508) gave a definition of leadership training:

The purposeful expansion of an individual's capacity focussed on leadership, in which leaders and groups learn how best to work together in productive and meaningful ways.

Various emergent examples of the development of leadership education programmes for undergraduate dental students have been reported (Taichman et al., 2009; Victoroff et al., 2009; Taichman et al., 2012; Taipale et al., 2018; Hayes and Ingram, 2019).

One such example (Victoroff et al., 2009) describes a programme based around three main themes: knowledge, skills and inspiration. Leadership knowledge was delivered by guest speakers and the issue of a relevant textbook; skills included the practice of public speaking, a 360° feedback competency, interaction with fellow students and leaders; inspiration was gained through listening to panel discussions, attendance at a dental association leadership institute and finally, dinner with the Dean.

A poorly responded survey (39%) of US Dental Schools (Taichman and Parkinson, 2012) found a variation in leadership education models used. Leadership education was situated within different settings: practice management, community outreach and public health programmes.

Kalenderian et al. (2013) provided more detail and reported on leadership programmes found in four US schools which took part in a facilitated conference workshop session. It is possible to identify contrasting educational philosophy and delivery methods in the given examples (table 6).

|                            | University of Michigan, School of Dentistry  | Case Western Reserve University, School of Dental Medicine   | Harvard School of Dental Medicine  | University of the Pacific Arthur A. Dugoni School of Dentistry   |
|----------------------------|--|--|--|--|
| Aims and mission statement | “to empower dental and dental hygiene students to envision and promote cultural changes.... those willing to wrestle with global issues facing the dental profession”. | “A focus on knowledge, skills and inspiration to lead in a variety of settings”  | “to enhance the ability of graduates to face the ‘significant challenges’ every clinician and researcher will face within his or her practice with colleagues, staff and patients” | “to help students develop practical leadership skills they can apply immediately and in their future endeavours” |
| Admission                  | Selective process  | Open to all students, years 1-4  | All year 3 students  | Years 1-3  |
| Requirement                | Optional/ extra-curricular   | Optional/ extracurricular  | Compulsory   | Optional/ extracurricular  |
| Approach to learning       | Active learning through group projects   | Active-learning in the classroom setting; panel discussion with role models; personal vision and goals for development | 54 hours Active learning in the classroom setting, lecture and discussion  | Group meetings, speaker series, mentorship programme   |

**Table 6.** Examples of leadership education philosophy and delivery methods from US Dental Schools. Adapted from Kalenderian et al., 2013, p.1511.

These examples reveal contrasts in approaches taken. The aims demonstrate differences in what is being expected in relation to leadership; whether it be “wrestling with global issues” or within the practice setting “with colleagues, staff and patients”. The issue of selection is also raised. As shown, one school took a selective approach while others allowed all students (within particular year groups) the option to take part. In addition, in only one school was this education compulsory. In relation to learning approaches, the schools favoured an active-learning approach, alongside speakers and the use of mentorship.

What content should be included and who should provide it?

Dental professional regulatory bodies in different countries specify a required set of leadership outcomes or competencies (table 7). These reveal differences in what is considered 'leadership' content.

| Source of learning outcome and structure  | Leadership specific learning outcome(s)  |
|---|--|
| <p><b>UK, General Dental Council</b>, 'Preparing for Practice', Dental team outcomes for registration, Revised 2015</p> <p>4 main domains:</p> <ul style="list-style-type: none"> <li>• Clinical</li> <li>• Communication</li> <li>• Professionalism</li> <li>• <b>Management and Leadership</b></li> </ul> | <p><b>'Management and Leadership'</b></p> <ul style="list-style-type: none"> <li>• <b>Managing self</b> <ul style="list-style-type: none"> <li>- Put patients' interests first and act to protect them</li> <li>- Effectively manage their own time and resources</li> <li>- Recognise the impact of personal behaviour on the health care environment and on wider society and manage this professionally</li> <li>- Recognise the significance of their own management and leadership role and the range of skills and knowledge required to do this effectively</li> <li>- When appropriate act as an advocate for patient needs</li> <li>- Take responsibility for personal development planning, recording of evidence, and reflective practice</li> <li>- Ensure that all aspects of practice comply with legal and regulatory requirements</li> <li>- Demonstrate appropriate continuous improvement activities</li> </ul> </li> <li>• <b>Managing and working with others</b> <ul style="list-style-type: none"> <li>- Take a patient-centred approach to working with the dental and wider healthcare team</li> <li>- Recognise and respect own and others' contribution to the dental and wider healthcare team and demonstrate effective team working, including leading and being led</li> <li>- Recognise the importance of and demonstrate personal accountability to patients, the regulator, the team and wider community</li> <li>- Where appropriate lead, manage and take professional responsibility for the actions of colleagues and other members of the team involved in patient care</li> <li>- Recognise and comply with the team working requirements in the Scope of Practice and Standards documents</li> <li>- Describe the impact of Direct Access on each registrant group's scope of practice and its effect on dental team working</li> <li>- Describe the scope of practice of the dental team and where appropriate manage and delegate work accordingly, in line with competence and professional practice</li> <li>- Recognise, take responsibility for and act to raise concerns about their own or others' health, behaviour or professional performance as described in Standards for the Dental Team Principle 8</li> <li>- Recognise the need to ensure that those who raise concerns are protected from discrimination or other detrimental effects</li> </ul> </li> </ul> |

|  |   |
|--|---|
|  | <ul style="list-style-type: none"> <li>• <b>Managing the clinical and working environment</b></li> <li>- Recognise and comply with systems and processes to support safe patient care</li> <li>- Recognise the need for effective recorded maintenance and testing of equipment and requirements for appropriate storage, handling and use of materials</li> <li>- Recognise and demonstrate the procedures for handling complaints as described in Standards for the Dental Team</li> <li>- Describe the legal, financial and ethical issues associated with managing a dental practice</li> <li>- Recognise and comply with national and local clinical governance and health and safety requirements</li> <li>- Describe the implications of the wider health economy and external influences</li> <li>-</li> </ul>  |
| <p><b>US, Commission on Dental Accreditation</b></p> <p>Accreditation Standards for Dental Education Programs, Updated 2019</p> <p>6 areas of graduate competency:</p> <ol style="list-style-type: none"> <li>1. Critical thinking</li> <li>2. Biomedical sciences</li> <li>3. Behavioural sciences</li> <li><b>4. Practice management and health care systems</b></li> <li>5. Ethics and professionalism</li> <li>6. Clinical sciences</li> </ol> | <p><b>'Practice Management and Health Care Systems'</b></p> <p>Graduates must be competent in applying the basic principles and philosophies of practice management, models of oral health care delivery, and how to function successfully as a leader of the oral health care team</p>   |
| <p><b>Australia, Australian Dental Council</b></p> <p>Professional competencies of the newly qualified dentist, 2016</p> <p>6 main competency areas:</p> <ol style="list-style-type: none"> <li>1. Professionalism</li> <li><b>2. Communication and Leadership</b></li> <li>3. Critical thinking</li> <li>4. Health promotion</li> <li>5. Scientific and Clinical Knowledge</li> <li>6. Patient care</li> </ol>                                    | <p><b>'Communication and Leadership'</b></p> <ol style="list-style-type: none"> <li>1. Communicate and engage with patients, patient's families and communities in relation to oral health care</li> <li>2. Present clear information in a timely manner that ensures patients are advised of and understand care and treatment options to be provided</li> <li>3. Communicate with other health professionals involved in patients' care</li> <li>4. Engage in mentor/ mentee activities and leadership within a health care team</li> <li>5. Recognise the importance of one's own, colleagues' and team members' health to occupational risks and its impact on the ability to practice</li> <li>6. Understand the importance of intra and interprofessional approaches to healthcare</li> <li>7. Understand effective information management</li> <li>8. Understand the principles of dispute resolution</li> <li>9. Communicate responsibly and professionally when using media</li> </ol> |

|   |  |
|---|--|
| <p><b>Europe, Association for Dental Education in Europe</b><br/>The Profile of Undergraduate Education in Europe, 2017</p> <p>4 domains:</p> <ol style="list-style-type: none"> <li>1. Professionalism</li> <li><b>2. Safe and Effective Clinical Practice</b></li> <li>3. Patient-centred care</li> <li>4. Dentistry in society</li> </ol> <p>Field et al., 2017.</p> | <p><b>‘Safe and Effective Clinical Practice’<br/>Management and Leadership</b></p> <ol style="list-style-type: none"> <li>1. Establish, manage and maintain a safe working environment</li> <li>2. Effectively manage their own time and resources</li> <li>3. Effectively integrate other members of the dental team with regard to risk management e.g. working posture, visual perception, the use of equipment, dealing with stress and burn-out</li> <li>4. Effectively raise concerns in an appropriate manner, at various levels, recognising that those who raise concerns are protected from discrimination</li> <li>5. Manage adverse events in the short and longer term</li> <li>6. Consider implementing changes within the team and the wider practise environment that will significantly improve efficiency and sustainability of resources</li> </ol> <p>Leadership is also mapped to learning outcomes in domains 3 and 4</p> <ol style="list-style-type: none"> <li>3.1. Effectively lead all members of the dental team</li> <li>3.2. Describe the role of all members of the dental team, and how they can contribute to a patient-centred approach to the delivery of safe and effective care</li> <li>3.20 Display appropriate behaviour towards all members of the dental team and in their dealings with other allied healthcare workers</li> <li>4.3 Effectively communicate and manage the hazards within the clinical environment including cross-infection control, use of hazardous materials and working with ionising radiation</li> </ol> |
|---|--|

**Table 7.** Leadership learning outcomes for competencies specified by dental professional bodies in the UK, the US, Australia and Europe.

There are differences in the level of detail given in each of the frameworks and differences in how leadership has been designated in relation to other areas. The frameworks also reveal and reflect something of the character/ nature of the leadership culture within these different countries and areas.

For example, the UK General Dental Council gives ‘Management and Leadership’ its own specific domain, alongside three well-established and fundamental areas, including the entirety of clinical education (GDC, 2015). This perhaps gives an indication of the level of importance and of expectation attached to management and leadership in the UK profession. When looking in detail at the learning outcomes what constitutes management and leadership includes themes such as compliance, accountability, adherence to regulatory requirements and procedure as well as legal and ethical issues such as raising concerns. This reflects the ‘regulatory’ agenda in UK healthcare, as described earlier in the ‘Practice’ section of this review.

The US competency example (Commission Dental Accreditation, 2019) relates to being a successful leader of an oral health care team. This takes a traditional

'leader-centric' approach and assumes the dentist as the leader of the dental team. The Australian competencies (Australian Dental Council, 2016) align leadership closely to communication and are less prescriptive in style. The European (ADEE) profile learning outcomes (Field et al., 2017) locate leadership within their 'Safe and effective clinical practice' domain. Here, safety and the management of risk and adverse events are important. Leadership also involves attention to working posture and visual perception. Learning outcome 6. brings in, for the first time, the issue of change in order to 'improve efficiency and sustainability'.

Leadership, as specified in these learning outcomes and competency frameworks, therefore takes on different forms and has, in some cases, very specific and pre-determined aims. The evidence base for these frameworks is not clear, neither is the specific expertise of the individuals involved in producing them. The only reference given in the European (ADEE) profile in relation to leadership is a text book by Swanwick and McKimm (2011): ABC of Clinical Leadership.

Suggestions in relation to content of leadership education for dental students, have also been made in the published dental education literature:

- Communication skills, self-reflection, critical thinking, problem-solving skills, professionalism, ethics and social responsibility (Taichman et al., 2012);
- Communication skills, self-reflection, critical thinking, problem-solving, emotional intelligence, negotiation, conflict management, vision development and strategic planning (Kalendarian et al., 2013);
- Organisation, finance, administration, characteristics and challenges of leadership work, communication skills, ethics, attitudes (Taipale et al., 2018);
- Written and oral communication, emotional intelligence, professional development, ethics and integrity, advocacy (Smith et al., 2016).

This suggests common themes of communication, reflection problem solving and attention to ethical issues.

#### Who will provide the leadership content?

The challenges faced by educators in establishing leadership education programmes relate to the difficulties of incorporation into an already 'dense' (Taichman et al., 2012) or 'over-crowded' (Smith et al., 2016) curriculum, as well as the lack of established good practice in the field of leadership education for dentistry, a lack of expertise of dental school staff and a lack of resources (Smith et al., 2016). A quote from this paper states:

We do not have qualified educators (leadership certification or training) to teach a leadership-specific course. Something (course) would have to be eliminated from the programme to incorporate leadership.

Smith et al., 2016, p.602.

Other challenges include time availability by dental school staff to teach, funding, institutional and institutional support (Kalenderian et al., 2013; Hayes and Ingram, 2019).

One of the most important challenges reported is the lack of clarity in relation to leadership itself, what it encompasses or how it is defined in the context of dentistry (Taichman et al., 2012). To address these issues, one approach has been for Dental Schools to 'buy-in' established business leadership content delivered by University Business Schools. This has been seen as a convenient solution which has the further advantage of exposing students to teaching outside of their discipline (Taichman et al., 2012). Taichman et al. (2012) however argue that dental schools need to develop context specific leadership education and that "it would be a mistake for us to look to other professionals, be it business or medicine, to provide content" (p.190).

#### A question of leadership competency

A competency approach to education with a future aim of establishing a set of dentistry specific competencies for leadership is seen as an important step (Willcocks, 2016).

The importance of a competency approach to education has been argued across the dental education literature in general (Chambers, 1994; Chambers, 1998; Oliver et al., 2008; Cowpe et al., 2010). In relation to leadership, Hayes and Ingram (2019) suggest the need for well-designed competencies as mark of an ideal leadership programme. Leadership competencies are referred to when outlining content areas (Kalenderian et al., 2013; Taipale et al., 2018). Smith et al. (2016, p. 603) specifically promote the need for competencies:

Formal competencies targeting quality leadership skills would guide educational programmes to enhance the promotion of a quality foundation of leadership concepts and skills.



The findings of their study involving interviews with faculty members involved in leadership education however refer to the challenges of measuring competence: “I’m not sure we measure leadership competence. It is difficult to tangibly measure (Smith et al., 2016, p.601).

Willcocks (2016) argues that the dental profession should follow the path taken in UK healthcare by using leadership competency frameworks. There have been a number of different iterations of these and have, in general, been used to establish the profile or scope of leadership activities, to provide clarity of expectations and to set universal standards. The current version used in the NHS was produced by the NHS Leadership Academy as described in the ‘Practice’ section of this review.

This model uses nine dimensions of leadership illustrated in the form of cube. The dimensions are: “Inspiring shared purpose; Leading with care; Evaluating information; Connecting our service; Sharing the vision; Engaging the team; Holding to account; Developing capability; Influencing for results” (NHS Leadership Academy, 2013a).

#### Postgraduate Leadership Education in Dentistry

At postgraduate level in the UK, leadership is included in:

- Dental foundation curriculum training (DF): Management and Leadership domain.  
Example outcome: “an understanding of the day to day running of a general practice, and any other areas of clinical practice relevant to their training, and where to find managerial assistance where necessary” (COPDEND, 2015, p.30);
- Dental core curriculum training (DCT): Domain 2.3: Demonstrates leadership skills. Example outcome: “make decisions when dealing with complex situations” (COPDEND, 2016, p.18);
- Curriculum for specialist registrar training in restorative dentistry (example).  
Example outcome: “communication, interpersonal skills and team leadership” (Royal College of Surgeons of England, 2009, p.2).

In relation to continued professional development (CPD), from 2018, all UK GDC registered dental professionals are now required to include leadership and

management as a compulsory component of their ongoing, recorded, enhanced CPD training. This requirement is set out as 'Development Outcome B':

Effective management of self and effective management of others or effective work with others in the dental team, in the interests of patients, providing constructive leadership where appropriate.  
General Dental Council, 2018.

Recently (July 2019), a survey of all UK dental professionals (dentists and dental care professionals) in relation to leadership training and development needs was released by Health Education England as part of the 'Advancing Dental Care Review' Leadership and Development Workstream, mentioned earlier in the 'Practice' section. This indicates an interest in leadership education in dentistry at a national level and that programmes will be developed in response to the findings. A quote from the survey gives insight into the nature of leadership development approach which is being applied:

Leadership development aims to help shape people's knowledge, skills and behaviours to help them become outstanding leaders, and for the NHS, it aims to develop inclusive and compassionate leaders working at all levels across the NHS to improve patient care, people's health and their experiences of the NHS.  
Health Education England, 2019.

Initial results of this survey indicate that 73% of respondents felt that leadership training is important, and 47% of respondents indicated a lack of awareness as a major barrier to leadership training uptake (Health Education England, 2019b). It is also worth noting that there was a poor level of non-dentist respondents to the survey.

An example of a post-graduate leadership course in dentistry comes from Spain, (Roig Jornet and Kalenderian, 2018) and was published in the European Journal of Dental Education. Again, this example gives insight into a particular approach to leadership development.

The paper describes the purpose of the course was to help "successful dentists" with their "knowledge, skill and confidence" (p.129) as well as a financial and economic benefit. Attendees on the course were dentists, no other members of the

dental team attended. The authors described the need for a 'crash course' in leadership, the format was therefore a 3-day classroom-based course using lecture presentations, small group problem-solving, facilitated large group discussions and guided self-assessments. The course was described as "Practical Leadership in Dentistry" (p.129) and topics included self-awareness, leadership qualities and personal branding. A Myers-Briggs analysis was included for participants. The course was delivered by the paper authors and they described themselves as "two experts in the field of dental clinical leadership education" (p.129). They claimed that the course was "solidly based on the latest literature in leadership training" (p. 129). The effectiveness of the course was measured by comparing pre and post course results of a leadership knowledge test as well as participants' self-assessment against 15 competencies (including compassion, empathy, integrity, conflict management). A statistically significant increase was found in both the knowledge test and in two particular competencies: dealing with difficult people ( $P=0.29$ ) and team guidance ( $P=0.02$ ). The authors raised limitations with the use of self-assessment competencies and recommend the development of more objective competency measures in order to reduce the subjectivity involved. Interestingly, the paper also reports that participants said that "they wished they had brought their clinic team members so as to better align the learned concepts and share the positive energy" (p.133). 71.4% of participants considered the course to be a positive return on investment.

Examples of multiple-choice questions used as part of the leadership knowledge tests in this paper are as follows (exact wording used):

A leader within a phase of delegation performs the following tasks:

- a. Many supervision tasks and few relationships
- b. Plenty supervision tasks and enough relation care
- c. Null supervision task and some relationship
- d. Null for both supervision and relation tasks

Which of the following is not a bad habit for a leader?

- a. Selfishness
- b. Bashing
- c. Having failed
- d. Envy

## Summary

In relation to leadership education in dentistry, the literature reveals the following:

- There is a recognised need for leadership development for all stages of the dental profession;
- There is seen to be a need to identify and 'grow' leaders from an early stage in professional development;
- At undergraduate level, dental regulatory bodies in different countries include leadership outcomes and place these differently in relation to other areas in the curriculum;
- A variety of emergent leadership development approaches are described and a move towards a competency approach is advocated, to mirror how this is applied elsewhere in healthcare;
- A 'leader-centric' approach to development emerges from the language used in descriptions of leadership development.

### **2.5.2 Perspectives on leadership education from the literature studies literature**

Leadership development is a global growth industry with many private and public organisations (including governments) investing heavily (in time and resources) in this area (Denyer and Turnbull James, 2016). As reported by Ford (2015a), in the UK alone, this is in the order of 20 million days a year in some form of defined leadership development activity. It can be assumed therefore that much is being expected of this investment. The form that this leadership development takes is, however, contentious.

#### Conceptualising approaches to leadership education

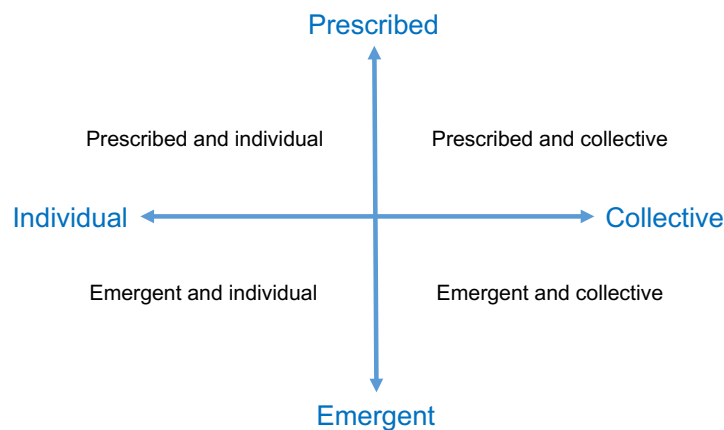
The arguments made in relation to leadership education approaches derive from the different ways in which leadership itself can be conceptualised and how this is translated into the area of development. Barker (1997) asks the fundamental question: "How can we train leaders if we don't know what leadership is?" A consideration of the various conceptualisations of leadership was made in the 'Theory' section of this review. This tracked the development of leadership theory from mainstream or 'heroic' approaches to 'post heroic' and critical approaches, including Leadership-As-Practice. It is these theories that have informed different and contrasting approaches to leadership training and development.

| Traditional leadership learning | 21 <sup>st</sup> -century leadership learning |
|---------------------------------|---|
| Prescribed                      | Emergent                                      |
| Standardised                    | Personalised                                  |
| Off-site                        | Onsite  |
| Classroom-based                 | Work-based                                    |
| Content-led                     | Process-rich                                  |
| Scale                           | Depth   |
| Leader development              | Leadership development                        |

**Table 8.** Contrasts between traditional and 21<sup>st</sup> century leadership learning. From Bush et al., 2007, p.87.

In table 8, the characteristics of traditional development approaches (which align to mainstream, heroic and individualistic theories of leadership) are compared to approaches which align to post-heroic, collective approaches.

Another way to illustrate contrasts is to consider dimensions of leadership (individual and collective) and leadership development (prescribed and emergent) in the model developed by Rodgers et al. (2003) (figure 2). The quadrants represent different development approaches.



**Figure 2.** Leadership development framework. From Rodgers et al., 2003.

The characteristics as described in the first column of table 8 and the 'prescribed and individual' quadrant of the model diagram (figure 2) above align to a functionalist educational approach (Mabey, 2013). Functionalism is one of four educational 'discourses' (functionalist, interpretivist, dialogic and critical) described

by Mabey and these provide a useful way to consider the different approaches to educational philosophy in relation to leadership development.

Functionalist approaches have been found to be dominant in the leadership development field (Rodgers et al., 2003). Functionalism is based on the ideas of individualism and performance (Carroll, 2015). There is an emphasis on prescription and standardisation and the use of formal educational processes such as testing (e.g. psychometric tests) and competencies. There is a transactional (as opposed to transformational) approach: expected and planned inputs, and expected and planned outputs. As Carroll (2015, p.99) describes, there is an expected “return on investment” – a focus on outcomes. One of the main characteristics of a functionalist approach relates to the issue of individualism. The focus is leader-centric (Jackson and Parry, 2011). This is illustrated in the language used to describe what is happening: *leader* development, as opposed to *leadership* development. This is an important distinction. Leader development, as described by Day (2000) is about development in terms of individual capabilities – so called ‘human capital’ whereas leadership development or the development of ‘social capital’ is about the development of interpersonal capabilities. Collinson and Tourish (2015) are highly critical of the individualistic (and heroic) approach and deride some of the rhetoric used by business schools to promote their leadership development programmes. For example; the aspiration of “turning students into inspirational leaders, capable of impacting powerfully and positively on the world” (p.576). There is seen to be an over emphasis on transformational models and on charismatic individuals (Collinson and Tourish, 2015).

Another criticism is that mainstream leadership development programmes tend to remove individuals from their own environments (Raelin, 2011; Raelin, 2016b), to the classroom. Learning happens within the confines of a short leadership course with much of the content being abstract, generic and pre-prescribed (Ford, 2015). This, in effect, decontextualises learning (Ford and Harding, 2007) with no consideration of the contextually specific issues that leadership needs to address. The result is that on return to their base, many of the course attendees are unable to apply this learning in a meaningful way.

A functionalist perspective also assumes leadership as a neutral or rational concept (Rost, 1991) which exists in an objective sense. Knowledge can therefore be imparted and learned detachedly and, in effect, acquired as a commodity. As Raelin (2004, p.131) describes, the intention is “to put leadership into people”. The educational philosopher Fromm (1976) equates learning in this sense as ‘*Having*’

as opposed to *'Being'* where development happens through engagement: "exploration, relating and becoming" (Carroll, 2015). Sinclair (2007, p.37) considers another educational philosopher, Freire (1972) and his concept of the 'banking model' of education where students are considered as 'empty vessels', ready to be filled with requisite knowledge in a controlled and deliberate fashion.

#### The competency approach to leadership education

The use of competencies in leadership development has grown in popularity since the 1960s (Bolden and Gosling, 2006). Competencies are used to define components of leadership including skills and behaviours and to inform assessment (Huotari and Carroll, 2019). Competency has been defined as "an underlying characteristic of an individual that is causally related to effective or superior performance in a job." (Boyatzis, 1982, p.21). The functionalist characteristics of individualism, performance, prescription and standardisation are characteristic of the competency paradigm.

There is strong criticism of the 'ubiquitous competency paradigm' of leadership in the critical leadership studies literature (Raelin, 2004; Bolden and Gosling, 2006; Carroll et al., 2008; Fisher and Robbins, 2015). Carroll et al. (2008, p.365) describe it as "functional, disembodied and technocratic." Raelin (2004) and Huotari and Carroll (2019) refer to competencies as 'lists' that provide the ingredients for a recipe of leadership. The inference is that if this is followed, effective leadership will result. Bolden and Gosling (2006) highlight the detrimental effect of competencies in limiting and restricting the initiative, creativity and scope of action that is allowed. This is despite the engaged, distributed, relational and situated activity that leadership involves. Competencies act to control and to define the scope of activity. The main criticisms of the competency approach are summarised:

- Reductionism: leadership and leadership development becomes fragmented into separate parts instead of being considered as a 'whole';
- Universalism/ generalism: the assumption that competencies can be applied in all situations with the same effective outcome. Competencies therefore have the effect of standardisation and predictability;
- Relevance: competencies are based on known requirements, scope is not given for future, unknown requirements;
- Instrumentalism: competencies focus on what is measurable, rather than what is not, therefore some aspects of leadership can be neglected. Competencies

can also be used as a 'disciplinary mechanism' (Carroll et al., 2008) and are described as "the real subtext behind the competency movement" (Huotari and Carroll, 2019, p.22). Measurement and evaluation against competencies can provide evidence to prove poor performance;

- Identity defining: competency lists can define what is important to individuals and organisations; they act to constitute values and purpose;
- Conformity: individuals and organisations are encouraged to conform as competencies are interpreted as 'rules'. This can lead to a reliance on rules and a 'tick the box' mentality with a resulting loss of conscious thought and action.

Based on Carroll et al., 2008; Bolden and Gosling, 2006.

Critical leadership scholars argue that competencies do not consider the "complex, diverse, and socially connected nature of leadership" (Bolden and Gosling, 2006, p.158). They are, essentially, inadequate. Huotari and Carroll (2019, p.31) go as far as saying that "if left unguarded, unchallenged and blindly followed", competency approaches are "dangerous."

#### A critical approach to leadership education

A rethinking of leadership development, away from competency approaches, offers alternatives. These are based on the principles of experiential, collective, reflexive and emergent development. They move away from the functionalist educational discourse to interpretive, dialogic and critical discourses (Mabey, 2013) where leadership is seen as socially constructed concept and where learners are considered to be more deeply and actively engaged in their development. As Collinson and Tourish (2015) argue, leadership cannot be taught as if it was a 'neutral' concept.

The critical discourse, in particular, challenges taken for granted assumptions about leadership development and asks fundamental questions about its purpose (e.g. who should be developed, what should be included in leadership development programmes and who should decide this?) (Carroll, 2015). These questions challenge a crucial and underlying tension in leadership development which relates to issues of power and control and the hidden subtexts involved, for example: "oppression, exclusion and domination" (Carroll, 2015, p.101). Here it is useful to draw again on the work of the educational philosopher Freire and his fundamental work on critical pedagogy: *Pedagogy of the Oppressed* (1972). This calls for an



emancipatory approach to education, considering it as the 'practice of freedom'. Rather than learners being controlled and directed to conform to existing norms they are encouraged to find their own ways to navigate the challenges they encounter; they are free to determine their own learning (Barker, 1997).

One of the first critical questions relates to who should be developed. As discussed previously, the distinction between leader and leadership development is important. Denyer and Turnbull James (2016) highlight Grint's (2010) notion of putting the 'ship' back into leadership. Rethinking leadership promotes a more inclusive and collaborative approach to leadership development, rather than a focus on individuals in recognisable, organisational positions of power. Raelin (2004, p.133) describes 'leaderful' development, designed to be inclusive of all involved in the work of leadership.

Another question asks what should be included in leadership development programmes. As stated previously, from a critical perspective, leadership is seen as a complex, diverse and socially constructed concept (Bolden and Gosling, 2006). Leadership therefore requires those involved to think constantly about how they engage in their work and to recognise and to ask themselves about their assumptions. Sinclair (2007, p.42) describes three main values that she argues should form the basis of leadership development: reflection, learning through experience and critical examination. Cunliffe (2009), in her paper titled "The Philosopher Leader" also encourages a critical examination approach: critical reflexivity. This involves critical thinking; challenging assumptions, questioning and trying to make sense of experiences. She proposes three aspects to this: relationality, reflexivity and moral activity. Relationality is about considering how we relate to others; reflexivity is the process of stepping back to consider how our ways of working are shaped by the situations and relationships that we are involved in. Finally, moral activity, involves a consideration of values and ethical dimensions in guiding our actions.

#### Leadership development from a Leadership-As-Practice perspective

Leadership development can also be considered with a Leadership-As-Practice perspective. Here, leadership is considered as an everyday, emergent, relational and contextual phenomenon. Leadership is lived through experience and all participants are considered to be involved regardless of their formal position. Leadership development focuses on practice, rather than competency (Raelin,

2007). In addition to the characteristics of critical leadership development approaches already discussed, Leadership-As-Practice specifically emphasises attention to what actually happens (specific practices) within the participants' own context and the everyday challenges that are found, to engage deeply in these issues (Denyer and Turnbull James, 2016). There is also an emphasis on collaborative working as part of the development process. This encourages a consideration of the emotional (Ford and Harding, 2007) and political (Denyer and Turnbull James, 2016) aspects of working collaboratively and in relation to others. Raelin (2004) suggests that work-based learning be used to facilitate this. 'Communities of practice' (Raelin, 2004) where individuals share insights and develop leadership capacity together, are advocated. Work-based learning is context-specific and collective, not decontextualised and individualised by keeping groups and teams together, to learn within their own working environments.

Another feature of Leadership-As Practice, as explained earlier when considering Heidegger's idea of building and dwelling modes (Theory section of this chapter, 2.1.2), is that much of leadership is carried out in an unplanned and unconscious way. Those involved in leadership need to be able to deal with unplanned situations. This has been described as "skilled, improvised, in-situ coping" (Chia, 2014, p.33). The processes described earlier: engagement in reflection, learning through experience and critical reflexivity are crucial in making sense of this improvised coping. This is what Weick (1995) describes as 'sensemaking'. It is important to recognise that it is through the process of leading and engaging in critical reflexivity that leadership development actually takes place. Leadership and leadership development are therefore "interdependent" (Carroll, 2015, p.102 drawing on the work of Pye, 2005) and the process is ongoing and continuous. This can be explained further by considering John Dewey's educational philosophy. Pring, referring to Dewey's thinking (2007, p.47) states, in relation to learning and development, that: "the aim is not an end separate from the means of its accomplishment". This can be translated and applied to leadership development: being effective in leadership (the aim) means continually doing what was done in order to develop it in the first place. Those engaged in leadership therefore are in a constant state of change and 'growth'. Growth results from experience (Dewey, 1916). Experience was key to the educational philosophy of Dewey (1916, p.144): "an ounce of experience is better than a ton of theory because it is only in experience that any theory has vital and veritable significance". In his book, 'Experience and Education' (Dewey, 1938) he described how experience is often

perceived as being separate and inferior to knowledge (Pring, 2007). Going back to the functionalist discourse described earlier, it is abstract, detached knowledge which is favoured. Dewey however, was critical of traditional, knowledge-based approaches, recognising their disconnect from the real world of experience; knowledge is “stuck on” (Pring, 2007, p.180). Learners are left “untouched” (Pring, 2007, p.34) and unchanged by this knowledge. This he termed “miseducation” (Dewey, 1938) as it has the effect of inhibiting educational growth and development. As Dewey (1938, p.24) states, “it may produce a lack of sensitivity and of responsiveness, then the possibilities of having richer experiences in the future are restricted”.

In relation to Sinclair’s values for leadership development: reflection, learning through experience and critical examination, the aim, as she states, is to raise awareness or consciousness (Sinclair, 2007, p.45). The idea of consciousness is fundamental to the educational philosophy of Freire. Like Dewey, he argues for the engagement of learners in their world, rather than disengagement. Freire (1974) describes different forms of consciousness including naïve and critical consciousness. Naïve consciousness he argues results from a functionalist or ‘technical-aid’ (Freire, 1974, p.133) discourse of education, where learning is passive. This “‘anesthetises’ learners and leaves them a-critical and naïve in the face of the world” (Freire, 1974, p.133). This reflects the ‘danger’ that Huotari and Carroll (2019) were alluding to in relation to competency approaches. Collinson and Tourish (2015) argue strongly against a-critical approaches: a lack of critical awareness they say:

Leaves students unprepared for the challenges that they will face when they encounter active questioning, and dissenting employees, or when they themselves might be faced with a decision about whether to disagree with their boss on an important issue.  
Collinson and Tourish, 2015, p.578.

Critical awareness by contrast actively engages learners in the real world, better preparing them to be able cope with continuous uncertainty and change.

### Summary

In relation to leadership education, the leadership studies literature reveals the following:

- Functionalist approaches dominate the leadership development field and are characterised by being leader-centric and prescribed;
- Competencies are used extensively in leadership development (as part of a functionalist approach) but a critical analysis of these demonstrates issues of reductionism, universalism, relevance, instrumentalism, definition and conformism;
- A rethinking of leadership development has challenged taken for granted assumptions asking questions about its purpose, who should be involved and what should be included. The ideas of inclusive, collaborative and contextualised development are promoted;
- Rather than a focus on the acquisition of knowledge, it is argued that leadership development should focus on the values of reflection, learning through experience and critical reflexivity.

### **2.5.3 Situating leadership education in dentistry within the wider leadership studies literature**

A critical analysis of the dental education literature through the lens of the leadership studies literature highlights a need to question assumptions made in relation to the purpose and practice of leadership education. Dentistry has begun to adopt leadership education approaches which are characteristic of the functionalist discourse; prescribed, standardised, classroom based, content led and leader-centric. The given postgraduate course example (Roig Jornet and Kalenderian, 2018) is a clear illustration of this. Here, a 'return on investment' was reported; education was transactional rather than transformational. The dental literature also sees the development of a set of dentistry-specific leadership competencies as a desired future aim, thereby following the path taken elsewhere in healthcare. The leadership studies literature gives a number of arguments against the use of competencies. Fundamentally, competencies cannot take account of the complexity and socially constructed nature of leadership. Arguments are made in favour of emergent, collective approaches with the aim of embedding learning within practice. This allows for more active involvement and learning through experience. There is scope therefore, at this early stage for leadership education in dentistry, to revitalise leadership learning (Collinson and Tourish, 2015) and to rethink how the profession can best prepare and encourage its members to engage in leadership learning throughout their careers.

## 2.6 Critical Literature Review – Closing Notes

This chapter has given a critical perspective on leadership in dentistry by situating the dentally based literature within the wider leadership studies literature. This has identified a number of opportunities for dentistry to rethink its approach to leadership in a number of ways in relation to the four, inter-linked dimensions; theory, practice, research methodology and education.

Opportunities to rethink leadership for dentistry:

**Leadership Theory:** to move away from heroic, essentialist, mainstream leadership approaches which privilege the role of the leader and to engage in post-heroic and more critically based leadership theory which takes into account the socially constructed nature of leadership and the importance of context.

**Leadership Practice:** to move away from the 'leaderism' agenda found in policy documents and the assumptions these make about who is involved in leadership towards an understanding of leadership in dentistry in practice: where, when, how and why it happens.

**Leadership Research Methodology:** to move away from the dominant positivist, objectivist and quantitative approaches to researching leadership towards a methodology and innovative methods which can take into account the complex, co-constructed, collective and contextually specific nature of leadership.

**Leadership Education:** to move away from functionalist approaches which are prescribed, classroom based, content-led and leader-centric and to resist the calls to produce a set of dentistry-specific leadership competencies. An alternative approach which embraces collective learning within the practice environment might offer an opportunity to revitalise leadership learning and better prepare and support practitioners in their working lives.

The next chapter goes on to explain the empirical work carried out in this thesis. This work is based on the opportunities for rethinking leadership for dentistry outlined above and illustrates how this rethinking might emerge in practice.

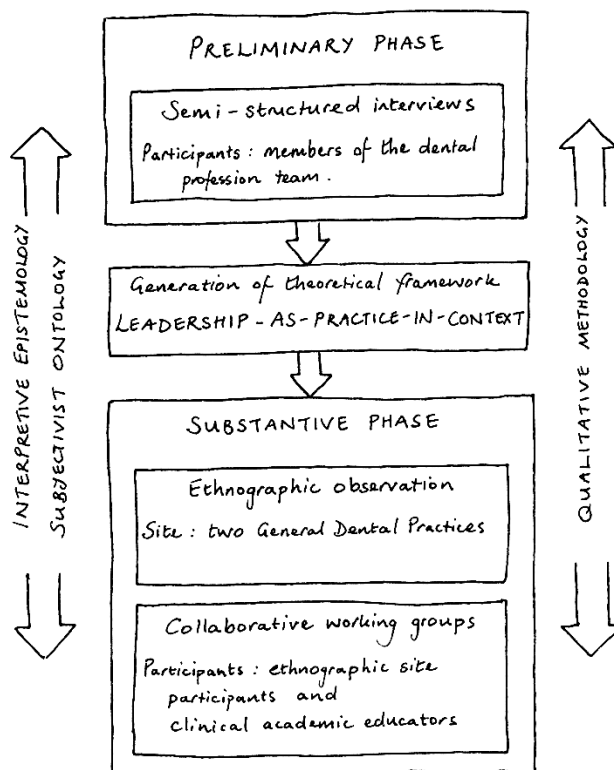
### 3. Methodology and Methods

#### 3.1 Methodology and Methods - Opening Notes

This chapter explains the exploratory journey that the empirical work undertook in order to address the aims of the thesis.

An explanation and rationale for the decisions and approaches taken at the different stages of the research journey is given. This includes an explanation of the chosen research philosophy and how this informed the methodology and the multi-methods used.

This chapter is structured around the research process itself and is illustrated by the following flow diagram:



**Figure 3.** Flow diagram to illustrate the inductive research process and the phases involved.

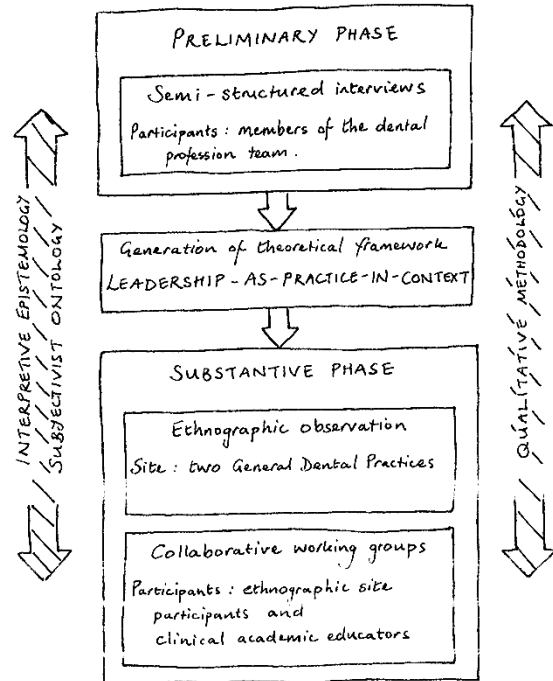
This diagram is used throughout the chapter, at the start of each section, to highlight the stage which is being considered.

This research started *de novo*. It took an inductive, exploratory approach with no pre-determined focus or path. The research was carried out in two main phases. The preliminary phase engaged with members of the dental profession, working in General Dental Practice to gain an initial understanding of leadership in relation to the broad overall research aim. The findings were used to generate a theoretical framework which informed the more in-depth substantive research phase and the main research aims. What emerged was a continued process of engagement with practitioners and the practice environment and led to a final collaborative stage of educational development activity bringing in clinical academic educators to participate alongside them.

Multiple methods were used as part of the overall research scheme; semi-structured interviews, ethnographically informed observation and collaborative participant working groups. This multi-method approach allowed a diversity of data to be collected from different perspectives.

In this chapter, definitions and explanations are given to aid in the understanding of terminology and there is an introduction to research philosophy to provide a basis for the chosen approaches taken in this thesis. The key issues of reflexivity in research and research ethics and how these applied to this thesis are also explained. Where specific methods are not commonly found in the dental research literature, these are explained more fully.

### 3.2 Research Philosophy and Methodology



The research undertaken in this thesis used an inductive, exploratory strategy and was based on an interpretivist epistemology, a subjectivist ontology and a qualitative methodology. The research philosophy was chosen to reflect the complex, co-constructed, collective and contextually specific nature of leadership which the Critical Literature Review chapter argued for as a move away from the dominant positivist and objectivist philosophical perspective. It was also chosen to allow the use of innovative approaches to qualitative research which was one of the aims of the thesis.

This section considers the philosophy of research and the varying philosophical positions which influence approaches to research. As research methodology in the field of dental research, or dental education research rarely refers to underpinning philosophical positions, the background to this is explained. Viewing research through a particular philosophical lens also influences judgements as to its quality. Quality markers which align to different philosophical positions are therefore considered.

#### Metatheoretical assumptions and alignment in research

Conventionally, when planning 'scientific' research there is a seamless move from establishing research aims to choosing research methods. An assumption is made that the methods chosen to address certain aims will produce results which will be a true representation of the nature of reality. What is meant by the nature of reality



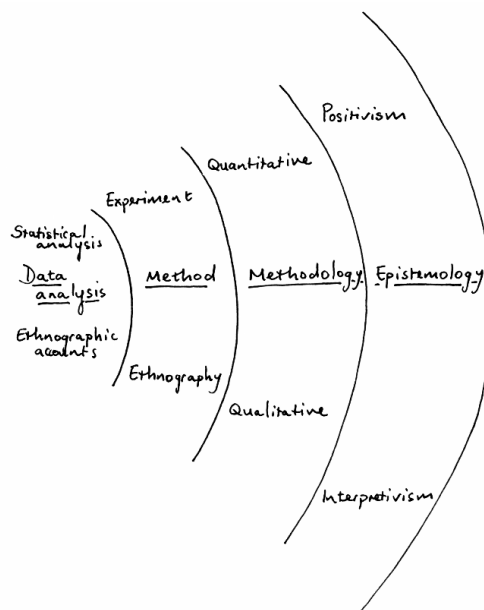
however varies depending on which philosophical approach is taken (Rosenberg, 2012). The important step of establishing the philosophical position taken by the research is often, unconsciously, missed out (Saunders et al., 2019).

All research is underpinned by a philosophical position and it is necessary to consider the broader implications of this when planning and undertaking research, especially when this deliberately moves away from conventional approaches (Benton and Craib, 2011). Research planning should be informed by the underpinning philosophical position so that the methodology and methods chosen demonstrate alignment throughout the process:

Our metatheoretical assumptions have very practical consequences for the way we do research in terms of our topic, focus of study, what we see as 'data', how we collect and analyse the data, how we theorise, and how we write up our research accounts.

Cunliffe, 2011 p.651.

One way of illustrating the principle of congruence and alignment of research philosophy, methodology and methods was described by Saunders et al. (2019). 'The Research Onion' (figure 4) represents stages of the research process as layers: starting with the outer layer of philosophy, moving inwards to the next layers to methodology. Diagrammatically, it can be seen how the different examples align towards a final stage of technique and procedures (methods).



**Figure 4.** Representation of the layers of research. Based on Saunders et al., 2019.

In general terms, it can be seen that alignments occur, for example: Positivism aligns with a quantitative methodology, methods such as experiment and statistical type analysis. Interpretivism aligns with a completely different methodology, methods and approach to analysis. This is a useful way to see how attention to the first layer, epistemology is crucial.

#### The nature of social reality – understanding the terms

What is valued in relation to the nature of truth, or social reality varies significantly between different philosophical or paradigmatic positions. Burrell and Morgan in their book 'Social Paradigms and Organisational Analysis' (1979) outlined four aspects for consideration in relation to the nature of truth and social reality which can help in understanding why there are such differences in terms of what is valued.

The four aspects are: ontology, epistemology, human nature and methodology.

**Ontology** considers an understanding of the nature of social reality and about who we are in the world - how the world relates to us and how we relate to it. "Is social reality external to individuals – imposing itself on their consciousness from without – or is it the product of individual consciousness?" "Is it given 'out there' in the world, or is it created by one's own mind?" (Cohen et al., 2011 p.5).

Morgan and Smircich (1980) consider two contrasting ontological positions: objectivism and subjectivism. Objectivism takes the position that reality is concrete and external to individuals. Subjectivism takes the position that reality is imagined or constructed by individuals.

**Epistemology** relates to the nature or basis of knowledge and asks what is accepted as valuable knowledge? The aim of any form of research is to generate knowledge (Caelli et al., 2003). How knowledge is acquired and communicated is key. For example, according to one epistemological position only knowledge or data that was acquired through objective testing, where variables were controlled and results repeatable would be valued. Any data produced from research which did not adhere to these conventions would be deemed as unacceptable as a basis for knowledge.

There are two main contrasting epistemological positions: positivism and interpretivism (Duberley et al., 2012).

Positivism requires that knowledge be derived from a formal, deductive process of testing where objective observation is a key requirement (Benton and Craib, 2011). Fundamentally, knowledge is 'out there' (Cohen et al., 2011) to be *discovered*. The aim is to produce universal or statistical proof and generalisability of findings (Hammersley and Atkinson, 2007). A priori theory is used to inform the design of the research (Duberley et al., 2012). A hypothetico-deductive strategy (Popper, 1959) is used and variables are controlled. Objective measurement is used to generate data and statistical methods used to analyse it.

Positivism is the epistemology which underpins conventional research within the natural/ physical sciences. When the same philosophy and assumptions are applied to the social sciences, it is assumed that:

'Good' knowledge is that which accurately and objectively captures and represents the processes, systems and laws underlying the way the world works, which when theorised and / or modelled, can be used to improve the way things are done.

Cunliffe, 2008, p.123.

Positivism dominates the general understanding of what is meant by 'scientific research' and what is accepted as valuable knowledge. There is, however, a different view of what can be considered valuable knowledge.

Interpretivism is knowledge that is based on the subjective interpretations of individuals or by social groups independently of objective experience (Duberley et al., 2012). It accepts that there are different and multiple interpretations of the 'same' phenomena between individuals and by individuals over time (Hammersley and Atkinson, 2007). Interpretivist approaches aim to *understand* phenomena, to describe a context and what goes on in it (Morgan and Smircich, 1980). A key aspect of interpretivism is that it seeks to understand how people make sense of their world; its stimuli, the actions and interactions of themselves and between others. The aim, in contrast to positivism, is not to produce generalisability but to produce rich insight into the complexity of situations. It is argued that the complexity of everyday life cannot be understood by condensing it into neat "schemes or models" (Denzin, 1971, p.168).

Understanding relates to human actions and the meanings behind these:

"intentions, motives, beliefs, rules, discourses, and values" (Hammersley and

Atkinson, 2007, p.7). They also consider how these are experienced, articulated and shared (Duberley et al., 2012; Van Maanen, 1979).

Interpretivism holds the following views:

- Human beings are not mechanistic and embrace multiple realities which need to be understood in context;
- The social world cannot be described without investigating how people use language, symbols, and meaning to construct social practice;
- No social explanation is complete unless it adequately describes the role of meaning in human actions.

Klenke, 2008 p.23.

Social constructionism is an aspect of interpretivist epistemology which considers that we continually shape and 'construct' our social reality (Hammersley and Atkinson, 2007). Reality is negotiated (Cunliffe, 2008) by individuals through their own interpretations of their environment or through the interaction and joint interpretation with others. Berger and Luckmann (1966) first described social constructionism in their book 'The Social Construction of Reality'. Fundamentally, "knowledge and truth are created, not discovered" (Klenke, 2008, p.22).

Guba and Lincoln (1989), outline a set of assumptions, characteristic of social constructionism:

- 'Truth' is a matter of consensus among informed and sophisticated constructors, not of correspondence with social reality;
- 'Facts' have no meaning except within some value framework; hence there cannot be an 'objective' assessment of any proposition;
- Phenomena can only be understood within the context within which they are studied; findings from one context cannot be generalised to another; neither problems nor solutions can be generalised from one setting to another;
- Data derived from constructionist inquiry have neither special status nor legitimisation: they simply represent another construction to be taken into account in the move toward consensus.

Guba and Lincoln, 1989, pp.44-45.

In relation to research using an interpretive epistemology, there is a focus on how individuals and groups interpret their environment (Cunliffe, 2010). Understanding of meaning attached to events, things and phenomena is key (Hammersley and Atkinson, 2007). Emphasis is placed on context and the complexity of the environment which they experience (Guba and Lincoln, 1989). Research using a social constructionist approach uses strategies which are inductive (Klenke, 2008) in order to ensure that knowledge gained is built upon the interpretations of participants and the researcher. This is in contrast to deductive strategies which require dependence on pre-existing theory. Cunliffe (2010) argues that research design should not be bound too tightly by the 'technical requirements' of particular research methods where this limits possibilities. Rather than dutifully following established processes, responsiveness and sensitivity to particular contexts is needed. 'Crafting' of research (Cunliffe, 2010) allows scope for innovation and creativity in research methods allowing more insightful findings to be drawn out. In addition, the researcher can be considered an active participant: "engaged in the setting, participating in the act of 'being with' the respondents in their lives to generate meaning" (Krauss, 2005, p.767).

Human Nature relates to how human beings interact with the world. Are they responders or are they creators? Are they a product of the environment, being controlled "like puppets" or do they have free will to determine their own actions and behaviour? (Cohen et al., 2011, p.6).

Methodology considers how the research process itself is designed and the approaches taken to data collection and analysis in relation to and guided by the underpinning research ontology and epistemology (Cunliffe, 2011; Rawnsley, 1998). The terms 'methodology' and 'methods' are often conflated (Klenke, 2008) but methods refer to the actual "tools, techniques or procedures used to gather data" (Caelli et al., 2003). Again, the methods chosen should be congruent with the methodology of the research.

Methodological approaches may for example be quantitative or qualitative, or, deductive or inductive. Broad definitions of each term are given:

Quantitative: "approaches to empirical inquiry that collect, analyse, and display data in numerical rather than narrative form" (Given, 2008, p.713).

Qualitative: “the study of things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them” (Denzin and Lincoln, 2018, p.10).

Deductive: a ‘top down’ process in which predictions or hypotheses derived from a priori theory are tested in order to prove/ confirm or disprove them (Rosenberg, 2012). In this way, knowledge is ‘discovered’.

Inductive: a ‘bottom up’ process which is exploratory, beginning with little preconception, and which uses observation as a starting point and through which theory emerges (O’Reilly, 2009).

Morgan and Smircich (1980) argue that when designing research and methodology in particular, the aspects of ontology, epistemology and human nature need to be worked out in advance so that methodology is informed by the philosophical position taken. This emphasises the importance of alignment in research.

#### Research Quality

Viewing research through a particular philosophical lens influences judgements as to its quality. Quality markers used in positivist science and quantitative methodology are clearly defined and accepted. The difficulty comes when these same markers are used to judge interpretivist research. This can lead to a misunderstanding of the value of the research and criticism of its methods and outcomes. Attempts have been made to translate quality markers used in quantitative methodology to qualitative methodology.

As an example, Lincoln and Guba (1985) translated quantitative terminology to a qualitative form (table 9).

| <b>Aspect</b> | <b>Qualitative term</b> | <b>Quantitative term</b>              |
|---------------|-------------------------|---------------------------------------|
| Truth value   | Credibility             | Internal validity                     |
| Applicability | Transferability         | External validity or generalisability |
| Consistency   | Dependability           | Reliability                           |
| Neutrality    | Confirmability          | Objectivity                           |

**Table 9.** Criteria to critically appraise findings from qualitative research. From Hannes, 2011, p.3.

These criteria were, from 2011 until 2017, used in guidance given by the Cochrane Collaboration Qualitative Methods Group (Hannes, 2011). The Cochrane UK is highly influential organisation in healthcare sciences and effectively sets the standards against which research is deemed acceptable for use when bringing together research findings in systematic reviews. Their guidance stressed the need for qualitative research to meet the requirements of rigour and trustworthiness, so that they could be considered as being worthy of the 'scientific' label. The difficulty for qualitative researchers situated within healthcare sciences was however that research that did attempt to move towards the interpretivist and subjectivist end of the spectrum was still judged by these more 'mainstream' criteria. More recently, a new set of guidance was released through the Cochrane Qualitative Methods Group (Noyes et al., 2018) which attempted to take account of what they call advances in methodological approaches. This represents a progressive step in the acceptance into mainstream healthcare science of this more 'alternative' form of research. Instead of quality criteria there is guidance on strengths and limitations:

- Clear aims and research question;
- Congruence between the research aims/question and research design/ method(s);
- Rigor of case and/ or participant identification sampling, and data collection to address the question;
- Appropriate application of the method; richness/ conceptual depth of findings, exploration of deviant cases and alternative explanations, and reflexivity of the researchers.

Noyes et al., 2018, p.51.

The use of criteria by which to assess quality is itself questioned in relation to qualitative methodology (Guba and Lincoln, 2005). It is argued that the very nature of this type of inquiry should not be constrained by a tightly defined list of universal criteria, resembling those applicable to positivist approaches, that can, in effect, serve to limit the scope, variety and imagination in the type of work that is done (Bochner, 2000). What must be established is a set of values and practices which are constructed and agreed upon by the qualitative researcher community. Sarah Tracy's model of eight "big tent" criteria for qualitative research (Tracy, 2010) helps to address this need. The 'big tent' name aims to capture the need to be inclusive of the broad spectrum of qualitative research approaches.

Tracy's eight "big tent criteria":

- **Worthy topic:** relevance, timely, significant, interesting;
- **Rich rigour:** use of sufficient theoretical constructs, data and time in the field, sample(s), context(s), data collection and analysis processes;
- **Sincerity:** self-reflexivity, transparency;
- **Credibility:** thick description, triangulation, multivocality;
- **Resonance:** aesthetic, evocative representation, naturalistic generalisations, transferable findings;
- **Significant contribution:** conceptually/ theoretically, practically, morally, methodologically, heuristically;
- **Ethics:** procedural ethics, situational ethics, relational ethics;
- **Meaningful coherence:** achieves what it purports to be about, uses methods and procedures that fits its stated goals, meaningfully interconnects literature, research questions, findings and interpretations with each other.

Tracy, 2010, p.840.

The research undertaken in this thesis aimed to meet these criteria.

### 3.3 Reflexivity in the Research

Reflexive practices were used throughout the research process. This section aims to explain the concept of reflexivity and how it was applied as well as introducing *my* reflexive voice.

Reflexivity is a process used as a crucial aspect of qualitative research to demonstrate integrity and sincerity (Tracy, 2010) and as a way to improve its quality. It is the means by which researchers may question and take account of their taken-for-granted assumptions which may influence them as they undertake the research process. As Mason (1996, p.6) explains:

Reflexive research means that the researcher should constantly take stock of their actions and their role in the research process and subject these to the same critical scrutiny as the rest of their data.



Research work which takes an interpretivist epistemological position 'constructs' rather than 'discovers' new knowledge. This construction is based on an interaction between research participants and the researcher(s) and their subjective and intersubjective interpretation of meaning. The researcher therefore takes an active role in the construction of research knowledge (Ybema et al., 2009). This is in contrast to the passive and objective stance, seen as a crucial aspect of positivist type research, where the researcher must at all times maintain neutrality. The point and purpose of reflexive practice is to encourage researchers to question and to reveal richer meaning (Cunliffe and Karunanayake, 2013). It is the responsibility of researchers who take an interpretivist approach to identify and take account of any factors which might influence their own interpretations and constructions of meaning. This is not to suggest that these factors become criticisms which may affect the integrity of the research, but to acknowledge that they are an integral part of the researcher's being, just like any one of us, that cannot be removed for the duration of the research.

The practice and process of reflexivity is seen as the means by which researchers engage in thoughtful, conscious self-awareness (Finlay, 2002; Guillemin and Gillam, 2004). It is seen as a process by which "questioning takes the form of a 'turning back' on knowledge (and) truths claims" (Cunliffe, 2003, p.984). Essentially it is about awareness – in oneself, the process one is engaged in and the people one works with. It is about being aware of assumptions, motivations, presuppositions and a constant process of questioning. Unlike 'reflection', 'reflexivity' is more complex (Haynes, 2012) requiring in-action (Schön, 1983; Yanow and Tsoukas, 2009) continued and dynamic thinking which 'lives forward', rather than thinks backwards (Weick, 2002, p.893).

There are criticisms of reflexivity. In exposing one's assumptions and biases, there is risk that the research itself could be undermined, in effect "paralysing" it (Cunliffe, 2003, p.984) with uncertainty and "intellectual chaos" (Cunliffe, 2003, p.990). In addition, the manner with which the researcher attempts to demonstrate their reflexivity can sometimes be interpreted as "navel-gazing" (Cunliffe, 2003, p.990).

In relation to how reflexivity is achieved, Haynes (2012) recommends that researchers ask the following questions:

- What is the motivation for undertaking this research?
- What underlying assumptions am I bringing to it?

- How am I connected to the research, theoretically, experientially, emotionally? And what effect will this have on my approach?

Haynes, 2012, p.78.

A number of strategies are suggested to enable the reflexive process including keeping notes of assumptions, thoughts, observations, incidents, and emotions. Discussion of these issues with other researchers is also recommended to aid in the exploration and understanding of these (Haynes, 2012, p.79). This approach was undertaken as part of this thesis.

Finlay (2002) discusses how the reflexive process can be applied throughout the research process, from the 'pre-research stage' and through the data collection and analysis stages. At the pre-research stage when research aims and methods are being formulated, it is suggested that researchers examine their motivations and assumptions. One aspect that can be considered is the potential nature of the relationship between researcher and research participant. Cunliffe and Karunanayake (2013) discuss four aspects of this relationship as 'hyphen-spaces' (Fine's (1994) notion of relatedness between researcher-respondent). These comprise of insiderness-outsiderness, sameness-difference, engagement-distance and political activism-active neutrality. Researchers may have multiple identities and these are at play when relating to research participants; they influence the interaction and shape meaning between them. These hyphen-spaces were used as part of the reflexive process adopted in this research and are used in the introductory account below.

### **Introducing *my* reflexive voice**

#### Motivations and assumptions

*My motivation for conducting this research stems from a desire to help young practitioners negotiate the world of practice and to encourage them to engage with leadership activities. As a member of the dental profession and as a dental educator I see this as important in preparing new practitioners for the world of work. I am aware that dental educators, situated within large university institutions, do not liaise closely or frequently enough with practitioners in order to understand the challenges and demands that are experienced in everyday practice and how these might translate into developments in education.*

*More broadly, I have a political motivation which relates to the purpose of education in dentistry which is both critical and progressive.*

*In relation to my own experiences, as a qualified dentist I was once a newly qualified practitioner going into practice for the first time; feeling naïve and unprepared and then moving through my career questioning the need to take a conventional path. I have sometimes felt like being situated on the edge of the dental profession, not quite in and not quite out.*

*My own involvement and experiences as a member of the dental profession has value in the sense that I already have a good understanding of the research context and the motivations of the research participants. I do however bring my own 'baggage' of experiences and emotions which have inevitably shaped my assumptions and opinions. In being able to look through the lens of a practitioner identity as well as an academic identity, I am able to provide a combined perspective.*

#### Relationship with participants

*I might be considered as both an insider and an outsider to the participants in this research. As an insider I am a registered member of the profession: a dentist. I went through dental school and qualified in 2001, then went on to do vocational training (now dental foundation training) in General Dental Practice and have a clinical master's degree in restorative dentistry. As a General Dental Council registrant, I undertake continued professional development (CPD) and regularly attend conferences.*

*I therefore have many of the same formative experiences as the research participants and identify as a member of the dental profession.*

*I can also be considered an outsider. I have worked within the university setting for most of my career, as an academic, focussing on dental education. I am therefore not part of the General Dental Practice community. It could be perceived that I come from an 'ivory tower', remote from the real world of everyday dentistry.*

*I share similar experiences to participants as a member of the dental profession. I am embedded within the culture of the profession and understand the accepted jargon and language that is routinely used. I hold similar values in relation to the importance of patient care and compassion, striving for quality and the ethical practice of dentistry.*

*Differences mainly relate to the academic nature of my background and current work. As an academic I value my autonomy; the degree of freedom of thought and action which come with the work. As alluded to earlier, I have not followed a*

*conventional career path and have had opportunities to study outside of the dentistry field.*

*In this research, I took an unstructured, non-participative observation role. As such, I don't engage in the daily activities of my research participants. Due to the multiple visits I make to the two research sites, I do however get to know the participants well and can see a development in our relationship as the research progresses. I am aware that I am dependent on my participants in their engagement with the research, especially the ethnographic and working group phases.*

*I took no activist stance within the research sites and sought to remain neutral in my interactions. I saw my role as trying to understand events and activities by asking participants about their interpretations. I did not intervene in any situation, allowing events to play out.*

*At the same time, I identified closely with the research participants and sought to tell their stories, including their daily successes, struggles and challenges.*

Reflexive practices were undertaken throughout the research process. The ethnographic observation and collaborative stages of the research process presented particular challenges as these heavily relied on the interaction and relationship with participants. Reflexive practices were therefore crucial, especially in maintaining a dynamic, in-action awareness of potential difficulties as well as in recording contemporaneous accounts which could be used as part of the research data.

### **3.4 Research Ethics Considerations**

Attention to ethical issues was an essential element of the research work undertaken in this thesis. This was particularly so, as it was involved, substantially, with human participants.

The fundamental purpose of ethics in research is to respect the dignity and wellbeing of research participants: to minimise harm, to ensure informed consent and to protect privacy (Shaw, 2008).

'Procedural ethics' (Guillemin and Gillam, 2004) involves the formal, prescribed process of gaining ethical approval prior to the commencement of a research project. This highly regulated process requires detailed and documented consideration of ethical principles to satisfy research ethics committees that due

diligence has taken place. However, an awareness of ethical issues in research does not stop once formal approval has been given. Once in the field, the environment is unpredictable and ethical challenges may arise which have not been anticipated. This emergent process requiring constant awareness and improvisation by the researcher can be described as 'ethics in practice' (Guillemin and Gillam, 2004). This is particularly pertinent to research methods such as observational ethnography where the researcher is immersed in complex, dynamic situational and interpersonal everyday events.

This section firstly outlines the 'procedural ethics' processes and ethical principles which were considered as part of the preliminary and substantive stages of the research. Secondly, ethical issues raised as the research process was undertaken are considered as 'ethics in practice'.

#### 'Procedural ethics'

Formal ethical approval from the School of Dentistry, University of Leeds Research Ethics Committee was gained at two main stages in the research process; prior to the preliminary phase and then prior to the substantive phase. It is important to state that at no stage, in either phase, was patient involvement in the research planned or undertaken. Advice was sought from the University of Leeds Medicine and Health Research Governance team in relation to the necessary formal approvals processes. The work was classified as 'Service Evaluation' and therefore Health Research Authority (HRA) approval was not required. Ethnographic observations took place in General Dental Practices. It was important therefore to gain the permission and consent of the dental practice owners or managers prior to the recruitment of individual dental professionals within these practices.

#### Preliminary research phase – ethical issues

The main ethical issues identified in relation to the semi-structured interviews with dental professionals were as follows:

- **Informed consent**

Potential interview participants were given information which outlined the purpose of the research, right to withdraw, confidentiality assurances and researcher contact details.

No less than two weeks were given between participants being initially approached with the study information details and for consent to be requested. Before starting the interview, individual participants were asked to read the information again before they then considered signing a consent form. There was an opportunity for participants to ask questions to the researcher directly at this stage;

- **Confidentiality and anonymity**

The interviews were held in a closed treatment room or staff room with only the participant and researcher present.

To ensure anonymity, interview transcripts included a randomly allocated letter of the alphabet for each individual participant. Anonymity was maintained in the write-up of data;

- **Right to withdraw**

Interview participants were advised that they were able to withdraw from the study up until the data was submitted as part of the thesis;

- **Data storage**

Interviews were recorded onto a portable USB audio recording device. The digital audio files were downloaded to a University of Leeds password protected PC. The audio files were then immediately deleted from the recording device. All anonymised interview transcripts were saved onto a University of Leeds password protected PC;

- **Potential coercion in the recruitment of participants**

Initial contact with part-time Dental School demonstrators was made by e-mail (rather than in person). The e-mail communication indicated that there was no obligation to take part;

- **Potential risks/ benefits to participants**

Participants were informed that there would be no direct benefits to themselves but that this was an opportunity to share their views on aspects of leadership in their role. Participants were not asked to disclose any distressing or potentially harmful information. There were no foreseen risks to research participants.

### Substantive research phase – ethical issues

The substantive phase of the research involved two methods: ethnographic observations in practice and collaborative working groups. The main ethical issues identified above for the Preliminary phase applied to these stages however there were additional, specific issues that needed to be considered:

Ethnographic observations:

- **Informed consent**

It was particularly important to inform potential participants (both dental practices and individual participants) of the nature of the study methods so that they were aware as to what to expect. This related to researcher's presence, the direct observation and interaction as participants went about their routine. The longitudinal time commitment involved was also highlighted. Written consent was gained from both the dental practice principals for the research to take place within their practices and at a further stage, written consent was gained by individual dental practice participants (members of the dental team). In this way, all members of the dental practice team were involved in considering the consent process. Meetings were held with the dental practice principals at the consent stage to discuss the nature of ethnographic research. The issue of participant confidentiality was considered. Although every effort can be made to maintain confidentiality (for example through the use of pseudonyms), given the nature of the presentation of the findings, this may not be absolutely assured.

- **Potential for sensitive issues to be raised**

This recognised that potentially sensitive and embarrassing issues may arise on reflection of experiences and incidents. This was managed reflexively by the researcher throughout the process;

- **Confidentiality and protection of patient related information**

No patients or patient related data was included in this research. The focus and aims of the research did not include the role of patients in the leadership activities of the dental practices, rather it focused on the leadership practices within the professional dental team.

Permission was sought from the treating dentist if there was a need to be within a dental surgery whilst a patient was being treated. As a registered dentist, the researcher was bound by General Dental Council 'Standards for the Dental Team'

(2013) regulations including the requirement to maintain confidentiality and the protection of patient information;

- **Requirement for disclosure**

This ethical and regulatory issue related to the requirement for the researcher, as a registered dentist, to raise concerns if patients are at risk. A 'Dental Practice' information sheet and consent form described how a potential issue would be managed;

Collaborative working groups:

- **Confidentiality and anonymity of research participants**

Due to the nature of the interactive discussions as part of the collaborative working groups, confidentiality and anonymity between research participants could not be maintained. Information sheets for both individual dental practice participants and clinical academic educator participants explained the need for all participants to maintain the confidentiality of the other research participants outside of the working group sessions.

### Ethics in practice

Once in the research field, the neatly pre-considered ethical issues outlined for the Research Ethics Committee seemed simplistic and limited. In practice, many of the ethical issues encountered were unanticipated and often arose suddenly, requiring an immediate, unplanned response. There was a realisation that an active awareness and recognition of ethics would be needed throughout the process. Immersion within the complex, dynamic situational and interpersonal events of everyday dental practice life brought out multiple ethical challenges. These were not necessarily significant ethical issues but none the less presented tensions and dilemmas. It is worth noting that the way in which these issues were handled could have affected the trust relationship with participants (Russell, 2005) and this was important to mitigate. Guillemin and Gillam (2004) use Komesaroff's (1995) term 'microethics' to describe the everyday ethical issues that arise in research practice. They also describe 'ethically important moments', "the difficult, often subtle, and usually unpredictable situations that can arise in the practice of doing research" (Guillemin and Gillam, 2004 p.262). Many of the micro ethical challenges encountered in this research related to the relationship that the researcher had to participants (Hammersley and Atkinson, 2007; Johnson, 2014). There was sharing

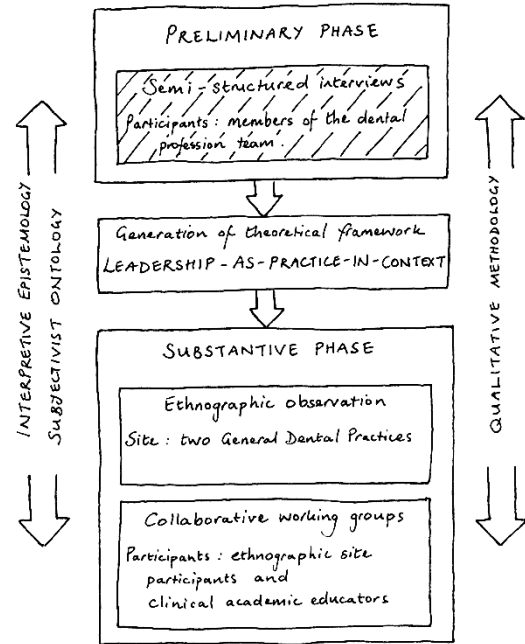


of confidential information and one request to share the findings of observations which could potentially have led to disciplinary action against a participant. Inevitably these issues led to a great deal of contemplation and reflection. The practise of reflexivity was helpful in managing these situations. Feeding back to research supervisors was one way to 'step-back' and to give the opportunity to take a critical approach to the issues and to think through options for responses whilst in the field. As experience grew and with increasing immersion within the dental practices, it became easier to pre-empt, recognise and respond to these ethically important moments. Getting to know individual participants and narratives of the practices also helped. This led to greater insight and some of these issues actually revealed something about the culture of the organisation, as well of course, about approaches to leadership.

Reflexive accounts of ethical issues are woven throughout the ethnographic observation data which is presented in the Findings chapter (4.1) as well as a final account in the Discussion chapter (5.3).

**Preliminary Phase:**

**3.5 Semi-Structured Interviews**



The preliminary phase of the exploratory and inductive research process aimed to gain an initial understanding of leadership in relation to the broad overall research aim and, crucially, to inform specific research questions and methods used in the next, substantive phase of the process. Additionally, it afforded the researcher an opportunity to develop familiarity with the research field and the role of an ethnographer, particularly in relation to the practice of interviewing in a research setting. A semi-structured interview method was chosen for this preliminary phase. The rationale for this and the process undertaken is explained.

Rationale for semi-structured interviews

The exploratory nature of the research necessitated an approach that allowed for a broad range of issues to be covered in a relatively short time period, and which would allow straightforward analysis. It was also important to choose a method which would align to the interpretivist and subjectivist overall philosophical approach and qualitative methodology.

Semi-structured interviews were chosen to allow participants the freedom to express their views and experiences, and to tell their stories – giving an insight into their experiences of leadership (Oppenheim, 1992). At the same time, the process could not be unlimited. Unlike the questionnaire method, interviews are inherently interpersonal, giving the researcher the opportunity to meet and interact with their

research participants directly (Miller and Glassner, 2011). Kvale (1996) outlines a set of key characteristics in relation to qualitative interviews. These are different from interviews which take a quantitative approach.

- Engage, understand and interpret the key features of the lifeworlds of the participants;
- Reveal and explore the lifeworlds of the participants;
- Focus on specific ideas and themes, i.e. have direction, but avoid being too tightly structured;
- Adopt a deliberate openness to new data, rather than being too pre-structured;
- Accept ambiguity and contradictions of situations;
- Regard interviews as an interpersonal encounter;
- Be a positive and enriching experience for all participants.

Kvale, 1996, p.30.

#### Participant selection

A crucial decision in relation to the overall research strategy related to the context in which the research would take place and the participants it would involve. General Dental Practice and members of the General Dental Practice team were selected purposefully. Leadership as it is found in the front-line of dental care provision was the focus.

In relation to the semi-structured interviews, these were held with members of General Dental Practice teams. There were no assumptions made as to who was likely to have a leadership role or have experiences of leadership. Therefore, all members of the dental team were open to selection. Participants were practising dentists, dental hygiene-therapists, dental nurses and practice managers with direct involvement in patient care. Participants were selected because they had the insights and experience necessary to allow exploration of the research topic. This was an example of purposive sampling. The strength of this approach is that “one can learn a great deal about issues of central importance to the purpose of the research” (Patton, 2012, p.46).

A non-probability sampling strategy was taken (Saunders, 2012). This aligned to the interpretive epistemological position of the research overall. The results were not intended to be statistically representative. The number of participants was

intentionally limited – giving sufficient scope to allow useful, in-depth data to emerge that would inform the next stage of the research process.

#### Participant recruitment

Participants were recruited via practitioner links with the University of Leeds School of Dentistry. Part-time clinical demonstrators who mainly worked in General Dental Practice were initially contacted by e-mail. This asked clinical demonstrators whether contact could be made to gain permission to recruit participants from the dental practices in which they worked. Hard copies of information sheets and consent forms for potential participants were sent by post to the dental practices. These outlined the purpose of the research, right to withdraw, confidentiality assurances and researcher contact details. Potential participants were invited to contact the researcher directly by completing an acceptance slip and posting this in a given stamped, addressed envelope.

On return of the acceptance slip, potential participants were then contacted by phone to arrange a mutually convenient time to conduct the interview.

Interviews took place in the participant's dental practice.

10 interviews were conducted with 11 participants (2 participants interviewed together) who represented different members of the dental team: 6 dentists, 1 practice manager, 2 dental nurses, 1 hygiene-therapist, 1 orthodontic therapist).

This represented an inclusive range of professionals within dental practice. All but one participant came from two main dental practices. The practices were all located in the Yorkshire region. Practices were representative of the private, corporate owned and predominantly NHS type found in dentistry.

#### Interview guide

The benefit of the semi-structured interview method is that it offers a balance between structure, which gives focus and direction and the opportunity for participants to divulge aspects not envisaged by the researcher (Alvesson and Ashcraft, 2012). This requires a flexible approach by the interviewer and although an interview guide is written in advance, which provides a degree of consistency in subject matter, it does not limit the discussion. For practical, feasibility issues such as availability of participants, there were necessary limits to the length of interviews. In this case, an interview guide was produced and followed best practice recommendations (Saunders et al., 2019). Interview questions were designed in an open-ended style to encourage participants to be descriptive and explanatory. It was important to be clear and concise in the language used to aid understanding of

the expectation of the question with care taken to avoid biases and framing which could have affected participants answers (Arksey and Knight, 1999).

The initial questions aimed to encourage participants to talk about their work and their personal history as a dental professional and to feel at ease with the interview process. These led on to a main set of questions which related more specifically to leadership issues. Probing questions were also asked to follow up on or to elucidate further information where participants gave limited answers (Yeo et al., 2014).

Pre-determined questions:

Initial questions:

- Please describe your role
- Do you have any roles in the practice outside your main clinical role?
- How long have you been in your present role?
- What roles have you held previously?
- When did you qualify/ start working in the dental profession?
- Why did you choose dentistry as a career? Does it meet your expectations?

Main research questions:

- Do you think you need to show leadership in your work?
- Do you feel there is an expectation to show leadership?
- What do you perceive leadership in dentistry to be?
- Do you think leadership in dentistry is different to that in other professions or organisations?
- What leadership challenges do you face?
- Do you think that your education prepared you for such a leadership role?
- Do you feel you have the skills needed to be an effective leader?

### Interview Practice

The interviews were conducted using best practice guidance (Cohen et al., 2011). Interviews were planned to last no longer than 30 minutes to take into account availability of participant's time within dental practice hours. Specific interview times were negotiated with participants so as not to disturb their patient appointments (Saunders et al., 2019). All interviews were held on a one-one basis except in one instance when two dentists (previous joint dental practice owners) were interviewed together at their own request. The interviews were held in a

closed treatment room or staff room to maintain confidentiality. Only the participant and researcher were present. The interviews were audio recorded onto a digital recording device and downloaded to a password protected, University of Leeds data storage drive.

Prior to the interviews themselves, introductions were made and the purpose and aims of the research were re-established. Consent forms were checked and there was an opportunity for participants to ask questions. On concluding the interviews, participants were again asked if they had any questions and reassured about the confidential nature of the data that had been recorded.

### Data Interpretation and Analysis

Interview recordings were transcribed by the researcher. Initial analysis of the data was thematic and NVivo software (version 11) was used to facilitate transcript coding. NVivo is a software tool that allows a structured and organised approach to the analysis of qualitative data allowing interview transcripts to be highlighted, iteratively to develop a series of themes which can be categorised into a hierarchy of main and sub-coded data. In this research, a series of key, broad ranging, main themes in relation to the participants' experiences were identified:

- Meanings of leadership;
- Experience of leadership roles;
- Embodiment of leadership;
- Challenges in leadership;
- Preparedness for leadership;
- Thoughts on leadership education.

Later in the research process, the data from the semi-structured interviews was coded further using the aspects of the leadership meta-framework as main themes and an education design theme. These were combined with and presented alongside data found from the ethnographic and collaborative working group methods.

Narrative analysis approaches were also adopted to explore the emerging storied accounts. These were personal narratives and wider practice narratives within the General Dental Practices. Each participant had a perspective on leadership within their dental practice and stories emerged by piecing these together. For example, in one case, there had been a recent take over and buy out of a dental practice by a

corporate dental company. The previous owners continued working in the practice and were adapting to a loss of control. The practice manager was adjusting to a different way of working and taking on more responsibility; a dental hygiene-therapist reflected on the changes to her experience of the culture within the practice and feeling that the family feel of the organisation was being lost. This was contextually rich data which revealed a great deal about experiences of leadership in dentistry.

#### Informing the next phase of the research process

Following the first stage of the research, it was necessary to reflect on the results of the interviews to consider how this would inform the next stage of the research. The emergent dental practice narratives had revealed rich data in relation to experiences of leadership. The visits to the dental practices to conduct the interviews had also, in themselves, been insightful.

Researcher reflections on the interview process:

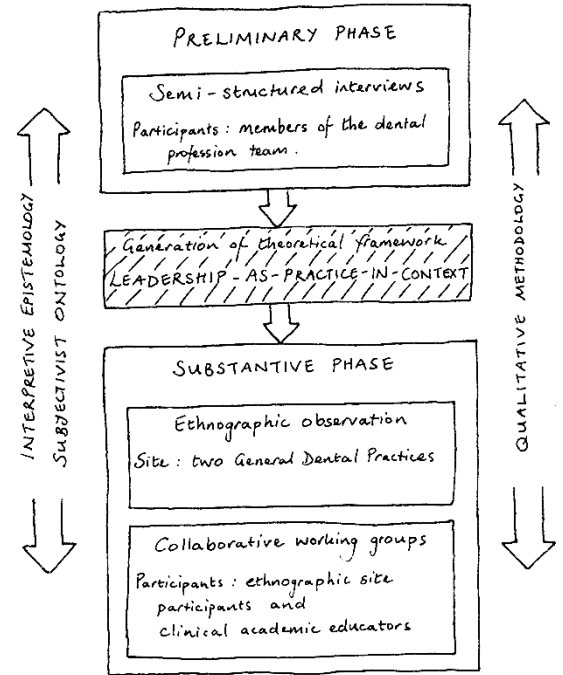
- The richness of the General Dental Practice environment in relation to leadership and the potential of this as a research context;
- The personal narratives – experiences of leadership over the course of a career in dentistry;
- The dental practice narratives – the leadership narratives that emerged from the interviews with participants from the same dental team;
- The lived experience of leadership – that leadership needs to be understood through the experience of those involved in it;
- Emotional aspects – that the experiences of leadership were deeply embedded within emotions;
- Relationships- that the interpersonal relationships with the people within practices are key part of the leadership experience;
- Ethical/ moral aspects – that these aspects are integral to leadership experiences;

- The interest of participants in the topic of leadership and the research process – that there was genuine engagement in this and a willingness to be involved;
- The role of a researcher– that there was a great deal of reflection following the dental practice visits that encouraged thinking in relation to *my* own experiences and assumptions. The inclusion of *my* voice in the research was important (reflexivity);
- What is the best way of researching leadership in dentistry? This raised the issue of what is said and what is done (theory and practice). Often interview participants would give cliché definitions or present ideal forms of leadership that were often theoretical. Mundane aspects of leadership were not talked as it was perhaps thought these were not of interest. Interviews did not therefore have the ability to capture the lived experiences of leadership, as it happened on a daily basis, in real life, ordinary situations – where, when, how and why leadership is practiced;
- What is the best way to develop leadership in dentistry? In relation to education, there was also an opportunity to translate a practice-based approach to leadership into leadership development for dentistry and to involve dental practice team at the front-line of patient care in exploring how this might be done.

These experiences and reflections informed the design of the next phase of the research process and the particular methods used. There was potential to continue the research within the General Dental Practice context and to involve all members of the dental team. Importantly, before commencing the substantive phase, a theoretical framework needed to be chosen to align, not only with the aims of the research, but also to consider the importance of context and practice in relation to leadership which was a key finding of the preliminary phase.



### 3.6 Theoretical Framework



The purpose of choosing and setting out a theoretical framework is to provide a guide by which to frame and focus research. The choice of theoretical framework was informed by the outcomes and reflections on the preliminary phase semi-structured interviews, in which the importance of context and practice was recognised. Such an approach has not previously been taken in relation to research on leadership in dentistry.

The ‘Theory’ section of the Critical Literature Review (2.1.2) explained a series of influential theories of leadership. An account of developments in thinking about Leadership-As-Practice was given (Raelin, 2016b) together with Wilson et al.’s, (2018) Leadership-Practice-In-Context approach.

An adapted version of these approaches was chosen as the theoretical framework for this thesis as it aligned with the outcomes of the preliminary phase research and provided an opportunity to construct a theoretical framework of leadership for dentistry.

It was at this point in the research that the specific aims for the thesis in relation to the leadership dimensions of theory, practice, research and education were elucidated:

**Leadership Theory:** to construct a theoretical framework of leadership for dentistry.

**Leadership Practice:** to understand leadership from within dentistry: where, when, how and why leadership takes place.

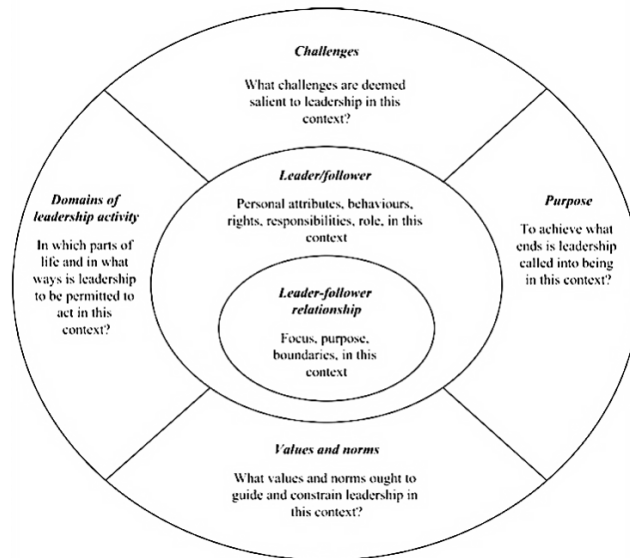
**Leadership Research Methodology:** to explore the use and value of innovative approaches to qualitative research to make sense of leadership in dentistry.

**Leadership Education:** to explore the needs of leadership education for dentistry, specifically in relation to what leadership development outcomes and approaches are relevant to dentistry.

In each of these dimensions, Leadership-As-Practice-In-Context informed the approach to further investigation within the substantive phase of the research.

#### Modification of the meta-theoretical methodology framework for theorising leadership

The use of a Leadership-As-Practice-In-Context meta-theoretical framework provided an opportunity to construct a theoretical framework tailored to the context of leadership for dentistry. To do this, the meta-theoretical methodology framework for theorising leadership proposed by Wilson et al. (2018) was adapted. The authors of this methodology suggest that it can be used flexibly in different ways. The original version is presented here to allow the rationale for the adaptation to be followed (figure 1).



**Figure 1.** A meta-theoretical methodology for theorising leadership. Wilson et al., 2018, p.47.<sup>6</sup>

The authors explain that the aspects of the outer ring of the meta-framework are more important. In the centre of the framework, those involved in leadership are placed. This separates the people involved in leadership as leaders or followers. This could be considered as taking a ‘dualist’ approach. There is also a focus on personal attributes and behaviours which could be considered as taking a ‘heroic’ approach. Both dualist and heroic leadership theories of leadership have been criticised in the leadership studies literature.

In modifying the meta-framework for use in this thesis (figure 5), these issues were considered. A more collective view of those involved in leadership was emphasised. A ‘People’ aspect was therefore added to the outer ring. This considered all those involved in leadership and how they work together to achieve leadership.

Another addition to the outer ring was based on the need to understand and bring attention to the ‘where, when and how’ of leadership which the Leadership-As-Practice theory emphasises alongside “the where, when, how and why leadership is done” (Raelin, 2016a, p.134), the ‘why’ was already covered by the ‘Purposes’

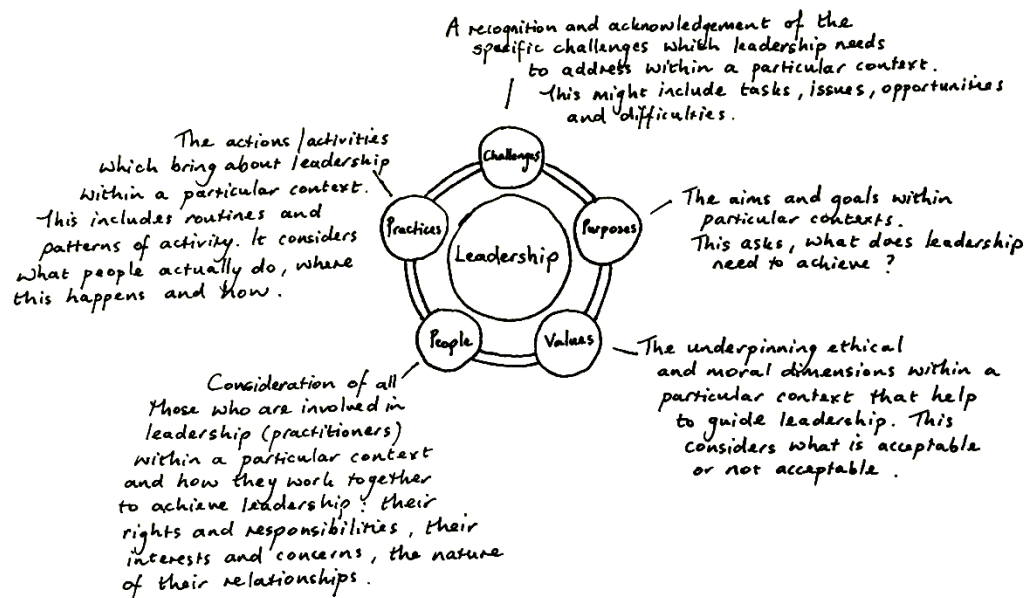
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<sup>6</sup> Republished with permission of Taylor & Francis Group LLC- Books, from *Revitalising Leadership: Putting Theory and Practice into Context*. Wilson, S., Cummings, S., Proctor-Thomson, S. and Jackson, B. eds. 2017; permission conveyed through Copyright Clearance Center Inc.

aspect of the framework. Given the emphasis on 'practice' it was felt that this should be added to the outer ring. This aspect would consider the actions / activities which bring about leadership.

The inner aspect of the framework was replaced with an inner general 'leadership' aspect with all the aspects contributing to leadership on the outer ring. It was also important to illustrate the interconnected nature of leadership by linking all of the outer ring aspects together.

This figure illustrates the final, modified meta-framework for theorising leadership:



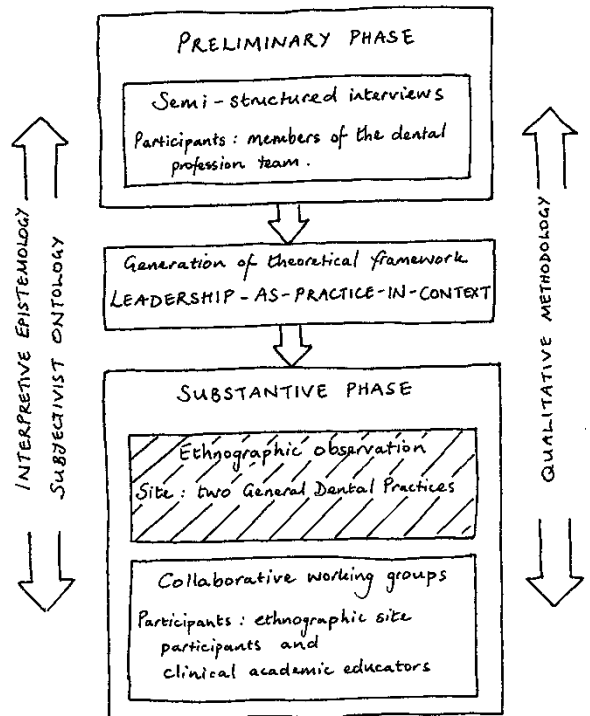
**Figure 5.** Modified meta-framework for theorising leadership.

The descriptions associated with each of the areas are a modified version of Wilson et al.'s (2018) original descriptions.

This meta-framework was used to inform the focus of the substantive phase ethnographic observations and formed an analytical framework which was used in the presentation of the findings and the construction of a specific theoretical framework of leadership for dentistry.

**Substantive Phase:**

**3.7 Ethnographic Observations**



This section considers the ethnographic observation method that was used as part of the substantive phase of the research process. Ethnographic methods have certain key characteristics but can be applied in different ways. It is important therefore to explain how ethnography was applied in this study such that it fulfilled the thesis aims.

As ethnographic methods are relatively unknown within the dental literature, as a starting point, an account is given of their use in the social sciences and organisation studies field. Even within these fields, although ethnographic methods are well known, and described, they are less frequently applied and reported in the literature and some of the reasons for this are described.

Background to Ethnographic Methodology

Ethnographic methodology has a well-established history within the social sciences field, particularly anthropology: the study of people, society and culture (Hammersley and Atkinson, 2007). Traditionally, anthropological study tended to be of interest because it told of exotic (Golden-Biddle and Locke, 1993), unfamiliar cultures and contexts. The application to more ordinary and familiar settings such as the workplace was driven by the 'Chicago School', a group of sociologists working at the University of Chicago in the 1920s-1950s (Hammersley and Atkinson, 2007). What evolved was a recognition that management in the workplace could be improved by gaining a better understanding of the "daily concerns and issues" (Zickart and Carter, 2010, p.308) of workers. In the 1920s

and 30s, industrial settings provided the context for such ethnographic research, one of the most famous and well critiqued being the Hawthorne studies (Roethlisberger and Dickson, 1956). These studies involved participant observation, investigating the effects of different environmental conditions on worker productivity. Notably, the Hawthorne studies are also synonymous with the 'Hawthorne effect'- in research terminology known as methodological confounding – "the effect of participants altering their behaviour in the presence of observers" (Zickart and Carter, 2010, p.310). Interestingly, one of the reasons for the later 'disinterest' in ethnographic methodology was the increasing focus on objective, positivist research methods which focussed on ensuring replicability and reliability of findings; the necessity for researcher objectivity and measurability of findings as well as statistical analysis. The qualitative and interpretive nature of ethnographic methodology was surpassed and fell out of favour.

Qualitative researchers, using ethnographic methods, have struggled to contend with this ever since (Cunliffe, 2010). There has however, over the past 20- 30 years, been growing interest in these methods. This stems from a recognition that in applying quantitative methods, valuable data is either lost in statistical analysis or not collected at all (Zickar and Carter, 2010). The main benefit of ethnographic methods is exactly that they focus and are embedded within culture and context and align with the inherent interpretive and subjective nature of the research. This research method has particular potential within the field of healthcare as argued by Draper (2015), where culture, context and practice have a significant influence on the effectiveness of patient care. One of the best-known ethnographic examples in healthcare is 'Boys in White: Student Culture in Medical School' (Becker et al., 1961). This was an extensive ethnographic study over a number of years, with the results being presented in the form of a book. Students were found to have developed collective approaches to the pressures of student life and a culture of coping (being selective with their work and attention in order to manage a vast amount of learning) (Atkinson and Pugsley, 2005).

There are many subsequent health context examples of ethnographic research in the nursing literature, (Williamson et al., 2012; McGibbon et al., 2010; Gabbay and le May, 2004). Gabbay and le May (2004) conducted a two-year ethnographic study within two purposefully selected general medical practices with the aim of exploring how primary care clinicians make individual and collective healthcare decisions. Non-participative observation, formal and informal interviews, practice team meetings, informal coffee room gatherings and documentary data types were used.

In dentistry, there are few examples. One recent example was a study that aimed to understand oral health knowledge and disease among humanitarian migrants in Canada (Keboa et al., 2019). Here, observation in mobile dental clinics was carried out as well as interviews. There are, however, examples in the dental literature where the ethnography method is mislabelled; illustrated by a study which reported on cross-sectional telephone interviews of 400 participants (McGrath et al. 2002).

### Key Characteristics of Ethnography

There are key characteristics which are recognised as being representative of this method; these are explained.

Ethnographic methods give emphasis to conducting ethnographic research within 'real' settings (White et al., 2004), observing everyday events and practices as they take place (Hammersley and Atkinson, 2007). This often includes 'mundane' aspects of working life (Ybema et al., 2009) which the researcher identifies as being of note despite their routine, everyday nature (Garfinkel, 1967). This is an inductive process with the findings within the ethnographic setting influencing and guiding the research, rather than being informed by a set of *a priori* theories (Adler and Adler, 1998). Settings are not 'created' or 'controlled' by the researcher; they are studied in their 'natural' state (Adler and Adler, 1998). Fundamental to ethnography is its interpretive nature, being strongly aligned to this epistemological stance (Draper, 2015). It aims to aid understanding and does this through giving insights into meaning; not just asking 'what' but asking 'how' and 'why'. The researcher becomes an essential figure as they are present within the setting throughout the process (McGarry, 2007). They take on the role of interpreter and translator and therefore have great influence in the production of the findings. The ability of the researcher to be reflexive within the research process is therefore key (Cunliffe, 2010; Allen, 2004). The findings of the study are presented in the form of written descriptions and accounts, interspersed with rich and thick (Geertz, 1973) detail taken from the setting and considered alongside broad theoretical frameworks using a critical approach (Van Maanen, 2011). Due to the detailed and lengthy study involved, it is necessary that ethnographic study is limited to a small number (one or two) sites.

Van Maanen (2011) describes ethnography as a research process that involves 'fieldwork, headwork and textwork' or as Cunliffe (2010) describes as two main phases: immersion and translation. These are further explored.

### Immersion

Firstly, the ethnographic researcher immerses themselves within the field, observing and interacting with the participants and environment. Immersion within the field is usually for an extended period so that the researcher can gain a deep understanding of the culture and its lived experience. To a chosen extent, the researcher will “live with and live like” (Van Maanen, 1988, p.2) participants becoming a full participant, engaged in the work of the organisation, or as an observer, present, but not participating in this work (McDonald and Simpson, 2014). This builds a picture of the culture of an organisation. Van Maanen (2011, p.221) describes culture as “the meanings and practices produced, sustained, and altered through interaction”. As White et al. (2004, p.2) argue, “only through living with and experiencing ‘native’ life in their own environment could a researcher really understand that culture and way of life.”

Data is gathered in the form of field notes (including timelines, observations, quotes, stories and reflexive accounts), interview and meeting recordings, photographs and organisational documentation such as e-mail and minutes of meetings. Reeves et al. (2008) outlines a series of ‘observational dimensions’ that can be used as a guide to the ethnographer:

- Space - physical layout of the place(s)
  - Actor - range of people involved
  - Activity - a set of related activities that occur
  - Object - the physical things that are present
  - Act - single actions people undertake
  - Event - activities that people carry out
  - Time - the sequencing of events that occur
  - Goal - things that people are trying to accomplish
  - Feeling - emotions felt and expressed
- Reeves, et al., 2008, p.512.

In addition, Cunliffe (2010, p.229) emphasises the need to attend to expressions of ‘sociality’ in the form of:

- Interactions and talk (stories, narratives, metaphors, gossip, jokes);
- Symbols (dress, logos, décor);
- Language (jargon, phrases, words).



It cannot be anticipated what data will be available and the researcher must be flexible and reactive to the opportunities for data collection as they arise.

### Translation

Secondly, the ethnographic researcher engages in a process of translation. This involves analysis and interpretation of findings, applying or relating these to theory and then writing an account which brings this together. This process, rather than being rigidly prescribed, has been described as craft work – signifying the creative (Fetterman, 1989) and tailored work that is involved. The ethnographer finds their own way to make sense of the situation that has been studied and finds the most helpful way (for example, using imagery, metaphor, and other literary tools) to explain this and to indicate resonance (Cunliffe, 2010) for the reader. This means that there are many different forms and styles of ethnographic writing. The writing of ethnographies can therefore be approached as a literary endeavour (Hammersley and Atkinson, 2007).

Golden-Biddle and Locke (1993) consider aspects specifically related to ethnography and how the interpretive perspective influences judgements as to what makes 'convincing' work. They describe three 'dimensions' which they consider as being crucial in relation to quality, rigour and relevance: authenticity, plausibility and criticality.

### **Authenticity:**

"Authenticity means being genuine to the field experience as a result of having 'been there'". (Golden-Biddle and Locke, 1993, p.599). The writing should therefore convince readers that the researcher has 'been there' and that the accounts that are given reflect what actually happened in the field – descriptions that only someone who was there could possibly have made.

### **Plausibility:**

This relates to how ethnographic work makes sense to the reader. Relevance, distinctiveness and personal connection are important aspects. Readers should be encouraged to see the wider relevance of findings that are specific to the context or organisation that is being studied.

**Criticality:**

This involves encouraging readers to question their assumptions – this is a fundamental aim of ethnographic work.

Strengths and weaknesses of ethnography

Ethnography draws its strengths from its inherent interpretive epistemological underpinning and its ability to create rich accounts of everyday life, placing the researcher and then the reader at the scene of action to gain understanding, insight and resonance.

Ethnography also has inherent weaknesses, risks and limitations which can deter its use. Often scepticism of this method relates to epistemological misalignment; this means applying positivist, quantitative perspective on quality judgements.

Strengths of ethnography

- **Places the researcher (and then the reader) at the scene of the action** (Yanow et al., 2012)

The researcher is situated within the context and can therefore see for themselves what is happening, alongside the participants. The researcher is not relying on the accounts of others;

- **Allows the ‘flow’ of events to be recorded** (Czarniawska, 2014). Ethnography copes with the complexity of activity and uncertainty of everyday life; this volatile, uncertain, chaotic, complex and ambiguous world, Van Maanen (2011). It can be flexible to react to events. As McDonald and Simpson (2014, p.16) explain:

To.... uncover the dynamic nature of managing, demonstrating shifts in pace, focus and priorities of organisational action and processes at a micro-level.

- **Contemporaneous data can be recorded**  
This method does not rely on ‘after the event’ accounts of participants (memory) where detail can be lost;

- **Allows the researcher to interact with participants**

One of the key characteristics of ethnography is that it does not observe participants passively; there is an expectation that researchers will interact with them to understand their perspective and what events mean to them. This interaction can be viewed as being a criticism as the researcher loses their 'objectivity'. However, Czarniawska (2007) argues that objectivity can never be achieved. Researchers become part of the construction of the findings along with the participants.

As Van Maanen (2011, p.228) states:

There is no other way to figure out what people are up to without attending to the ways they read the situations they face and the many ways they express it in what they say and do.

- **Attends to the individual perspective rather than the general, societal perspective** (Draper, 2015)

This refers to 'emic' (individual) or 'etic' (societal, collective) perspectives. Draper (2015, p.38) explains that "the emic perspective refers to the insider's point of view: the reality seen, experienced, understood and expressed by the individual." The etic perspective is not, however, therefore neglected. Ethnography can be informed by or informs etic perspectives, but in itself, it concentrates on the emic perspective;

- **Allows rich, thick data to be gathered and presented** (Geertz, 1973)

'Credibility' and 'resonance' are included in Tracy's (2010) 'big tent' criteria for quality in qualitative research (considered earlier in the first section of this chapter). Use of rich and thick data description is an important way in which to demonstrate these. Generalisability often means a reductionist approach needs to be taken during the analysis of data where much of the rich detail of the raw data is lost;

- **Allows data and insights to be gained that participants may not notice**

"The researcher may discover aspects which interviewees may be unaware of or which, for other reasons, they find difficult to articulate" (Alvesson, 1996, p.467). Tacit practices, routines and norms can be noticed by the researcher. These would not be discovered at all if relying on the accounts of participants. As Tracy (2010, p.843) argues, "hidden assumptions and

meanings guide individual's actions whether or not participants explicitly say so." In uncovering these, more insight can be gained;

- **Focuses on practise rather than theory**

The everydayness of life (Garfinkel, 1967) is the focus. Cunliffe (2008, p.124) describes Garfinkel's notion that "a sense of the real is a practical accomplishment, achieved through the contextual, embodied, ongoing interpretive work of people." It is often the mundane routines of everyday life that can be most insightful – "the unheroic work of ordinary practitioners in their day-to-day routines" (Whittington, 1996, p.734). Chia (2004, p.33) describes the "skilled, improvised in-situ coping" that is inherent in everyday life. Ethnography has the ability to capture these;

- **Scope for craft work by researchers**

There is no fixed recipe as to how to undertake ethnography. This gives scope to the researcher to be creative and to adapt or craft (Cunliffe, 2011) their approach to the needs of the context under study. This therefore has much greater potential for useful data to be collected and then written up in a way which best illustrates and illuminates the issues for the reader.

#### Weaknesses of ethnography

- **Gaining access to research settings and people**

There may be a reluctance by organisations to allow access (Sutherland, 2018). Organisations may not wish to be scrutinised in this way, especially when there is no obvious benefit to them. A lack of understanding of the purpose of the research and what it will involve can put off potential participants;

- **Resource heavy**

This relates mainly to the time commitment necessary (Alvesson, 1996). Ethnographic researchers need to be present within a research setting for a considerable length of time, sometimes continuously. Analysis of a large volume of research data also brings time commitment. Sometimes research settings will be a considerable distance from the researcher's main base and therefore travel and accommodation may be needed. This may require considerable financial resources (Sutherland, 2018);

- **Uncertain outcome**

It is not possible to be certain as to the outcome of ethnographic research (Mintzberg, 1973). The research is inherently inductive rather than deductive and the researcher must adapt to the unfolding events of the setting. This can cause difficulty in the planning and perhaps funding of the research as no clear outcomes can be anticipated;

- **Burden on research participants (Gill, 2011)**

Individuals and organisations may experience additional pressure due to the presence of a researcher. The 'hosting' of a researcher can add to workload. There may be a reduction in productivity or activity due to interruptions by the researcher and a frustration in having to explain and reflect on actions. Existing routines and systems may be disrupted (Flick, 1998). Unanticipated conflicts may arise between the researcher and research participants or between research participants themselves in relation to the process of the research;

- **Researcher dependence and bias**

The interpretive nature of ethnographic research relies heavily on the experience of the researcher. The researcher can influence outcomes through their biases or assumptions in relation to the work– theoretical, political, experiential and emotional. This can be done through being selective; what is noticed, recorded and then interpreted as data.

For example, the 'Halo' effect describes how researchers can overlook negative aspects by believing in the goodness of participants (Cohen et al., 2011). Conversely, the 'Horns' effect overlooks positive aspects and favours negative aspects (Cohen et al., 2011).

If researchers are too familiar with a context, by being too close, they may overlook, or not actually see aspects which are significant. This is often described as the researcher 'going native' (Alvesson, 1996) – losing perspective whilst carrying out the research;

- **Observer effects**

As explained previously as the 'Hawthorne' effect, this is the alteration of the behaviour of participants in reaction to the presence of a researcher or "staged performances" (Monahan and Fisher, 2010).

When viewed from a positivist perspective, this is problematic as the objectivity of the researcher is crucial. It is however, impossible for the researcher to be invisible, or as the analogy goes, an ethnographic fly on the wall (Gill, 2011; Czarniawska, 2007);

- **Nature of the findings**

Ethnographic findings are written accounts. Meanings and explanations can be ambiguous and uncertain. It is not always easy to draw conclusions from the data. The use of reflexive accounts as part of the findings can also be seen as unnecessary 'navel gazing' – focussing on the researcher's perspective rather than actual data (White et al., 2004);

- **Generalisability**

The small-scale nature of the research (sometimes involving just one research setting) means that data findings cannot be generalised in the way that positivist principles allow. The findings cannot therefore be extrapolated and applied to all situations. The findings are context dependent, but they do allow researchers to theorise from these data and to provide findings that may resonate with other contexts;

- **Ownership of the data**

Data ownership can become problematic for the researcher if there is dispute in the use of data, especially if organisations or individuals are not perceived to be portrayed in a positive light. Participants may retain the right to withdraw from research as part of the ethical approval process. Unexpected withdrawal by participants can end a research project resulting in a waste of time and effort by all concerned (Hammersley and Atkinson, 2007).

### **Planning of this research study**

Having explored the theory behind the use of ethnography, this next section describes how the method was applied in this study. Considerations in relation to the choice of research context and specific sites, recruitment of participants, researcher position and the collection of data are explained.

### Choice of research context

General Dental Practice was chosen as the context of the ethnographically informed study. Most of the dental profession work in general dental practice and the majority of dental graduates (dentistry and dental hygiene and dental therapy) will begin their careers in this context. Data elicited from this context would therefore be most relevant and meaningful to members of the profession, including students. 'Lessons' taken from General Dental Practice serve as a good grounding in leadership generally.

General Dental Practice presented the opportunity to study interactions between members of the dental team. This was important to the concept of leadership as something that is not the exclusive domain of those in traditional positions of power such as dentists. The practices of leadership which took place among all members of the dental team could be found.

Most importantly perhaps was that the research would be taking place in the environment within which the outcomes were intended to be of benefit (Rowley et al., 2012).

The requirements for choice of dental practices in relation to these points were that they had at least two dentists (not single practitioner) and that there were a range of members of the dental team (including levels of experience and roles).

### Recruitment and access

As explained previously, recruiting and gaining access to research sites is a known challenge with this type of method and ethical issues need to be taken into account. As a starting point, the dental practices that had taken part in the exploratory interview stage of the research were contacted by letter asking them to consider taking part in the substantive phase of the research. Included in the letter was an information sheet and consent form. These documents outlined the purpose of the research, the nature of the research methods and the key ethical issues for consideration (these were explored in the Research Ethics Considerations section of this chapter, 3.3).

One of these dental practices agreed to continue with the process. An important factor was the rapport that had been established with the dental practice team, almost all of whom were interviewed as part of the research. A meeting was held with the Practice Principal to discuss the research and to give the opportunity to answer any queries in relation to it. Questions related to the nature of the ethnographic research, how the observations would work, what boundaries would be in place, how long, how frequent and over what period of time the observations

would take place. It was agreed that there would be ongoing communication and feedback so that any issues could be resolved as soon as possible.

In relation to the other dental practices contacted, in one case there had been a change of ownership of the practice having been taken over by a corporate company. The previous manager and the owners had been enthusiastic participants in the exploratory interviews, however, a change in both manager and owner meant that involvement in research was not a priority. They declined to be involved further. In another case, the dental practice team did not respond to the letter or to follow up contact and so no further request for involvement was made. Other routes to recruitment were therefore explored. Links with dentists and dental hygiene-therapists who worked part-time at the Leeds School of Dentistry were made. Where interest was expressed, a letter of invitation (including information sheet and consent form) to the dental practice principals/ owners was sent out. In one case, the dental practice principal and owner was particularly interested in taking part because one of their aims as an organisation was to be involved in research. A meeting was held at his dental practice to discuss potential involvement. The practice manager also attended this meeting. Again, questions related to the nature and scope of the research and the observations involved. It was important to them that the normal activity of the practice was not disrupted and that information was kept confidential between participants in the practice, as well as outside it. Following discussion, the dental practice principal/ owner agreed to take part in the research. They agreed to hold discussions with their team at their next practice meeting. At this, there was general agreement to involvement in the research. One further point of query related to the use of audio recording. Assurances were made that specific permission and consent would be sought for each instance of audio recording and that this would only be used for formal interviews. It was also obvious that due to time commitments that not all consenting participants would be able to attend the later collaborative working group sessions.

Having gained consent for the dental practices to be involved in the study, a set of individual participant information sheets and consent forms were sent out to dental practices. Before starting the research, the consent forms were checked to determine whether any dental practice member did not give their consent to take part. All dental practice members gave their consent to take part in the study except one Hygiene-Therapist in the 'Northby' practice. This individual worked part-time in the practice and was rarely present when research visits took place.



Recruitment was limited to these two dental practices. On the basis of ethnographic research practice (Draper, 2015; Yanow et al., 2012) this was deemed to be sufficient in relation to the nature of the ethnographic research and then subsequent in-depth working group sessions.

#### Characteristics of the recruited dental practices

The two General Dental Practices are named in this thesis as Westby and Northby (as pseudonyms). Both dental practices were owned by the Principal Dentist who worked within the practice. They both provided a mix of NHS and private funded treatments,

More detailed information in relation to the two dental practices is given in the Findings chapter.

#### Timeline of ethnographic study

The ethnographic observations took place over the course of 10 months with two main spells of one full day visits in each practice. In each spell, there were 4 visits with approximately two weeks between each visit. The collaborative working group sessions were held after each spell of practice visits. This allowed time for data analysis and preparation prior to each working group session and the participants could reflect on the data and findings presented during the process of the research.

This level of immersion within the field was achievable within the time constraints of this study and availability to conduct the research.

The ethnographic observation visits to the two dental practices continued until the nature of the data collected became repetitive and no new insights were found; the data reached a point of saturation. Overall, 8 visits were made to 'Westby' and 8 to 'Northby'.

#### Researcher position

An unstructured, non-participant observation role was taken. Here the researcher plays no direct involvement in the work of the organisation. Involvement was limited to making the tea and coffee at break times. The practise of reflexivity was undertaken throughout the research. The principles of reflexivity are explored in the 'Reflexivity in the Research' section of this chapter.

### Data collection

Recommendations made by McDonald (2005) in relation to the practical collection of data were followed; notebooks were used to record field notes which were made on an ongoing basis, with as much as possible was recorded at the time.

Mentoring from research supervisors allowed debriefs of challenging or difficult situations encountered during the ethnographic observations and interactions.

Opportunities for data collection included:

- Observation during and outside surgery hours  
This was the main opportunity for data collection. Participants were observed as the day unfolded. Observations took place in reception areas, decontamination rooms, dental surgeries and staff rooms;
- Coffee breaks and lunchtimes (multiple);
- Staff member appraisal meetings (3)  
Permission was sought from individual staff members and the dental practice manager to attend appraisal meetings;
- Staff meetings (1 at each dental practice);
- Individual meetings with staff members including dental practice principals and manager (multiple).

Data was collected in the form of:

- Contemporaneous field notes  
These comprised written records of events, times, speech, actions and interactions which were observed.;
- Informal and formal interviews  
These were arranged at convenient times for the participants. Interviews were either audio recorded or recorded in written note form (where informal interviews took place ad hoc);
- Documentation  
Dental practice policies and protocols, Care Quality Commission (CQC) reports, agendas and minutes of dental practice staff meetings, nurse meetings, notice board messages;
- Artefacts  
In one case this was a newspaper which was present within the patient waiting room on a particular day;
- Photographs

Photographs were taken (and with specific permission) of the dental practices to illustrate the context of the research site. No participants appeared in these;

- Reflexive accounts

Written reflexive accounts were made both during and following (sometimes in the evening, sometimes in the following days after) observation visits.

#### Maintaining relations in the field

Ethnographic research practise guidance was followed in relation to maintaining relations within the field.

- Appearance: blending into the conventions of the dental practices – smart, professional dress (not clinical dress);
- Demeanour: being open and flexible to events, willingness to actively listen and to answer questions;
- Consideration for participants and their needs (empathy, giving them space when needed);
- Discrete note taking: being aware of the impact of note taking in the presence of participants and as events are unfolding. In addition, being careful to keep notes confidential;
- Managing emotions: not engaging in conflict or disagreement with participants or showing reaction to events (whilst remaining human);
- Ethical practice: gaining trust by following the principles of consent and confidentiality;
- Negotiating time and access: allowing participants a say in their interaction with the researcher;
- Respecting local rules and conventions;
- Asking for feedback: giving the participants the opportunity to raise concerns or to offer feedback.

Hammersley and Atkinson, 2007.

#### Analysis and translation of the data

Hammersley and Atkinson (2007) argue that ethnographic work does not separate out the analysis of data as a distinct stage in the research process. Although the analysis process should not be considered as being formulaic, it is important that it should be “systematic and rigorous” (Brewer, 2000, p.106).

In this research, the analysis approach was tailored to the data, and the aims of the research. The process undertaken was as follows and was guided by approaches

advised by Brewer (2000), however, it is important to state, that this process occurred continuously, particularly in relation to the review of written observations, as the ethnography unfolded:

1. Review of written observations (7 books of written notes).

Notes were highlighted where there were instances of interest (events, actions, interactions, speech, routines). Formal interviews (10) data was reviewed. Data in the form of documents was highlighted for aspects of interest.

Initial coding of this highlighted content allowed the data to be organised, ready for further analysis and translation;

2. Translation of the data into:

- Dental practice narratives (telling the story of the practices – their history, composition (building layout, numbers of staff))
- Individual participant narratives (career background, current role)
- Narratives of specific events (including actions and interactions between participants, verbal and non-verbal communication)
- Patterns of behaviour and practise
- A comparative analysis between the dental practices in relation to culture;

(Pseudonyms were used for dental both the dental practice names and individual participants).

3. Thematic coding of translated data in relation to the Leadership-As-Practice-In-Context meta-theorising framework: 'challenges', 'purposes', 'values', 'people' and 'practices';

4. The development of illustrative leadership scenarios (for use in the collaborative working group sessions, Appendix A).

These were informed by the data findings and focused around a leadership purpose theme. The scenarios were written and designed to be used as part of the collaborative working group sessions. The aim was that the scenarios would give a focus to discussions in order to bring out further insights into leadership and that could then be used for translation into the development of leadership development.

This method has similarities to the use of vignettes in social science research (Barter and Renold, 1999); they give “concrete examples of people and their behaviours on which participants can offer comment or opinion” (Hazel, 1995, p.2). Hughes (1998, p.381) says these are “stories about individuals, situations and structures which can make reference to important points in the study of perceptions, beliefs and attitudes”. The difference here is that the scenarios were based on real characters and situations; vignettes are based on hypothetical characters and situations.

The following principles in the design of scenarios/ vignettes were used but these were adapted to that the scenarios would be tailored to the purpose of the study.

- Emphasis on the topic being discussed (in this case, leadership);
- Attention to the perceived importance of the scenarios to the readers (in this case dental professionals);
- Attention to the authenticity and plausibility of the scenarios (as discussed earlier in considering Golden-Biddle and Locke’s (1993) paper on how to do convincing ethnographic work); attention to detail, use of mundane instances;
- Attention to the need to encourage reflection;
- Relatively short and easy to read and to make sense of.

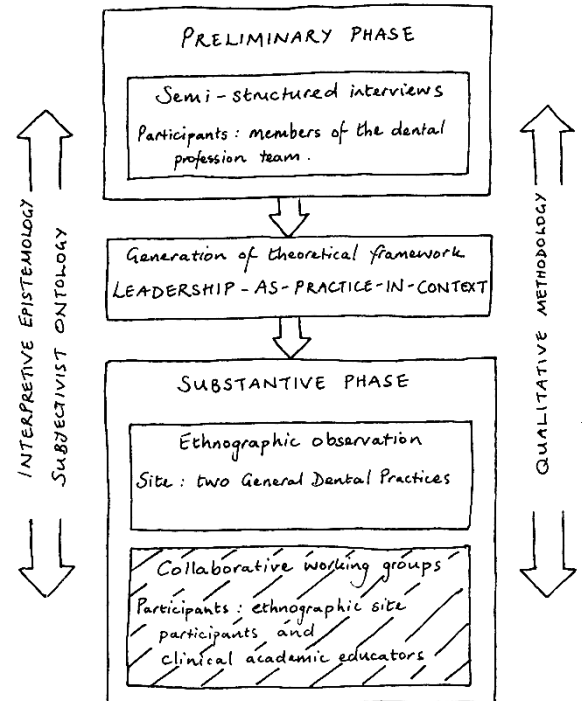
Based on Barter and Renold, 1999.

Ethnographic data was brought together to illustrate examples of leadership in each dental practice. These focused on particular events or instances or on more prolonged activity in relation to a particular aspect of dental practice work. The scenarios told of events or work that had been successful for the dental practices. The scenarios incorporated various forms of ethnographic data types: direct observation, written records of conversations, interviews, policy documents, minutes of meetings, external reports and artefacts such as an extract from a newspaper that had been in the waiting room of one of the practices at the time of the event.

The positive nature of these scenarios was important to the next stage of the research: the collaborative participant working groups. The use of these scenarios is discussed in the next section of this chapter.

**Substantive Phase:**

### **3.8 Collaborative Working Groups**



This final method in the process used a collaborative approach. This brought together members of dental practice teams with clinical dental academic educators, in a series of working groups, to combine their insights and experience in relation to the thesis aims, and particularly in relation to the final, education aim to explore the needs of leadership education for dentistry by translating the findings of the earlier ethnographic observations.

The working groups were designed around the principles of the focus group method and incorporated an appreciative inquiry approach using illustrative scenarios generated from the ethnographic observation data to encourage engagement and to generate discussion. The sessions were designed to be collaborative and participatory however issues of feasibility and acceptability had to be considered as part of the design. This section describes the process and methods involved.

#### Practitioner – Academic Collaborative Inquiry

Before explaining how the collaborative method was used in this thesis, a consideration of why this form of research beneficial as well as acknowledging the challenges involved.

The perceived differences between practitioners ('doers') and academics ('knowers') (Lunt et al., 2010) perpetuates a separation of the worlds of practice and theory across research and education; so termed 'the great divide' (Rynes et al. 2001). It is the belief that practitioners live in the real world while academics live in ivory towers that drives this separation.

Most practitioners want studies that provide 'answers', while many academics prize theory –driven research which may have no obvious practical application.

Martin, 2010 p.211.

Rowley et al. (2012) describe the divides between education and the NHS; the 'siloed working barriers' in the healthcare context which inhibit successful joint research work for both patient and organisational benefit.

It is proposed that when practitioners and academics do collaborate there is an opportunity to bring the two worlds together and to do research which has both scholarly and practical impact (Pettigrew, 2001, Posner, 2009). Bridging the divide with collaborative approaches brings challenges and requires dedicated effort that should engage participants in the topic itself at both clinical and academic levels (Rowley et al., 2012).

There are many proposed benefits to collaborative inquiry as an approach to research. The approach however comes with inherent challenges which must be addressed if it is to work successfully.

Proposed benefits:

- Collaboration between academics and practitioners (knowledge, skills and experience of both are brought together);
- Generation of practice-relevant research;
- Better informed policy making;
- Enabling academics to engage beyond other academics.

Assimilated from Orr and Bennett, 2012.

Perceived challenges:

- Achieving engagement (buy-in) of practitioners;
- 'Bridging gaps' (Posner, 2009) between the expectations of academics and practitioners - the inherent politics of the process, and the need for negotiation (Orr and Bennett, 2012);

- Achieving a balance between the two groups.

To collaborate means 'to work jointly on an activity or project' (Oxford Dictionary, 2005). Involving practitioners means that they have an active role in generating research findings (Lunt et al., 2010). There are different 'levels' of practitioner engagement within the research process that can be considered as being collaborative. Martin (2010) identifies a model of co-production in research outlining five levels or 'types' of practitioner involvement:

Type 1: Practitioners as informants;

Type 2: Practitioners as recipients;

Type 3: Practitioners as endorsers;

Type 4: Practitioners as commissioners;

Type 5: Practitioners as co-researchers.

The level or type considers the degree of involvement of practitioners in different aspects of the research process. Type 5 involves practitioners at all stages in the research process: design phase (initiation, methodology), evidence gathering, analysis and dissemination stages. This can be defined as full co-produced research. Type 1: Practitioners as informants are only involved at the evidence or data gathering phase. The relative challenges involved in collaborative research, as described, increase with increasing level of practitioner involvement. In all forms of collaborative research, the principles of equity of participants, reciprocity and mutuality are key (Heaton, 2016). Equity considers that potential power or position differences between participants are broken down so that all participants feel they have an equal role and influence within the group. Reciprocity and mutuality consider that participants should be interested in learning from each other and that the value of collaborative research comes from combining knowledge and experience from both practice and academia.

In this study, dental practitioners were considered as 'informants' working alongside clinical academic educators. They were involved in generating data but were not involved in the design or analysis stages in the research. This was a deliberate choice. It was felt that the challenges in extending to a full co-produced approach would have been too great; particularly the time commitment and level of engagement of the practitioner participants.



Despite the challenges, dental practice participants from the dental practices involved in the ethnographic observation study took part in two collaborative working groups.

### Design of Working Group Sessions

The working group sessions were designed along the principles of the focus group method. Focus groups are designed to encourage the interaction of participants within a group to discuss a given topic and to reach a collective view (Morgan, 1988; Gill et al., 2008). The key element is participant interaction (Smithson, 2000). This social interaction between participants gives an opportunity to share understanding, experiences and ideas. The emergent data and outcomes are therefore socially constructed where influence is shared among group members thereby replicating a more 'real life' situation (Krueger and Casey, 2009).

Advantages of the focus group method include:

- Generating hypotheses that derive from the insights and data from the group;
- Gathering of qualitative data;
- Generating data quickly and at low cost;
- Gathering data on attitudes, values and opinions;
- Empowering and encouraging participants to speak out and to voice opinions.

Cohen et al., 2011, p.436.

Disadvantages include:

- The data can be difficult to analyse;
- The number of people involved tends to be small;
- The group dynamics may lead to non-participation by some members and dominance (Smithson, 2000) by others (status differentials may operate);
- The number of topics covered can be limited;
- Intra-group disagreements and even conflicts may arise;
- Inarticulate members may be denied a voice.

Cohen et al., 2011, p.437.

There are a number of issues to consider in relation to the design of focus groups:

- Communication and explanation of the purpose of the focus group to participants (Kandola, 2012);
- How many focus group sessions to run;

- The size of the group;
- Participant diversity in relation to the topic to achieve sufficient representation;
- Encouraging engagement and discussion of the topic;
- Appropriate facilitation to achieve a balance in structured and unstructured discussion.

Morgan, 1988, pp.41-48.

### Recruitment of Participants

Dental practice participants were recruited from the two dental practices in which the ethnographic observations were carried out. Details and information of this stage of the research had been given out at the time of taking consent for the substantive phase of the research so participants were already informed of the plans for the collaborative working group sessions. A reminder and further explanations were necessary at this stage. As stated above, Kandola (2012) advises that communication of the purpose of focus groups is essential to gain engagement of participants. It was also important to state that there would be no advantage or disadvantage to dental practice participants who chose or not to take part. This had been agreed with the dental practice principal or manager in advance. It was acknowledged that participation in this aspect of the research meant a considerable non-paid and voluntary time commitment and that not all of those who had consented to the substantive study would actually be able to take part.

Specific details of timing and location were negotiated with the participants closer to the time of the working groups. This was done to help make the sessions as feasible and accessible as possible. Availability of time in evenings and travel to the venue after the working day was a limitation. Lead contacts in the two dental practices were approached to negotiate these timings and discussions were held during the ethnographic study visits. As part of the ethical approval for the study, it was agreed that travel expenses and refreshments would be provided. Once agreement had been reached, an invitation to attend the first working group was sent out to the two practices. This contained details of the specific timings – start and finish times, location as well as the aims and objectives for the session. Any questions relating to the arrangements for the session were discussed during the visits to the practices and this helped to address any queries which if not allayed may have led to non-participation.

Clinical academic educators were recruited at this stage. A heterogeneous, purposive sampling strategy was used with the aim of recruiting a diverse range of educational roles and levels and to represent the different members of the dental team. Potential participants were identified from members of School of Dentistry, University of Leeds staff. They were initially sent an e-mail invitation to take part. An information sheet and consent form were specifically designed for this group. These documents contained information on voluntary participation, confidentiality and the altruistic nature of taking part.

The recruitment of participants to the collaborative working group sessions was as follows:

**Dental Practice participants:**

Dental Practice 1

Dental Surgeon and Dental Practice Principal

Dental Foundation Trainee

Dental Nurse

Dental Nurse

Dental Nurse

Dental Practice 2

Associate Dentist

Dental Foundation Trainee

Dental Foundation Trainee

Clinical Dental Nurse Manager

**Clinical Academic Educator participants:**

Senior Lecturer in Restorative Dentistry (Dental Surgery Programme)

Senior Clinical Teaching Fellow (Dental Surgery Programme)

Lecturer and Specialist in Periodontology (Co-Lead of Dental Hygiene and Therapy Programme)

Clinical Teaching Fellow and Outreach Teacher (Dental Surgery Programme)

Senior Tutor Dental Nurse (Dental Nursing Programme)

Senior Tutor Dental Technology (Dental Technology Programme)

Senior Clinical Teaching Fellow (Dental Surgery Programme)

Senior Clinical Teacher in Dental Hygiene and Therapy (Principal tutor Dental Hygiene and Therapy Programme)

### Practicalities of Organising the Working Group Sessions

Finch et al. (2014) recommend a number of factors that should be considered when organising focus group sessions:

- **Timing:** time of the day, time of the week, time of the year;
- **Venue:** type of establishment (ethos), building (access), location (proximity, safety), room (size, comfort, privacy, quiet, ambience), physical arrangement (seating, table);
- **'Hosting' the group:** management of transport, meeting and direction of participants, refreshments, incentives;
- **Recording:** quality of equipment, familiarisation, checking before and after group.

Finch et al., 2014, p.235.

In this study the working group sessions were held on evenings, from 6.30pm until 8.30pm. This was to facilitate the attendance of all participants who were working during the day. Dental practice participants needed time to travel to the venue with the journey time being approximately 45 minutes to 1 hour. The choice of day and week was decided through negotiation with dental practice staff in advance of advertising the session to maximise the potential for attendance. The sessions were held in the University of Leeds Medical School and Business School. These venues were chosen not only for convenience and familiarity to the researcher and clinical academic educator participants. The Leeds city location was approximately halfway between the location of the two participant dental practices - them being on either end of a train line which passed through Leeds.

Large flat space rooms with audio-visual equipment to display a PowerPoint presentation were used. Movable tables allowed the room to be set up as desired (figure 6).



**Figure 6.** Arrangement of room for a working group session.

A member of Dental School administrative staff was employed to support the session. Support involved preparation of handout copies, name badges, checking of consent forms, help to set up the rooms and registration of participants (including management of late arrivals) as well as managing catering arrangements. This helped a great deal with the smooth and efficient running of the sessions where time was limited. Refreshments were provided for arrival at the sessions. An evening meal was provided between discussions in a separate room. The working group table discussions were audio recorded for later transcription. Guidance was taken from a professional transcriber as to how to best achieve quality.

The digital audio files were then transferred to a backed-up University of Leeds storage file and deleted from the individual devices. Transcription of the recordings was carried out by a professional transcriber approved by the University of Leeds. Confidentiality agreements were signed in advance of transfer of files.

#### Content of Working Group Sessions

It was important that consideration was given as to how discussions could engage participants such that they felt able to openly and comfortably explore aspects of leadership which focused on the world of practice and then broadened out to envisioning leadership development. It was important to encourage critical reflection, and deep thinking taking into account the limitations of time.

The working group sessions were designed in two parts. Part 1 focused on examples of leadership taken from the dental practices which were taking part in the study and which would be familiar to the working group dental practice

participants. Part 2 focused on thinking about educational aspects of leadership and how the insights from dental practice could be translated for educational purposes.

Participants were introduced to these topics through a short presentation at the beginning of each part of the session (Appendix B). This reaffirmed the background and aims of the research and gave a flavour of the academic leadership and dental education literature. For Part 1 of the session, dental practice participants were kept together in their dental practice groups with clinical academic participants split between the two groups. For Part 2, all participants were mixed up into different groups so that there was a mixture of participants from both dental practices as well as clinical academic educators.

Ethnographic observation data was used to illustrate examples of leadership that took place in the two dental practices. An anticipated concern was the potential for discussion which would generate feelings of critical judgement and negativity especially amongst the dental practice participants. The risk was that scenarios might focus on negative outcomes or on aspects of poor leadership and then result in the apportionment of blame and criticism. Feelings of scrutiny by academic educator participants who were involved in discussions might fuel this. At best, this may have led to disengagement in the research discussions and, at worst, might have led to breakdowns in relationships between dental practice staff members. Another concern was that working group participants would not see (envision) the relevance and broader translation to educational aspects and to think more deeply about this.

An Appreciative Inquiry approach was used as a method of encouraging positive and collective involvement in the process. Appreciative Inquiry was specifically designed to move away from traditional “problem-solving” or “deficiency” based inquiry where there is a focus on “fixing problems” (Bushe, 2013, p.41). It reportedly seeks to generate a process that is “more effective, convivial and sustainable” (Bushe, 2013, p.41). Appreciative Inquiry has been defined as: “Collective inquiry into the best of what is, in order to imagine what could be” (Bushe, 2013, p.41). This approach was first published by Cooperrider and Srivastva (1987). Particularly important are the principles upon which Appreciative Inquiry is based:

The constructionist principle, the principle of simultaneity, the poetic principle, the anticipatory principle, the positive principle (hope, inspiration, openness to new ideas, cognitive flexibility).

Stavros et al., 2015, pp.101-103.

These principles aligned to the aims of this aspect of the research process. The constructionist principle was, importantly, congruent with the overall interpretive methodological approach to the work in general, and therefore another reason for choosing this approach.

Appreciative inquiry is based on four 'D's: Discovery, Dream, Design and Destiny.

**Discovery:** What gives life? The best of what is. Appreciating.

**Dream:** What might be? What is the world calling for? Envisioning results.

**Design:** What should be – the ideal? Co-constructing.

**Destiny:** How to empower, learn and adjust/ improvise. Sustaining.

Bushe, 2013, p.42.

The scenario narratives and questions for discussion were designed along these principles.

#### Working group scenarios

Scenario narratives (stories) derived from data gathered during the ethnographic visits to the two dental practices were used in the working group sessions as a means to stimulate discussion using the Leadership-As-Practice-In-Context theoretical framework (Appendix A). These focused on everyday individual incidents or ongoing themes in which leadership had been integral and important. The 'everydayness' of the scenarios was important to illustrate to participants that leadership was integral to their working lives in general dental practice. The scenarios chosen were deliberately positive in outcome and demonstrated the achievement of a particular purpose which was important to the dental practice organisation as a whole; working group 1 focused on 'leadership for patient benefit'; working group 2 focused on 'leadership for staff benefit'. The scenarios were kept short and easy to read so that participants of the working groups did not need to take a long time to read and interpret them as part of the limited discussion time.

### Discussion questions

Questions were designed to encourage participants to consider the scenarios through an appreciative inquiry lens and to think about the leadership challenges purposes, values, people, and practices involved.

In each group there was a Dental Foundation Trainee. They were asked to consider two further questions as part of discussions in their groups to gain additional insight into early experience and relevance of leadership in dental practice. Following on from this, in part 2 of the session, questions were used to encourage discussion of the broader educational relevance of the scenarios.

### **Working Group 1: Leadership for patient benefit:**

Part 1 Discussion questions in relation to the practice scenarios:

- Why does this success matter to your organisation?
- What inspired you to become engaged in achieving this goal?
- Work through the scenario – what acts, activities and interactions were involved?
- What 'unheroic' work was involved?
- What difference did you make working together?
- Continue the story of how this success was achieved
- What themes appear from these scenarios that are worth others learning from?

For Dental Foundation Trainee participants:

- How have you benefitted from being involved in these successes?
- What have you learned that you can apply to your future practice?

Part 2 Discussion questions:

- What leadership development/ educational outcomes do we want to achieve?
- What values do we want to bring to leadership education?
- What are the best ways to engage/ inspire our students in leadership issues?
- How can we use the curriculum to do this?
- What student transition points do we need to link to?



## **Working Group 2: Leadership for staff benefit:**

Part 1 Discussion questions in relation to the practice scenarios:

- What main themes/ issues arise from the scenario?
- What acts, activities and relational aspects, if any, were involved?
- How do you bring out the best from others working in your team?
- What makes working in your organisation feel fulfilling?
- Why does this matter in the success of your organisation?

For Dental Foundation Trainee participants:

- How have you benefitted from being involved in these successes?
- What have you learned that you can apply to your future practice?

Part 2 Discussion questions:

- What themes appear from the scenario that are worth others learning from?
- What do we want our students to learn/ experience/ develop?
- What kinds of learning opportunities could be provided?
- How could the learning be assessed?

### Educational Outcomes and Approaches

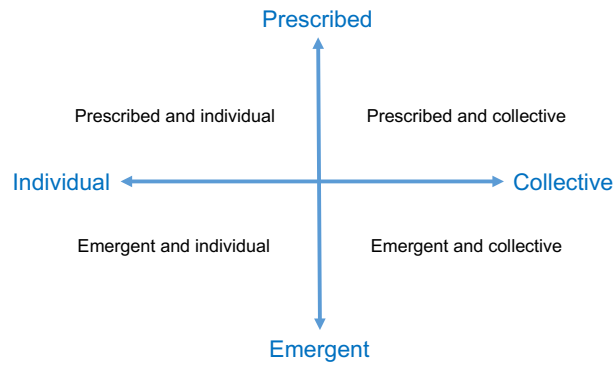
Although the working group sessions had discussed educational translation of the leadership issues discussed, it was felt that this process needed to be supplemented by an additional phase of this aspect of the research. In this way, the research could generate more focused outcomes and principles and more fully meet the educational aim of the thesis.

A further working group session was held with clinical academic educators who had been participants in the previous sessions. This was held following analysis of the initial working group data and meant that this could be presented to the group.

The specific aim of this session was to discuss how educational design (educational approaches, methods and assessment) could be used to engage students in leadership as part of the pre-qualification curriculum. This would apply to all members of the dental team in training.

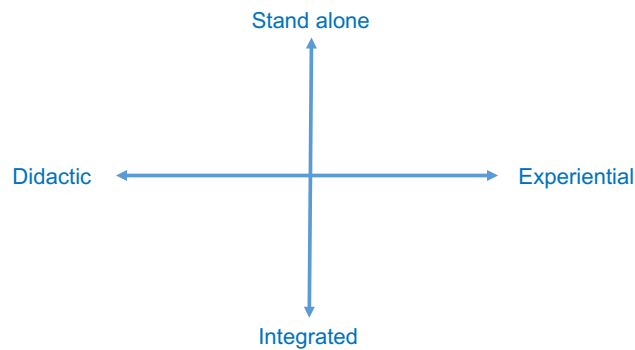
The session was held in the Leeds Dental School and lasted 2 hours. As with previous working group sessions, a presentation was given at the beginning of the session.

Participants were asked to review analysed thematic data which considered the themes of leadership 'challenges', 'purposes', 'values', 'people', 'practices' and 'educational design'. Participants were then asked to consider how students could be engaged in these themes through education: the educational style used, the teaching methods used and the methods of assessment. In order to facilitate discussion, a 'framework of leadership development' was used. This was based on a framework design from Rodgers et al. (2003) in which divergent 'principles' are set together in diagrammatic form to illustrate a spectrum of options. This format was extended, in relation to development methods and assessment, for use in this thesis (figure 7). The divergent principles were developed in line with the literature discussed in the 'Leadership Education' section of the Critical Literature Review chapter (2.4.2).

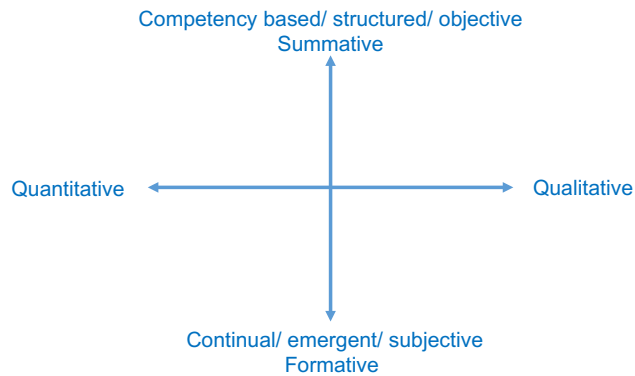


Rodgers et al., 2003.

A framework of leadership development methods:



A framework of leadership assessment:



**Figure 7.** Frameworks for leadership development, methods and assessment.

Participants were asked to discuss the issues surrounding these and to agree on the desired principles illustrated on each of the diagrams.

### Analysis of Working Group Data

A multi-method approach was taken to the analysis of working group data. Initially, descriptive narrative analysis was used throughout the transcripts to interpret discussions. This considered areas of specific content in relation to leadership as well as the nature of discussions between participants. For example, emphasis was placed on the process of joint reflection and how this helped participants interpret the scenarios. Further thematic analysis aimed to identify particular aspects and examples of leadership using the leadership 'areas' developed as part of the theoretical framework. This used the categories of 'challenges' of 'purposes', 'values', 'people' and 'practices'. 'Educational design' was also coded as a theme. The transcripts were coded using NVivo (12 Mac version) software. This analysis was used to allow illustration of leadership themes as part of the translation of the data into educational learning outcomes.

### Reflections on the Process

Participants were each individually given a written questionnaire to complete anonymously. The purpose of this was to ask participants to reflect on their experience of taking part in the working group process and this added to the research data. It was also important to allow participants to feedback to the researcher any issues or concerns in relation to the process.

This was the final stage in the inductive research process. Data from all stages of the research (both preliminary and substantive) involving semi-structured interviews, ethnographic observation study and the working groups was collated and contributed to the final outcomes and conclusions of the thesis.

### 3.9 Methodology and Methods – Closing Notes

This chapter has explained the exploratory research journey undertaken.

In summary;

- An inductive process was undertaken with a preliminary phase informing the choice of theoretical framework and the design of a substantive phase;
- An interpretive epistemology, subjectivist ontology and qualitative methodology were used throughout the research process;
- The process of reflexivity was used to aid in the understanding of *my* role in the research and its findings;
- The principles of ethical research theory were applied in practice;
- A theoretical framework based on the principles of Leadership-As-Practice-In-Context was chosen to inform the substantive phase of the research;
- The meta-theoretical methodology for theorising leadership proposed by Wilson et al., 2018, was modified for use in this thesis;
- The research was embedded within the General Dental Practice context;
- A multi-methods approach was taken, using semi-structured interviews, ethnographic observation and collaborative working groups. This allowed progressively more rich and insightful data to be revealed.

In the next chapter the findings of this research process are revealed.

## 4. Findings

### 4.1 Findings - Opening Notes

This chapter presents the empirical exploratory research findings in relation to the previously considered leadership dimensions: theory, practice, research methodology and education.

The chapter is presented in two parts:

**Part 4.2:** addresses the 'theory' and 'practice' research aims. Here semi-structured interview, ethnographic observation and collaborative working group findings are presented and analysed together according to leadership themes based on the adapted framework for theorising leadership which uses: leadership 'challenges', 'purposes', 'values', 'people' and 'practices'.

**Part 4.3:** considers the 'education' dimension and the aim to rethink leadership education in dentistry.

Enquiry in relation to the 'research methodology dimension' is inherent in the application of the approach that was explored in the Methodology and Methods chapter.

This chapter does not include a literature-based analysis in order to allow focus within the specific research settings and to embed the findings within them. The following Discussion chapter will go on to consider the findings in relation to the research aims and the broader theory, practice, research methodology and education literature.

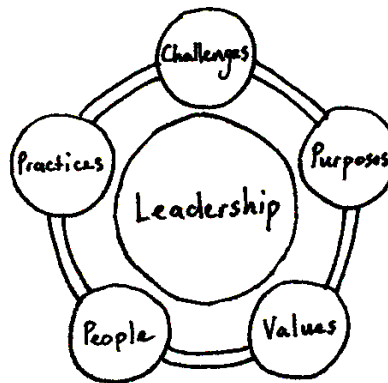
## 4.2 Exploring Leadership-As-Practice-In-Dentistry

This part of the Findings chapter specifically addresses the theory and practice aims of the thesis:

**Leadership Theory:** to construct a theoretical framework of leadership for dentistry;

**Leadership Practice:** to understand leadership from within dentistry: where, when, how and why leadership takes place.

The Critical Literature Review explained how leadership theory and practice can be integrated as a theory of practice (Leadership-As-Practice), giving emphasis to the situated, socially constructed, lived, day-to-day experience of practitioners in specific contexts. The Methodology and Methods chapter explained the development of an adapted meta-theorising framework for the construction of leadership theory in specific contexts. This considers leadership challenges, purposes, values, people and practices.



This meta-framework is used to provide a structure for thematic analysis and each area is presented separately. For each area of the framework an assimilation of relevant, thematically analysed semi-structured interview quotes, illustrative ethnographic accounts and collaborative working group findings is presented along with a concluding 'mind-map' of key findings to provide a visual summary. Inevitably there is overlap between the areas of the framework and, where appropriate, a different perspective, according to the areas of the framework is taken on specific events or instances to demonstrate the multiple interlinking aspects of leadership.

The findings are embedded within and are centred around the two main research settings; the dental practices Westby and Northby, and the first ethnographic accounts set the scene for the findings.

#### **4.2.1 First Ethnographic Accounts**

##### **Westby**

Westby is a well-established dental practice founded by its current owner and principal dentist 28 years ago. There are two surgeries (one added 8 years ago), three dentists, four nurses and a part-time receptionist.

There are two modern surgeries, one downstairs and one upstairs. The principal dentist works in the downstairs surgery and the Dental Foundation Trainee dentist works in the upstairs surgery. Downstairs there is a reception area and main waiting room (for about 8 patients). Upstairs there is another waiting area (for 2 patients), a locked patient notes storage area, a decontamination room and a bathroom.

This dental practice provides predominantly NHS dental treatment (90-95%) with some private treatments offered. The owner/ principal dentist is responsible for all aspects of the practice administration and governance including human resources as well as being a trainer to the DFT dentist.



| Character | Role                                 | Profile   |
|-----------|--------------------------------------|---|
| Colin     | Principal dentist and Practice Owner | Experienced dentist, established Westby from scratch 28 years ago.  |
| Jon       | Associate dentist                    | Works in Westby practice 1 day per week.  |
| Sally     | Dental foundation trainee dentist    | Works full time under supervision of Colin and Jon. Recently started as dental foundation trainee. The training post lasts for 1 year.                    |
| Martha    | Dental Nurse                         | Worked at Westby practice for 12 years. Started as a dental nurse on a YTS scheme at age 16. Experienced dental nurse. Works part-time.                   |
| Judy      | Dental Nurse                         | Worked at Westby practice for 8 years. Worked since age 17 and for 33 years. Works part-time.   |
| Tracy     | Receptionist                         | Worked at Westby practice for 25 years. Works part-time.  |
| Nicola    | Dental Nurse                         | Worked at Westby practice for 5 years since qualification at the local dental hospital. Works full-time.  |
| Alison    | Dental Nurse                         | Recently started working at the Westby practice as temporary cover for maternity leave. Had worked at a previous dental practice for 15 years. Full-time. |

**Table 10.** Characters from Westby Dental Practice (pseudonyms used).

This account describes *my* first arrival to the practice as part of the study.

*I had previously checked with Colin what time to arrive – 8.30am. I am early and the practice door is still closed. This brings back memories of my first day as a dentist in my vocational training practice. I had been eager to get in early and get settled before seeing my first patient.*

*Right on time, I meet one of the nurses (Martha). She recognises me immediately and seems pleased to see me again<sup>7</sup>. I am thankful for her welcome. Another nurse (Alison) I hadn't met previously has also arrived. She asks if I have an appointment. I introduce myself and say I am here to do some research – had Colin mentioned it? Martha reassures her and they get on with their preparations for surgery while Martha chats to me.*

*There is a fish tank in the corner of the waiting room on the opposite side to the reception area. It is the job of the first person in to feed the fish. Later, I think about the 'fly on the wall' thing in ethnographic work. The fish in the tank have a perfect view of what was going on in the practice. I, however, can't be hidden. I am conscious of this already. Where should I leave my things, where will I stand to take everything in? I don't want to get in the way or seem to be intruding.*

*At the reception area, policies and information for patients are on display. These aren't in any particular order but are referred to by staff during conversations with patients. All staff wear a uniform of blue clinical tops. This has been changed recently and several patients comment that they all look smart in their new uniforms.*

*Martha and Alison get on with setting up their surgeries – they will be working with the dentists all day. Alison had only recently started work here and she is covering maternity leave for a permanent nurse in the practice. She had worked in a previous practice for 15 years but felt she needed a change. When I ask why, she becomes defensive and doesn't wish to comment (I think about the trust that I will need to build-up with participants in order to allow them to tell me their views and thoughts). Meanwhile the phone is ringing. Nicola has arrived and is now on reception. Suddenly it is busy.*

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<sup>7</sup> Martha had been a participant of the preliminary, semi-structured interviews.

*Colin arrives, as he says, later than expected, then Sally. There is a lot of interaction and greetings of arrival between everyone. Colin checks what is going on, he is able to direct things easily because of the proximity of his surgery to the reception area. He is back and forth frequently between them. He is constantly active, and there are things to sort out. He says aloud what he is thinking and what he is going to do and why. "I'm just checking the patient list, I see that ..."* There are instructions to colleagues: "Can we just check that..." It is clear who is in charge and who is directing the work of the practice. Colin also frequently runs up the stairs to the upstairs surgery to check on Sally. At this point she is going over tooth eruption dates with Alison as there is a child patient coming in next.

*Everyone needs to get organised before patients arrive and there is joint help in this. Tracy arrives and takes over on reception. Sometimes Colin and Tracy will have a conversation through the door, shouting through.*

*On Mondays and Tuesdays there is always one nurse who works outside of the surgeries. They therefore do the decontamination work and help out on reception when needed. Flexibility of roles is helpful to the functioning of the surgery although many of the nurses tell me that they really didn't like being on reception. In the reception area, very much the domain of Tracy, the area is kept neatly. The others tease Tracy about how she likes to keep things in order and keep things neat. There are handwritten post-it messages on the inside of the reception desk – reminders not to forget things.*

*Going through into the surgeries, they are bright, modern and well equipped. The downstairs surgery has large patio style windows at the back which looked onto a neatly kept garden. The dental chair is positioned facing out towards it. Upstairs, in addition to the bright modern surgery there is a small seating area which I use frequently as a space to sit and write up notes or to collect my thoughts. There are times when I need to give participants some space too so I feel I need to be away from them for a time. Given the small and compact nature of the practice it is challenging not to get in the way.*

*Everyone is very welcoming, and kind and I am left to do and go where I want and encouraged to ask questions and find out as much as I need.*

## **Northby**

The Northby dental practice was established 50 years ago. The practice is large with 7 separate surgery rooms (2 located downstairs with a large waiting room and 5 located upstairs with a small waiting room). There is also a decontamination room, radiography room, staff room, practice owner office and a practice manager office.

The practice provides approximately 80% NHS treatment and a range of private dental treatment options including implants.

The practice has been part of the British Dental Association's 'Good Practice' scheme for 16 years.

The practice manager is responsible for all day to day aspects of the administration and has also assumed a role in assisting the practice owner in a number of key areas such dental foundation training administration, staff appraisals, quality assurance and business planning. The clinical nurse manager is responsible for the clinical governance of the practice including audits.

| Character | Role                                 | Profile  |
|-----------|--------------------------------------|--|
| Nat       | Principal dentist and practice owner | 14 years in dentistry, all at Northby practice, started as a vocational trainee, became owner 5 years ago.   |
| Sandra    | Practice manager                     | 42-year career (all at Northby dental practice) started as a trainee dental nurse aged 18.<br><br>Full-time practice manager.  |
| Denise    | Clinical nurse manager               | Worked in Northby practice initially, then worked for a corporate owned dental practice and returned to work at Northby practice. Full-time.<br><br>Responsible for audits, supervision of nurses and marketing. |
| Martin    | Associate dentist                    | Full time. 5 years in dentistry.<br><br>Worked in Northby practice for 2 and a half years.   |
| Natalie   | Associate dentist                    | Works part time. 3 years in dentistry.<br><br>Worked in Northby practice for 1 year.   |
| Richard   | Associate dentist                    | Full time (apart from one afternoon per week).<br><br>21 years in dentistry. Worked in Northby practice for over 15 years.   |
| Holly     | Dental foundation trainee dentist    | Works full time under supervision of Martin. Dental Foundation dentist. The training post lasts for 1 year.  |
| Resham    | Dental foundation trainee dentist    | Works full time under supervision of Nat. Dental Foundation dentist. The training post lasts for 1 year.   |
| Audrey    | Receptionist                         | Part-time. Experienced receptionist, worked in Northby practice for over 14 years.   |

**Table 11.** Characters from Northby Dental Practice (pseudonyms used).

This account describes *my* first arrival to the practice as part of the study.

*I have arranged with Sandra (the Practice Manager) to arrive at 9am. When I arrive into the practice the receptionists have their heads down working on their computers.*

*I introduce myself and instantly regret how informal I am: "I'm Jane, I'm here to see Sandra". I hear another receptionist call to a patient that "Mr.. is ready to see you now". A visitor book is brought out for me to sign and I write in my details. The receptionist phones Sandra and in a few moments, she arrives to meet me as planned. She invites me through a set of frosted doors into the downstairs clinical area. There are a lot of rooms and corridors and I get a sense of the scale of the place. We go up a stairway and into Sandra's office. She tells me about her routine and what she needs to do today: rota planning, e-mails, a phone call to an electrician, the wages (but she is waiting on Nat to get back to her about this before she can complete this), doing the accounts. She tells me that she will routinely check on how things are running throughout the practice.*

*Her office is busy with paperwork on the desk but everything is tidy and neatly arranged. She has two computer screens on her desk where, on one, she can access the patient lists for the day, and on the other she can view the live CCTV images from inside and outside of the dental practice. I ask particularly about the view of the reception area:*

*Referring to the receptionists; "I do look at this, yes. I look at the position of the chair and the contact with customers. If they are having a discussion – a good time- I will phone down and ask if they have any filing that needs doing". She points to one of the receptionists seen on the screen and, in particular, points out her seating position.*

*Sandra asks me what I want to see while I'm here. I say that I want to observe the routines of the practice and to find out what, why and how things happen. As it's my first visit, I want to explore and to meet people, and observe.*

*I know I need to start by finding my way around. I walk along the long upstairs corridor. There are multiple doors along one side of this, only the radiography room door is open. I can hear suction units and dental drills in the background so the surgeries are in action. Without the sound, it seems empty – no one is around.*

*Downstairs, I avoid the dental surgery rooms and go into the reception area. Here there are three receptionists working (one is an apprentice nurse). I am struck as to how little interaction there is between them and that they don't move from their seats. Everything is very efficient, and I feel I shouldn't try to talk to them as they seem completely absorbed in their work. The reception area is well organised. There are adverts for dental treatments – posters on the wall and leaflets for patients. The 'Friends and Family' patient feedback cards are clearly displayed. On the back wall behind the reception desk there are multiple different policies and a 'designated persons' list for the accident book, first aider, chaperones for patients, complaints etc. I notice the CCTV camera on the ceiling, in the corner of the reception area, and another in the waiting room. I realise that I can stand directly below the one in the corner of the reception area and not be seen by it. I wonder at the time whether I will also be scrutinised.*

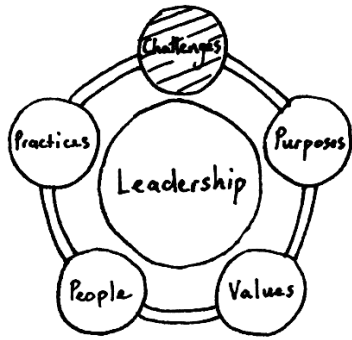
*I go through into the staff room which is on the downstairs floor. This is quite a large room with space for staff members to leave their belongings. There are multiple pairs of shoes left on a shelf (all clinical staff change into scrubs and surgery shoes). The area is also used for some storage and there is a kitchen area. There are notices on the wall urging cleanliness. Policy documents are also pinned onto a notice board. On another notice board are messages for staff and things to read – and then to sign that they have been read. There is also a message saying that messages should not be posted on the boards without prior approval from Sandra. Various people come and go into the staff room while I'm there – usually it's a dentist-nurse pair who have a short break. In other cases, people come to get things out of their bags. A nurse is currently sitting at one of the tables dispensing mouthwash tablets into plastic cups so that they are ready for the surgeries- she has been directed to do this. There is a tall stack of cups. One of the dentists comments to her: "think of the ones you've done". Sandra is around and about in the practice and when she comes down from her office she uses it as an opportunity to check things.*

*I don't see Nat until later. He is not in scrubs and is helping Denise in his office with some administrative work. He has had a meeting and then a tutorial with his dental foundation trainee. Denise is on the computer looking at the practice website. Nat's office is messy (I don't say this, but he admits it). Sandra has also told him that she thinks it's messy.*

*I realise that it's going to be difficult to get to see everyone. There is a board on a wall of the downstairs corridor that says who is in on that day and I note that there are some who I have not seen at all. It is easy to isolate yourself in this building and to keep to yourself, if you wish. One dentist as far as I am aware doesn't leave their surgery all day and a nurse tells me that they don't take a lunchbreak. I'm going to have to be pro-active in seeking out opportunities to interact with people and to find out more than what was initially on display.*

These introductory accounts of Westby and Northby set the scene. The findings which follow are presented according to the areas within the Leadership-As-Practice-In Context meta-theoretical framework in order to construct a dentistry-specific version of this. A summary illustrating this is presented at the end of this part of the chapter.





## 4.2.2 Leadership ‘Challenges’

*A recognition and acknowledgement of the specific challenges which leadership needs to address within a particular context. These might include tasks, issues, opportunities and difficulties. Identification of these allows leadership to be targeted at their resolution.*

The preliminary, interview research stage had identified ‘challenges’ as being a key theme for consideration in relation to leadership in dental practice. These are revealed in representative quotes. The ethnographic accounts, from Westby and Northby, are then used to give an insight into the everyday, ordinary, lived realities of these challenges.

In all, there was a recognition that challenges were always going to be present and that in order to be successful, adaptation to change was key:

Principal Dentist: *You have to be prepared to take on new challenges all the time.*

### **The interviews**

| Subtheme                                 | Representative Data  |
|--|--|
| 1. Scope and variation in responsibility | <p>Associate Dentist: <i>You have to be a business person as well as a clinical leader and they are completely different things.</i></p> <p>Dental Hygiene-Therapist: <i>It's a big job to look after. You literally have your thumb in every pie, but you are short of acting, this is my ship.</i></p> <p>Dental Nurse: <i>It's a different job every day and challenges that come up every day, with different patients that come in and that's what I tend to like about it.</i></p> |

|  |   |
|--|---|
| <p>2. Compliance with changing regulatory requirements</p> | <p>Practice Manager: <i>Compliance on its own is massive.</i></p> <p>Dental Nurse: <i>Keeping up to date with everything that's going on because there's so many changes that go on in certain you know like the decontamination room, you know everything moves and we've obviously got to apply to so many guidelines now.</i></p> <p>Dental Hygiene Therapist: <i>I think dentists are seeing the need for management more especially when they are under all the challenges like the CQC<sup>8</sup> and I think there is too much for the principal to handle all that and do their job. That's why you know there are people having nervous breakdowns and stuff you know it's too much pressure and I think at first, they thought they had to do it and whereas now people are changing, and managers are being brought in.</i></p> <p>Practice Manager: <i>There's been more dentists moving away from running their practices since the introduction of the CQC ...because the burden of making sure all of that's in place and that you're compliant as well as still being the director of the business as well as being the dentist is a huge ask.</i></p> |
| <p>3. Complexity of human resources</p>                    | <p>Practice Manager: <i>I think the HR side of it is more challenging than anything else.</i></p> <p>Practice Manager: <i>When you're getting the emotions of the people coming in and it's very difficult.</i></p>   |
| <p>4. Human costs in coping with challenges</p>            | <p>Practice Manager: <i>I find it hard to get rid of my stress because I do feel as though it sits very heavily on me, really heavily on me.</i></p> <p>Principal Dentist: <i>I would probably have spent sixty hours per week probably for the last twenty years working including our clinical and admin time...I mean that does include the clinical time, so the admin stuff has been burdensome.</i></p> <p>Foundation Dentist: <i>I also saw that it can be quite stressful when you, if you're just a dentist and you run a practice, you do your work, you've got the stress of work then you kind of leave and that's done but obviously when you've got the responsibility of running the practice you've got to pay people's wages and stuff, a bit more stressful.</i></p> <p>Principal Dentist: <i>It's a bit lonely really because you train to be a dentist and you don't know anything about management really.</i></p>   |

**Table 12.** Interview data in relation to leadership Challenges.

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<sup>8</sup> CQC – Care Quality Commission – a regulatory body in healthcare which inspects General Dental Practices (and all other health care providers in the UK).

### **The ethnographic accounts**

Further and deeper insight into the challenges experienced in General Dental Practice leadership is provided by ethnographic accounts from Westby and Northby.

The owners/ principals of Westby and Northby were both independently responsible for all aspects of the business and the delivery of patient care (they were not part of a corporate company). The Westby practice owner/ practice principal was individually responsible for all aspects of practice management. In Northby, this responsibility was shared between the owner/ practice principal the practice manager and the clinical nurse manager.

Firstly, in Westby:

*There are a number of issues to sort out this morning. Already, before patients arrive, there is a problem with an operating light in the upstairs surgery which is flickering. One of the autoclaves has stopped working leaving one in function. This adds pressure to the nurses in managing the turnaround of sterilised instruments. There is also an issue of having patient notes ready. The addresses of new patients have not been put on some forms and they don't know where the notes have been left. I offer to make coffee for everyone but it's ok, they can make it.*

*There is tension. The new nurse, Alison, Judy explains to me, "is a bit stressed". She has been trying to be helpful and the patient notes are upstairs, but this is not where they are usually kept. This has caused some confusion between Alison and Nicola and, although I don't witness it, there has been an exchange between them. Nicola has been in the practice for five years and has found it hard for someone new (Alison) to come in as part of the team to replace a colleague who is on maternity leave. Alison, who has only been in the practice for a few weeks is also finding it hard to adjust to a new environment, new people and new processes. Judy tries to keep things calm, especially in the waiting room area. Nicola goes straight to see Colin and tells him that she doesn't want anyone speaking to her like Alison had done and that this problem needed to be brought up at the next practice meeting. After that the surgery starts and all is calm.*

*Later, Colin deliberately goes upstairs to the surgery where Nicola is working and talks to her further. It is difficult to find separate space to talk without others being present. Sally is in the surgery as the conversation happens. I don't go with him but the conversation is recounted back to me later by Colin.*

*Downstairs, Nicola apologises to Alison and they make conversation.*

*At lunchtime, Colin reflects on the morning:*

*"It's been a successful morning really: the electrician is coming to fix the light, someone is coming to look at the autoclave and Alison and Nicola are ok and all seems fine. Sometimes you have to have a word and sort things out". "Fundamentally, there's nothing wrong. Alison is trying to impress – over trying and I said to her that she didn't need to try to impress, just do her job". "I said three things to Nicola, - I can tell you're under stress, - that's not the Nicola I know and – I'm asking you to think about it. Nicola apologised to Alison on her own will – she wasn't asked to apologise".*

*During the lunchbreak, Colin supervises Sally with a surgical extraction in the upstairs surgery. This is a planned event. It went well, and Colin explains in detail to me what approach he took to the extraction.*

*During the afternoon, Nicola reflects on events in the morning. She acknowledged to Judy that she was stressed and hadn't slept well. Colin's surgery door is kept open between appointments and he can see what's going on between everyone. Nicola and Alison are working well together.*

*Colin left early that day as planned. He commented to me: you'll have enough to fill a book by now". He is in a hurry, but he still checks the cash records, a lab prescription and confirms arrangements for Nicola's leave in a few weeks' time.*

*On leaving, he says with a smile, "well done today, Nicola."*

*She replies: "sorry for having a meltdown today."*

*Colin, in response: "no, we're all human."*

*Judy reflects to me on another occasion that the compact nature of the building means that they are working in close proximity to each other all the time.*

*“You need to be able to have disagreements and then make up quickly”.*

*Colin tells me on interview:*

*“We’re actually a support group for each other, the dentistry sort of comes second!”*

In Northby:

*I interview Nat, the practice principal/ owner and he tells me about how the practice is run. “I have two people I can trust – who have my best interests at heart”. He is referring to Sandra and Denise. They do the staff management and human resources as well as the clinical management and CQC related work. He talks about the strong team he has around him. “One person doing the leadership – no, that doesn’t exist in this practice. The practice is run by the three of us”. He talks about the confidence he has in Sandra and Denise – they all have the same way of thinking, he tells me.*

*At the end of one particular day, Sandra tells me of the challenges she has faced that day. She had written a ‘to do’ list and found that this “went out the window”.*

*Sandra tells me that she finds it hard to switch off from thinking about the practice when she gets home. She feels she mulls things over. Looking back, she tells me of a particularly challenging period of time last year when she had effectively run the practice single-handedly. It was a time of great uncertainty and what she described as a “lonely place”. The weight of responsibility had impacted on her. In the end though, at a practice meeting, Sandra had been given a round of applause by the whole practice team. Nat had said to the meeting: “it’s nice to know the practice can run without me and that I’m not needed to make it work”. These were the words told by Sandra herself and she was obviously proud in recounting them.*

*I spend time with Denise (clinical nurse manager). The responsibility of her role as the clinical nurse manager comes with challenge. She told me that she feels the weight of responsibility, "if there is any come back, it comes back to you – and you go in front of the GDC".*

*I am able to attend Denise's annual appraisal meeting held with Sandra and Nat. In this, there is discussion about how she has progressed in her role as clinical nurse manager. Denise is asked: "Overall, are you getting satisfaction and enjoyment from it?" There is acknowledgement that she is but that there are challenges. Sandra and Nat are pleased that Denise has got a number of practice policies up to date and that audits are on track. She is on "the same wavelength" in the ways they work; having things organised and attending to detail. The challenge of managing staff is also discussed and this is something that Denise would like more help with. How to deal with colleagues who don't look after things in the way they should. For example, in one surgery, she found materials that were five years out of date. This relates to an issue with one particular nurse and this issue seems to be well known about. "I feel I really do struggle to deal with it. I hate that there is an atmosphere". Nat suggests that she should stand her ground and get people involved. Sandra suggests that, sometimes, making an example of people makes others see things. Sandra goes on: "you'll never be loved by a manager. All you can do is your best. You need to learn to keep a distance and they'll respect what you are doing". Nat reassures Denise that it is he who is ultimately responsible for what happens in the practice and that she can go to him for advice: "at the end of the day, it's my neck on the line". Denise makes a sarcastic joke in reaction to this, that trying to track Nat down can be difficult. There is agreement that things are getting better in the practice and that this will help with allowing more of a focus on developing the practice: Nat says "the better the practice is run, the more we can invest".*

*Finally, Sandra offers this advice to Denise: "keep your chin up, you can never please all the people all the time and sometimes you're made to feel like the wicked witch of the west and you go home affected by it. Don't let them get you down. Sometimes you need reassurance and acknowledgement for good work. We all have our breaking point though: I'm human too".*

In examining the issues that emerge from the findings, challenges that repeat across the data are loneliness and the human effects that coping with challenges bring. Not only are dental practices in themselves isolated (they are discrete and independent organisations and each is responsible for its own success), individuals can become lonely in their experience of leadership and management responsibility. In Westby, Colin had to cope with multiple, diverse clinical, technical and human resource 'mini' challenges on a day-to-day basis. The example given recounts just one day. He has to keep many issues in his mind as the day progresses and he is individually responsible for addressing them. A Westby nurse comments:

*"He does very well. He keeps calm, he's very good really. I hate to admit it."*

Opportunities to share difficulties and to receive advice and support are scarce. Even within the dental practice organisation, there can be isolation between members of staff. In Northby, the individual surgery doors were closed for most of the day and dentists interacted infrequently. At one of the working group research sessions, one of the Northby trainee dentists commented in relation to her interaction with dental technicians:

*"They are literally just down the corridor but I'm so busy that I don't see them."*

This was described by another working group participant as being akin to being in a trench:

*"I think the way that dentistry is its very focused on output so we all get into a bit of a trench don't we and we don't actually come out of that.... because actually we are up against quite significant difficulties and targets have to be met its hard going and I know because I work in practice. At the end of the day you walk out and you are exhausted and your neck aches and your back aches."*

Another participant described it as:

*"We're all just tunnel vision into what you're doing with the patient."*

In both dental practices, human resources challenges were present. In Westby this was illustrated in the breakdown between the two dental nurses. One of the recognised human relations challenges is how people interact when they are under pressure. This was explained by a working group participant:

*"I think it's very difficult .... you've got a huge turnover of patients, it's the same with the hospital. People, if they're rushed or they're stressed or they're busy they might*

*forget their manners, they might forget how to interact with other people because they're very focused on one thing and it might be there's a problem with the patient it might be that there's a problem with the treatment, something like that that takes the mind off being kind to people because it takes time doesn't it to do that."*

In Northby, the human relations challenge related to the expectations individuals had of each other. This led to frustration in trying to achieve outcomes in relation to the ongoing management and compliance work which they were responsible for looking after. In this case, Sandra passes on advice to Denise in how to manage this.

The types of challenges encountered by both dental practices raise the issue of whether these can be constituted as being aspects of leadership, management or professional practice. In using traditional or conventional definitions of these, it may be difficult to identify the challenges identified as being involved in leadership: using a visionary, change making and influencing portrayal of leadership. Definitions of management (nuts and bolts, day to day and bureaucratic) may be more appropriate. At the same time, the challenges encountered could be considered as being part of everyday professional practice, with no need for the additional labels of leadership and management. The accounts demonstrate the interconnected nature of these aspects; that it is difficult to separate out a discussion of these.

Tensions between managerial responsibilities and clinical accountability was also found: the need to balance the needs of staff and the need to ensure the delivery of high quality patient service. This is another challenge that leadership needs to address within the dental practice context.

A summary mind-map of the key points found across the data in relation to 'Challenges' is presented (figure 12).



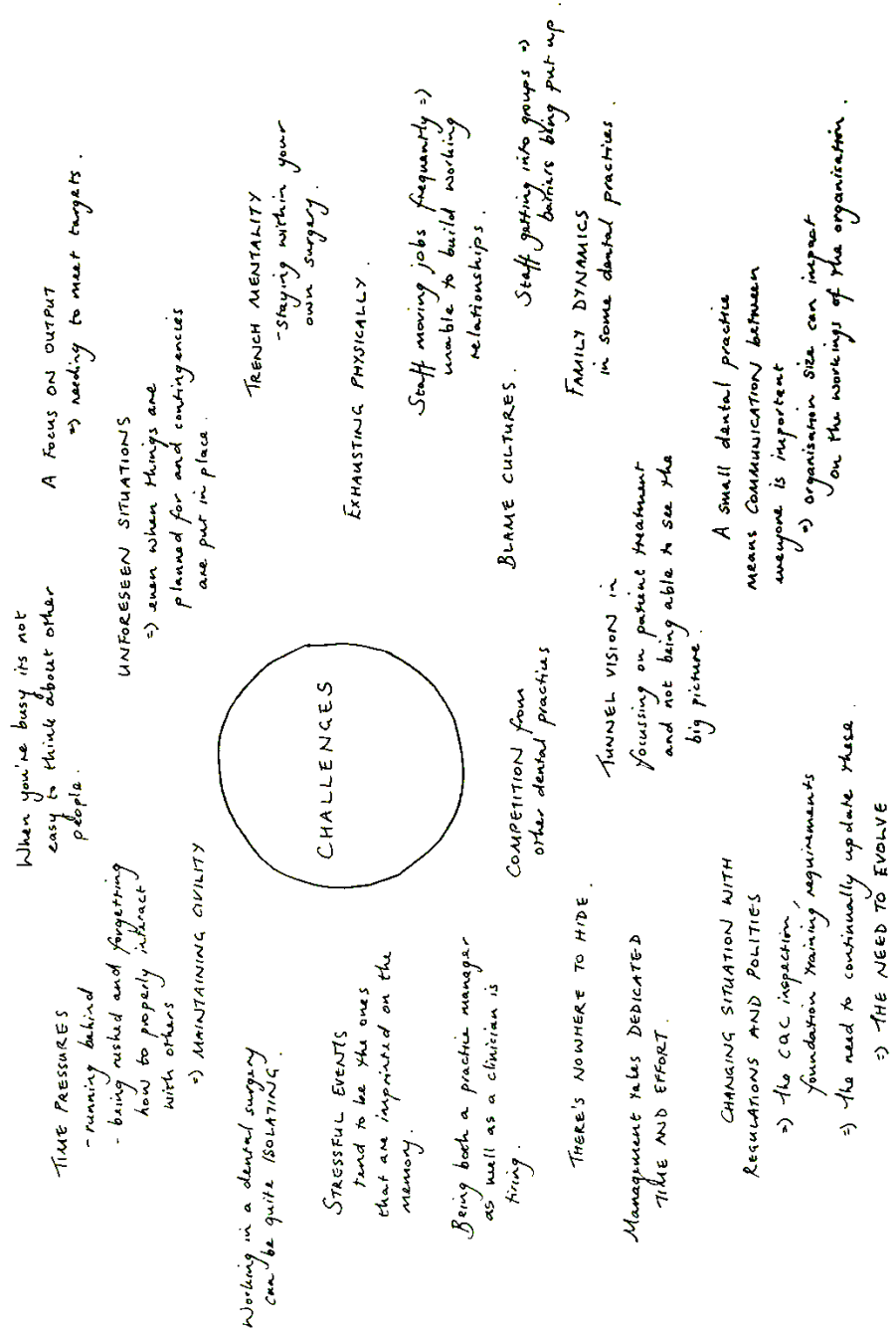
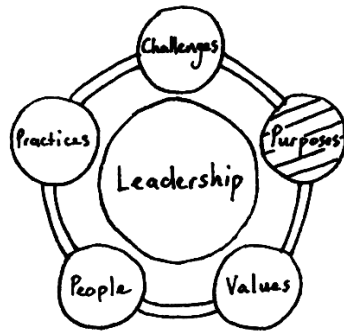


Figure 8. 'Challenges' Mind Map.



### 4.2.3 Leadership 'Purposes'

*The aims and goals within particular contexts. This asks, what does leadership need to achieve?*

In relation to the 'purposes' area of the leadership framework, the preliminary interviews revealed the importance of maintaining and enhancing patient care, meeting regulatory requirements, running a dental practice as a financially successful business and developing a dedicated team of colleagues. It is important to recognise that General Dental Practices, unlike most other healthcare settings, are effectively small businesses organisations.

Ethnographic accounts from Northby go on to give an insight into the influence of these purposes on the work of leadership within General Dental Practice.

**The interviews**

| Sub themes  | Representative data   |
|---|---|
| <p>1. Maintaining and enhancing patient care</p>                    | <p>Orthodontic Therapist: <i>I think also the clinicians sometimes forget that there's a person attached to the set of teeth and I think that's what we're quite good at and we tend to know the patients much better... whereas they don't so I see that patient won't be able to tolerate that, there are certain things we can see.</i></p> <p>Associate Dentist: <i>Where I am as an associate, I lead in my surgery, myself and my nurse lead, work very closely together and achieve much better outcomes for our patients.</i></p>   |
| <p>2. Meeting regulatory requirements</p>                           | <p>Practice Manger: <i>I'm making sure my staff are following all the guidelines and that we're doing it as per the protocols so there's a lot more tick boxes as a practice manager in the dental industry.</i></p> <p>Principal Dentist: <i>Its constantly being on top of new regulations, for example, an HTMO105 came in and we had to go through the whole document with a fine tooth comb and then develop things, processes within the practice.</i></p>  |
| <p>3. Financial success</p>   | <p>Principal Dentist: <i>If you sit still you'll just plod along, if you want to have a really successful business you've got to be constantly thinking about what are you going to be doing, how are you going to change things, what are you going to offer as a service, what are the ways that you can improve the practice so that you get more patients and you can be more cost effective and also have a nice environment to work, and how do you do it so that you come to work and you have a positive experience.</i></p> <p>Associate Dentist: <i>A major difference between it and the other aspects of healthcare where there is direct patient contact is that there are finances involved and thereby with the patient needs it's different, it's got to be more of a business.</i></p> |
| <p>4. Maintaining and developing a dedicated team of colleagues</p> | <p>Principal Dentist: <i>I think as well from leadership it's not just meaning a successful business or successful practice, are you, you are meaning how you deal with your team and how you look after everybody.</i></p>   |

**Table 13.** Interview data in relation to leadership Purposes.

### **The ethnographic accounts**

In the next ethnographic accounts the Northby dental practice story is continued. More is revealed about the issue of meeting regulatory requirements. Much of the leadership activity in Northby is driven by this aim. The goal is not just to comply but to go 'above and beyond.'

*Patients are given a medical history document to complete before they see a dentist. This is handed out on a clip board in reception. The clip board also has a copy of the practice newsletter which this time has, as a headline, the outcome of the recent inspection of the practice by the CQC (Care Quality Commission).*

*"Following a recent CQC inspection we received glowing feedback and the practice's services are described as caring, safe and well-led". The practice is keen to promote this success.*

*I am able to access the official CQC report. There is a section on leadership. This extract is from the report:*

*We found that this practice was providing well-led care in accordance with the relevant regulations. There was a clearly defined management structure in place and all staff felt supported and appreciated in their own particular roles. The practice manager was responsible for the day to day running of the practice.*

*The practice held monthly staff meetings which were minuted and gave everybody an opportunity to openly share information and discuss any concerns or issues which had not already been addressed during their daily interactions.*

*The practice undertook various audits to monitor their performance and help improve the services offered.*

*They conducted patient satisfaction surveys.*

*Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner.*

*All staff were aware of whom to raise any issue with and told us the practice manager and registered manager were approachable, would listen to their concerns and act appropriately. We were told there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.*

*Care Quality Commission Report*

*The CQC is mentioned often throughout my visits and when I ask about the reasons for doing certain things, for example, having policies in place and holding staff meetings, meeting CQC requirements is key. The CQC inspection report impacts on the reputation of the practice and the ability to promote the practice as being of high quality.*

*CQC requirements drive many of the routine actions within the practice.*

*Denise (the clinical nurse manager) spends much of her time outside of the surgeries (but will cover when needed). She works regularly in Nat's office and is often on the computer. She is responsible for clinical audits, management of decontamination activity and practice marketing. She is also partly responsible for the other nurses in relation to their clinical work. She is aware of the need to keep up-to-date with policies and the required paperwork. Policies and standards are important to her: "I'm always on the BDA (British Dental Association) website looking for updates". We talk about the in-house training that staff complete regularly. They have recently been through safeguarding policy and the management of medical emergencies. Everyone needs to sign a document held by Denise do indicate that they have completed this training. "There is no excuse for not knowing" she tells me. Denise stresses to me that the practice, as a whole, aims not only to meet the regulations but "to go above and beyond them". Denise and Sandra have produced a series of check-lists for each member of the dental team (nurses, reception, dentists, practice manager). These outline a list of questions that relate to CQC requirements and have been developed following their experience of the inspection. It is the responsibility of each member of the team to be able to answer these.*

*I ask Denise how she goes about addressing poor standards in the practice. She talks about the importance of regular checking and monitoring. She will, for example, do spot checks. She also brings up issues in staff meetings.*

*There are regular checks of the individual surgeries for stocks of equipment (checking the expiry dates) as well as the decontamination room. The apprentice nurses go to her with queries and she is able to assist them. This is done supportively. Denise holds a regular nurses meeting. I am shown an example agenda for one meeting.*

*Items on this agenda included:*

- *As previously discussed, when wiping down after patients, gloves MUST be worn*
- *When working in the decon room, full PPE needs to be worn in the dirty side, this is for your own safety. I'll be popping my head in every now and again.*
- *Expiry dates on pouches and materials must be checked weekly, found some LA cartridges in a surgery 3 years out of date!!!!!!*

*I see that emphasis is added were needed!*

In an extract of a working group session, the participants consider why the outcome of the CQC inspection is important to Northby. Denise takes part in this along with Clinical Academic Educators who provide useful facilitation and scrutiny of the discussions.

When asked why the outcome of the CQC inspection is important:

*Denise: Because it gets published in the press, doesn't it? it's available on the website for anyone to view. So, if we had a bad report from the CQC then it would affect the way patients think about us. People might decide to leave, go elsewhere.*

***CAE (Clinical Academic Educator): Just out of interest, do you know any practice in the area that didn't perform well? Is there the word on the street, as it were?***

*Denise: I don't think there is in our area. I think we're all pretty good, to be honest.*

***CAE: And you have to be, or else you wouldn't be competitive with everybody else, would you, I suppose?***

*Denise: No, because there are a few practices in the area, but there's another one that we, sort of, compete with, particularly.*

*Natalie (Associate dentist): Quite a lot!*

**CAE: Do patients ask, 'Have you got your CQC report?' Do they mention it? I mean, I know patients are more aware, now, aren't they?**

Denise: No. I've never-

**CAE: So, do you think it matters to you, personally? Do you personally take pride in how you've done as a practice?**

Yes (general agreement).

Denise: I think, because it's (the practice) been there forever, basically, it's got a good reputation.

**CAE: So, you feel more confident in just getting on with your job, because you know the basics are all sorted, and watertight?**

Natalie: Yes, and they're being monitored.

Denise: Audited.

Holly (DF dentist): Loads of policies! (Joking.)

Denise: Policies that are needed, Holly. We have to have them! We don't just make them up. (Laughter.)

Resham (DF dentist): I think it ensures that we're meeting the standards, the requirements, to ensure good patient care. Good quality of service, as well. So, you know you're at the right place, where you should be.

Denise: I want the practice to be the best that it can, and promote ourselves, and just make people aware of us, basically.

In this extract, the issues of competition and reputation are brought out. What emerges is that for Northby, awareness of their competitors and maintenance of their reputation are crucial aims and these drive their approach to leadership. There is pride in the high standards that have been achieved. The need for external recognition by complying with regulatory requirements is important to the

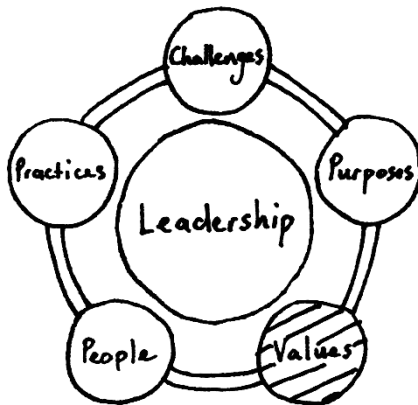
practice. This allows them to advertise and promote their work to attract new patients.

The purpose of gaining and maintaining regulatory approval was essential to both dental practices. In Northby, this was found to be a key driver for activity and was crucial to the aim of the practice as being known externally as being of high quality. A lot of time was dedicated to this aim and there was a focused determination in achieving it. It is worth reflecting on how this impacts on the work of staff and how this external validation of quality is a marker of success. It can put pressure on all those within dental practices who must balance this with the everyday delivery of dental care.

A summary mind-map of the key points found across the data in relation to 'Purposes' is presented (figure 13).







#### 4.2.4 Leadership 'Values'

*The underpinning ethical and moral dimensions within a particular context that help to guide leadership. It includes a consideration of the norms of activity: what is acceptable or not.*

The preliminary study findings recognised professionalism and setting an example for the team as values that were integral to leadership in dental practice and these are illustrated in interview quotes. The ethnographic accounts tell of the personal histories of some of the Westby and Northby participants and these give an insight into the origin of the values found within these dental practices.

**The interviews**

| Sub themes                                | Representative data  |
|---|--|
| <p>1. Professionalism</p>                 | <p>Principal Dentist: <i>I think the main issue is professionalism really, leadership by example so I think you have to be professional at all times and that extends to arriving in the morning in the right frame of attitude, the right frame of mind even if you are not at all that day wanting to work or whatever problems you have you have to have a positive approach to the day.</i></p> <p>Principal Dentist: <i>The secret is by treating people as you would like to be treat yourself.</i></p>  |
| <p>2. Setting an example for the team</p> | <p>Dental Hygiene-Therapist: <i>You need to set an example....to the other staff, predominantly the dental nurses. I would say just show a good work ethic and obviously you want a good work ethic for your other colleagues as well.</i></p> <p>Principal Dentist: <i>If we turned up late for work, we weren't turned out properly, if we acted inappropriately, all that behaviour would filter down to the rest of the staff who would do the same and the business would deteriorate as a result.</i></p> <p>Dental Nurse: <i>I mean the more experienced staff like myself I suppose have a little bit more responsibility to you know when new staff come in, to set an example so they obviously know what's expected, allowed and not allowed.</i></p> <p>Practice Manager: <i>I think that's one of the most emotional parts of the job is forever having to be an upfront person that's happy, smiley, setting a good example.</i></p> |
| <p>3. Externally imposed values</p>       | <p>Dental Hygiene-Therapist: <i>I think it makes it harder to be understanding of where they are coming from when they are telling you to do things and there is a lot of corporate... I am allowed to swear? ...bullshit (laugh) there is a lot of corporate jargon and when they first took over there was a weekly board of corporate aims and objectives of the company that we had to read and they had like little questions and quizzes to prove that we had read these mission statements so that was a whole new thing coming in and the general feeling of the practice is "for god's sake" sort of thing. I felt really patronised because it was all about how you should treat patients and how to work together and it was like telling us stuff we already knew, we were already doing.</i></p>   |

**Table 14.** Interview data in relation to leadership Values.

### **The ethnographic accounts**

In Westby and Northby, values were more implicit in everyday practice as compared with the last interview quote but a strong sense of their importance was evident. They had constructed values as guided by a legacy of past history and personal experience. The following accounts tell the stories of how these had evolved and the people involved. Personal histories of some of those involved are presented.

Colin is the principal dentist and practice owner of Westby dental practice.

*Colin and had built up Westby dental practice (in his local area) from scratch 28 years ago, initially working part-time with a one dental nurse, then quickly establishing a full-time service*

*Colin was excited by dentistry. He had seen a number of changes over his time in the profession: the adoption of cross infection control standards, developments in equipment and materials. He was proud of the developments in his skills, for example, the use of digital dentistry techniques. He embraced change and was keen to keep up to date.*

*He was critical however of the 'red tape' of dentistry. The requirements of continual evaluation against external standards (for example, the Care Quality Commission) was burdensome and this workload had significantly increased over his professional lifetime.*

*Colin described his leadership and management style as being open, honest and ethical.*

*"I feel that if you manage a situation clearly by being straightforward, by being honest and always if you like be the same, usually people will respect you for that and I feel that over the years my staff do because as you probably find out when you speak to them, I hope anyway, most of them have been with me for a very long time".*

*"I think it's really important that you, we use that old adage the team ethic, we work as a team to maintain everybody as a team".*

This account illustrates Colin's long-standing dedication to dentistry. He had built his practice through his own efforts and had a sense of what he felt was important: serving his community, excellence in skill and building a strong and caring team of colleagues around him.

Judy was one of Westby's experienced dental nurses. Her history and experiences are crucial in understanding how values are constructed.

*Judy had been a dental nurse since age 17 and had been working for 33 years. It hadn't been a planned career; it was something her mother had arranged to go onto after working in an office.*

*Over the years, she had worked in different general practices and in one practice for many years. She had grown up alongside a group of young dentists who had set up a dental practice. She was nostalgic about her memories of this dental practice; she felt the owners had got it right in the way it was run. She felt like an equal in the team and could contribute ideas and influence change, for example, extending appointment times to allow proper cross infection procedures between patients – she still remembered this many years later. The dentists had grown disillusioned with dentistry (the changes in expectations on them) and had retired early.*

*Judy had worked for the Dental Practice Board for 15 years. She very much enjoyed going out to different practices and working with the Dental Officers who were responsible for checking the quality of treatment provided by dentists in that area. The Dental Practice Board was disbanded and no longer exists and Judy was concerned about this. She saw the value in monitoring the quality of treatment given to NHS patients and saw how this had made a difference.*

I describe Judy's activities in the practice and the stories that she told me about her experiences in dentistry.

*"I don't think I'm a leader" Judy told me in an interview.*

*"Who is a leader then"? I asked.*

*Judy tells me about someone she used to work with in another dental practice:*

*“Now xx, she, I would say was the leader of the practice, she would never be called, she didn’t want the title of practice manager, but she was the key, she was the key person. Leadership is not necessarily being big, demonstrative, bossy, not that at all and she had a quiet way with her and if you ever had an issue with anybody you would quietly have a talk with xx and she had a way of, a soft way of dealing with things”.*

*Downstairs, Alison (the new dental nurse) is on reception duties. She says she is stressed by being on reception, it is a different computer system than what she is used to and is still learning.*

*Judy is aware of the difficulties reception work has for the nurses “none of them like working on reception – it’s not really what they’re trained for”. She gives Alison some reassurance and guides her with the system. It’s done without fuss and Alison seems able to continue. There is continued help on reception with patient enquiries and in sorting out appointments, sharing information about patients’ needs. On one occasion, there was an issue of having to fit in a toothache appointment. It was suggested that a new patient appointment be cancelled to allow for the toothache patient, “no, it’s not right to cancel new patients” Judy says in response. There is recognition from the team that another solution needs to be found. Here Judy acts as an arbiter of what is right. The rest of the team respect her judgement and move on to thinking about another solution straight away.*

It is important to pause at this point to highlight this part of the account as it could easily be ignored. Here, Judy reminds her colleagues of the values they hold in relation to patient care. What might be an easy solution is not right. A working group participant reflects on the need to uphold the standards of the profession:

*“The thing is, patients’ interests first so you’ve just got to think, ‘What’s the best for them? What would they want, how would they like to be treated? If that was me, how would I like it?’”*

*Another time, Alison asks Judy about what cement to use for a crown fitting. They don’t have the same type of cement that she is used to here. Advice is given, and Alison is able to go back confidently into the surgery, knowing what to use.*

*There is another query about what CPD requirements there are – what each of the nurses have to do in terms of hours and topics. Again, advice is given and there is reassurance that they are on track. There is no need to panic.*

*During an interview Judy reveals that she had experienced bullying in the past as a young dental nurse.*

*“I was bullied, when I was sixteen. I vowed that if ever I saw anything like that going on in a practice, I would stop it straight away.”*

*Because her mother had known the dentist she worked for, this was held against her by other nurses in the dental practice.*

*“I’m always thoughtful about these things happening. I was always mindful to look after young people when they started because you know it’s hard and they need help and support and you don’t need agro.”*

*Judy tells me later about the experience of the previous DFT dentist who had worked in the Westby practice. He, she told me, was shy and quiet and wanted to keep himself to himself. Judy had noticed that he wasn’t happy, he had told her that, at times, he didn’t want to come in because two of the nurses were making his life really difficult and he was upset by this. She described their approach as being like a ‘pincer movement’ on him where they controlled him and his clinical activities. Judy had advised him to be more assertive and ways to demonstrate control of situations. Over time, she told me, things had settled and when she had explained to the two nurses the issues, they had felt bad and hadn’t actually really noticed the effect they were having.*

*She explains that she often points things out to Colin and Jon – this is about emotional intelligence – when people are busy often they don’t notice issues around them. She is effectively Colin’s guide to these ‘hidden’ issues – she will point them out and also suggest how to manage them. They are both receptive to this and value it.*

In this account, Judy demonstrates a strong and personal value in supporting her colleagues. This has been forged through her own experiences in the profession.

Judy, herself, is valued by Colin and the rest of her colleagues in taking a particular interest in this area.

A working group participant reflects on this: *“if you’re valued then you are going to be a bit more passionate about what you are doing.”*

*A few weeks later, I arrive and the routine preparations in the surgery are being made before patients arrive. I offer to make the tea and coffee for everyone and they let me do this. I am conscious of the proximity of the sink when I fill up the kettle and the electrical equipment nearby... In the reception and the waiting room area everyone is gossiping about their personal lives. Nicola is getting married; there is a lot to discuss. Every day, the Times newspaper is delivered for patients to read (and Colin at lunchtimes).*

*Today, the newspaper headline reads:*

***‘Happiness is the best medicine, grumpy doctors and nurses told’.***

*I get the opportunity to read the article. It reports on a statement by Henrietta Hughes (the new whistleblowing chief for the NHS). She says that “low-level grumpiness could harm patients and contribute to a mistrustful “toxic environment.... every single person in the health service had to help make it a happier place to work and end a culture of bullying and poor care... the NHS needed more of the “trust and joy and love” hormone oxytocin... staff are urged to start living ...the NHS that they want to work in...staff should not sit back and let others try to solve the problem. It’s about every single person seeing this as their responsibility.”*





*A lone patient who was reading the newspaper in the waiting room called to Martha, Nicola and Tracy:*

*“Are you happy?” He points out the newspaper headline.*

*There is a lot of banter between them, some sarcastic comments and they jokingly wind each other up about it.*

One of the Westby nurses reflects on this during a working group session:

*“I think if you kind of work that way every day it just comes naturally. In the end I don’t think it’s a matter of you have to be taught it I think it’s the example that everybody sets.”*

For the staff of Westby, values were implicit in their everyday work. They didn’t need a set of corporate values to be put up on a notice board and for each of them to record that they have been read or to be told by an NHS chief how to behave, this can be patronising. The members of the Westby practice were enabled to act according to their own values without prompting and were self-led in this. As the practice was small, all of the staff were visible to each other, they held each other to account and supported each other. It is also interesting to reflect that Judy’s description of a previous colleague as having a quiet way with her, and a soft way of dealing with things was how Judy herself could be described. She had learned from example and experience.

In Northby, practice values had been forged in the past and were a legacy of a past dental practice principal dentist. Sandra (Practice Manager) and Nat (Principal Dentist and Practice Owner), who had ‘grown-up’ with these were trying to maintain these into the future. Again, personal histories are given as part of the account.

*Sandra had started as a dental nurse aged 18. She had initially hated dentistry and wasn't getting on well until she felt things just 'clicked' and she then thrived in it. She had started out in management by covering for the then dental practice owner for the occasional day and gradually, with the increased administrative requirements of dental practices, she took on more responsibility until eventually, she became a full-time practice manager. "In the past I've swept the pavement outside the practice and polished the brass plaque". For most of this time, she had worked for a practice owner who she had respected immensely. This practice owner had left somewhat of a legacy with many of the long-serving staff members referring to him and what he had meant to the place. Sandra had taken his values of hard work, dedication and a focus on quality to maintain the strong reputation of the dental practice within the community. There was also pride in the results of various official inspections which demonstrated external validation of the quality of the service that was provided. There was seen to be a need to constantly reinforce and instil these values in her colleagues and to maintain these high standards. Sandra had not taken any specific management training and had not seen a need to do this. What she did and her approach, she felt, worked well and this had been learned through many years of experience.*

*Sandra describes to me aspects of character or attitude that she thinks are important: "commitment, loyalty, having a bit of 'get up and go' or being 'spritely'". I wonder at the time if she is regretful that these are not as evident any more in the people around her. One of the things she emphasises is 'respect for seniors'. She tells me that "40 years ago if a senior had told you to jump, you would ask how high". She tells me about her respect for the people she has worked with in the past, especially one particular dentist who was the most recent past owner of the practice. He had embodied an ideal character and others, were in effect, compared to him. During her time working with him, the practice had achieved an 'Investors in People' award and had gained their first British Dental Association 'Good Practice' award. This had represented what might be described as the 'hay-day' of the practice where there had been joint effort*

*in achieving these important goals that had brought people together. The ethos was about going 'above and beyond' and of high standards. Sandra sees her role as maintaining these standards and to discourage complacency.*

*On one occasion, early in the morning, Sandra tells me that there is an issue with the two apprentice nurses. She has received a report from the nursing college that the two nurses are behind on their course work and their online learning accounts have been suspended. She arranges to see the two nurses together to discuss this. "I need to speak to them because I'm not happy". Sandra encourages me to sit in on this discussion. To the nurses, it is made clear that their behaviour is not what is expected and that they need to deal with it straight away – today. She checks later in the day with the nursing tutor that the requirements have been completed.*

Here, Sandra's disappointment in the two apprentice nurses reflects the values that she had grown-up with and her need to instil these in others.

Nat, the present dental practice principal / owner was also keen to espouse the values that had been instilled in him.

*Nat has spent all of his practising career in the Northby practice. He had started as a trainee dentist 14 years ago. He had stayed on after completing his vocational training and took the position of associate dentist. He then became a partner owner of the practice when one of the two owners had retired. About five years ago he had taken over as sole owner and principal dentist when the other partner had also retired. The retirement of this partner had been a significant event as he had been the main lead in the practice for many years and everyone had held him in high regard. Nat had been told by him to 'put your own stamp on things'.*

*Since then, the practice building had been developed. Nat had plans for further development of the practice building and expansion of the business.*

*I am able to interview Nat about his leadership work in Northby:*

*“Usually I just concentrate on the dentistry but now I have to be aware of the bigger picture” he tells me. He talks about his history in the Northby practice, where he has spent all of his practising career. I ask him about the influence of the previous practice owner on him in relation to his values and approach to work.*

*“The main thing is about honesty” he told me. “Being open and honest, the basics of patient care, being transparent and not cutting corners – we make sure things are done properly. We don’t play the game with UDAs<sup>9</sup> and we make sure there is a level playing field for everyone in the practice”. He talks about the value of being a family dentist providing long-term care and what brings him to work is seeing patients who he has seen many times and has been able to build-up a relationship with. The words “working hard” are used frequently as I speak to Nat. He emphasises that working hard is how the practice has become successful: “you need to be working hard day-day”. Being professional, caring and involving the team are all important values. I ask him how he brings out the best in his team. He gives the examples of leading from the front, showing them how things should be done, working hard and giving them something to progress to. Nat also talks about the importance of being a role model to others.*

*The development of his staff, he feels, has contributed to the very low turnover of staff within the practice. He works out that only two nurses have left in five years and the reason for them leaving had been personal – to move abroad with their families. No one has left the practice on “bad terms”. The retention of staff had helped the emergence of a “family style” within the practice: “it feels as though they are part of the building, part of the practice and things are maintained – people take care of things”.*

*One of the nurses tells me about a buddy system for nurse mentoring and this helps to maintain standards. “This is a tight ship” says one nurse.*

*Several nurses have been through this process with ‘generations’ of nurses having been mentored now mentoring.*

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<sup>9</sup> Unit of Dental Activity: this forms part of the NHS payment system in General Dental Practice. Dentists have contracts for a certain number of UDAs in a year and are required to meet certain targets.

In Northby, the influence of the previous practice principal and owner, who had retired about five years previously was still evident. The descriptions of this person and his work in the practice were almost heroic and mythical – he had embodied an ideal character. Both Sandra and Nat had a ‘romantic’ sense of the past when the practice had achieved various accolades. They wanted to do things right and, it is emphasised, be successful as a result. Values had been, and were still being instilled through generations of dental professionals – dentists and dental nurses within the practice.

This area of the leadership framework has given an insight into the way that values are internally constructed within the dental practice context. They can be instilled through ‘generations’ of dental professionals and can be formed through personal experience and a dedication to make things better for others. Values can also be externally ‘sourced’, through official and formal professional standards and, as one interview participant described, through a corporate business company. Whether values are explicit or implicit, they must be put into practice so that they become useful; values need to be applied and enacted. Here a disconnect can be found and this will be explored in the later ‘Practices’ area of the leadership framework.

A summary mind-map of the key points found across the data in relation to ‘Values’ is presented (figure 14).

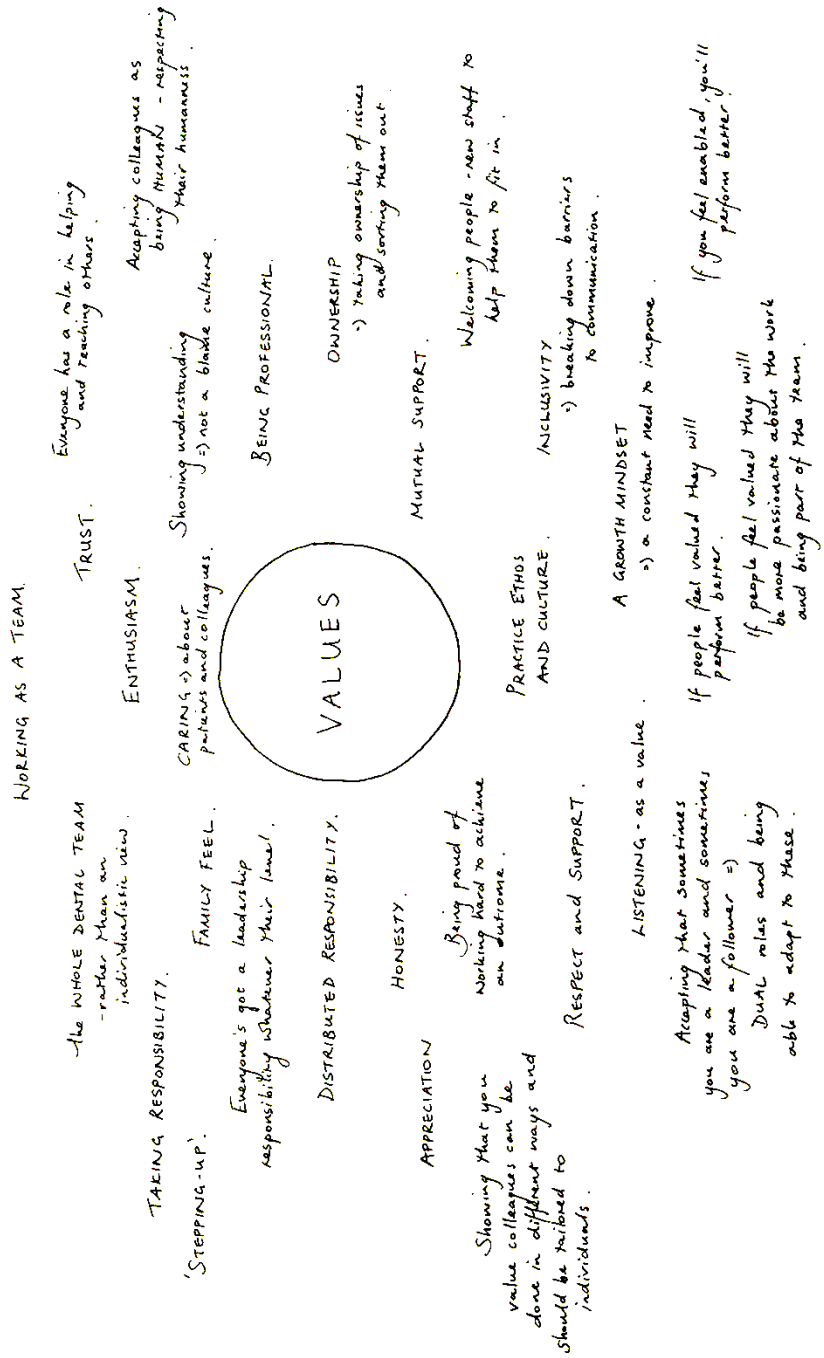
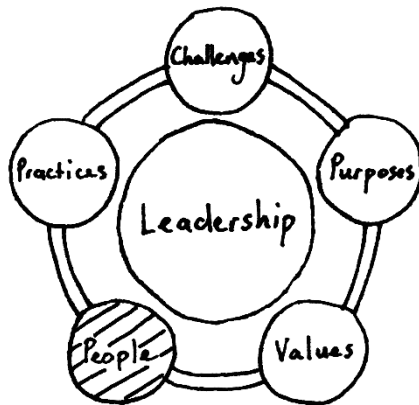


Figure 10. 'Values' Mind Map.



#### 4.2.5 Leadership 'People'

*Consideration of all those involved in leadership (practitioners) within a particular context and how they work together to achieve leadership: their rights and responsibilities, their interests and concerns, the nature of their relationships.*

The 'People' area of the framework was found to be the most rich, complex and insightful. This aspect of leadership gives attention to working lives and to how leadership is experienced. There were multiple inter-personal dynamics and issues to consider and these revealed tensions, irony and contradictions in the way that leadership was played out among those involved.

The preliminary study had revealed 'people skills' to be one of the areas that participants had identified as being key and one that needed particular focus at the substantive study stage.

**The interviews**

| Sub themes  | Representative data  |
|---|--|
| <p>1. Poor reputation for human resources leadership in dentistry</p> | <p>Orthodontic Therapist: <i>The people skills and management, yes, definitely I think these are the things that are lacking in dentistry in my experience.</i></p> <p>Dental Hygiene-Therapist: <i>People can be treated quite badly, and I joke to my friends that dentistry is the worst profession for HR and being treated correctly, whereas when you are in a big company there are rules to follow. It seems like this lawless, a lawless state of dentistry. I've heard a lot of horror stories.</i></p> <p>Orthodontic Therapist: <i>I think that happens a lot within dentistry that you always get the wife as the practice manager, you know things like that, so the leaders are not quite as professional as they should be.</i></p> <p>Dental Nurse: <i>You know staffing ...you always had one girl who was always, always off sick you know and in some ways the people who were always vigilant and always turned up are not the ones that are looked after, it's the ones who don't seem to behave as well - they are the ones that seem to win.</i></p>   |
| <p>2. How to engage the dental team</p>                               | <p>Principal Dentist: <i>You've gotta engage with your team because you want them to follow your direction but your acting as a guide really.</i></p> <p>Practice Manager: <i>I mean you've got to know staff from their 60s to right down to, I think my youngest is 18 or 17...and it's being able to gauge each one with patience.</i></p> <p>Principal Dentist: <i>I mean the word is genuine, you can't fake it, because anyone can pick up a fake, so you have got to be interested and want to nurture your staff because I mean you can have this us and them attitude where they just think oh you know he's just paying me next to nothing and he's creaming it in so you've got to get away from that attitude and make the staff feel as if you're looking after them.</i></p> <p>Associate Dentist: <i>You won't get any sort of good work out of an oppressed man.</i></p> <p>Orthodontic Therapist: <i>We have a very good management team here where it's always been quite inclusive, so we always have meetings and discuss things, it's not often when we're just told that this is how it is, we often have discussion periods and review meetings and things where we discuss the changes, not always but mostly.</i></p> |

**Table 15.** Interview data in relation to leadership People.



### **The ethnographic accounts**

The ethnographic accounts reveal contrasts in this 'People' area of the leadership framework between the two dental practices, for example; active participation and collaboration versus passive participation and compliance. These contrasts are exposed in the accounts of a formal staff meeting.

The dental practice 'official' meetings provide rich insight into the working relationships between staff members. Practice meetings are a chance for staff members to get together to discuss issues affecting the practice. Each practice holds an official meeting regularly and the CQC includes practice meetings in their inspection check lists and agenda and minutes from these practice meetings are scrutinised as part of this process. This common event in the life of the two dental practices allows a more direct comparison between them and for contrasts to become more obvious.

*In relation to context, both meetings are held at a designated time, arranged in advance within the practice waiting room. All members of staff are expected to attend and each has an agenda. In the Westby practice the meeting is held at a lunchtime. The door to the practice is locked and the phones switched off. Members of staff (6) are eating their lunch as the meeting is held and there is a relaxed atmosphere. As it is near to Christmas time, mince pies are being shared and individuals get up to make tea for each other throughout the meeting. In this practice, it is normal for staff to eat and chat together at lunchtime. They often discuss various issues together and work things out during this time.*

*In the Northby practice it is rare for all staff to meet together at one time, in fact these regular meetings are the only time everyone sees each other. One of the nurses comments to me that this was one of the most helpful aspects about the meeting – it is a chance to catch-up with colleagues. In all there are 18 staff members present and they sit in a large circle arrangement in the downstairs waiting room. The meeting is held at 2pm and an hour has been designated. This means that patient appointments are blocked for all members of staff. These meetings are written in the diaries well in advance to make this possible. During the meeting, there is no movement of staff out of their places and the atmosphere is quite formal.*

*I feel quite nervous sitting in the circle and I sense a degree of tension, as if everyone is 'on their toes'.*

*The convention in the Westby practice is that the role of meeting chair is rotated for each meeting. Last time, Judy, one of the experienced nurses had chaired the meeting. She tells me about not particularly enjoying this but she does see the point that Colin, the practice principal is trying to involve everyone. This time it is, Sally, the DF dentist's turn. This is something that Colin tells me that he thinks is important to experience as part of training in a dental practice. In effect the items on the agenda list are read out by Sally and then Colin explains or comments on the issue but does give a chance for Sally to manage the order of discussions. The agenda contains the following: 1) Review of deanery visit, 2) Sally's appointment diary and lessons for next year, 3) Waiting list – new patients, 4) CPD (continued professional development), 5) Cleaner, 6) Jane Wardman research project, 7) Christmas 2016, 8) Holidays 2017 including Christmas, 9) Christmas meal, 10) AOB. Throughout there are inputs from the nurses, and Tracy, the receptionist. For example, in a discussion relating to the waiting list, which was closed to new patients, one nurse comments that they are still accepting new complete denture patients. It is commented that in doing this, other patients are being discriminated against. This is felt to be an ethical issue and they feel uncomfortable about it. They feel able to raise this and I am conscious that the nursing team are aware of ethical issues and have strong values about fairness in patient care.*

*The Northby practice meeting is chaired by Sandra, the practice manager and the agenda is read out to the group at the beginning of the meeting. I had discussed the upcoming meeting with Sandra earlier in the morning. Nat, the practice principal was due to take the 'staff training' part of the meeting. It is their convention to split the meeting into two parts with general housekeeping issues and then a chosen staff training topic which this time is to be on whistleblowing. Sandra had prepared her part on housekeeping issues which included going through patient feedback comment cards, medical history forms and the importance of updating patient contact details as well as arrangements for the upstairs waiting room renovation. I met Sandra just before 2pm, she had just been told by Nat that he wasn't able to do the staff training part of the meeting, although he*

would be present, "there has been a slight change of plan". Sandra would have to take on the whole meeting, including the training. This was quite a big ask for her and she didn't have time to properly prepare for this but she goes ahead. Sandra very much directs the meeting and it doesn't appear that she has been given short notice of her role. Sometimes there are comments between those sitting together while Sandra is talking. Denise is given an opportunity to talk about her work and the audits she has planned. She also talks about regularly coming into surgeries to check cross infection control. The issue of proactivity is brought up. Nurses are advised that they needed to be thinking about what they were doing, rather than just repeating what they do every day. She gives everyone a "well done" and offers to help with any problems.

When it comes to the staff training, Sandra reads out some guidance (from a website) in relation to whistle-blowing that she had been given. She asks some questions – in what situations would whistle-blowing be appropriate? There is no reply from anyone in the group, so Sandra asks particular individuals to answer – this time it is one of the apprentice nurses. One of the associate dentists, is asked directly for a definition of clinical governance. Nat chips in with some comments and clarification. It is proposed by Sandra, that all members of staff have to complete a specific online CPD package on the topic of whistleblowing. A notice will be placed on the board in the staff room and each person needs to sign that they have completed the training. A deadline of a week is given. By the end of the meeting, I note that many members of staff have not said or contributed anything.

In the Westby practice, before the meeting starts, Judy, had says to me that this is going to be a difficult meeting. She seems to think that there is the potential for staff members to be upset by proposals made. Towards the end of the agenda, there is discussion about arrangements for leave, in particular, over the Christmas break – not just coming up shortly in 2016 but also looking in advance to 2017. The issue, as it becomes clearer, relates to fairness in allowing leave over Christmas. Colin approaches this by reminding the team that they have an obligation to run a service over the holiday period – as a healthcare provider this is important. There has been one member of staff who regularly has the Christmas week off and this was not possible for everyone. Things are going to need to change. "As a team,

*we always work together. I can't take a request for the booking of the entirety of Christmas off from any one member of staff". He goes on to explain the strategy he is going to take. "I want to throw it out there, I would like each member of staff to let me know if you would like leave". He would then look at the overall picture and allocate days off, trying to be fair to everyone- "I want to deal with it fairly and as amicably as possible and we can discuss it". As recorded in the meeting minutes "If the need to pull names out of a hat to allocate certain days arose then this will be the case". It is concluded that further discussion will not be held today and that staff should think about what had been said and that individual conversations would be held with everyone. It is reiterated that they have obligations to meet in terms of patient care. By the end of the discussion, all attendees have contributed or made a comment in some way. It was difficult not to be involved. There was some humour when they had confirmed arrangements for their Christmas meal. They brought up memories of previous meals they had been for as a practice team and it was clear that all of them were looking forward to the next one.*

At a working group session, there is reflection on how the Westby practice operates:

***Clinical Academic Educator (CAE): It does strike me you're very open to being flexible and taking on other people's viewpoints. Is that how you feel?***

*Judy: I think we all do. I think, we don't feel particularly, 'You haven't been there as long as me,' 'You've been there longer.' There's none of that, because we actually jest, don't we?*

*Martha: We don't have a pecking order, do we?*

*Judy: Not at all.*

*Colin: We will kick it around a bit and then we might say no or we might say we will give it a try, we will trial it to the next meeting.*

**CAE: So, let me give you a scenario. Let's say there's a problem that you've identified, and you have a chat with your other colleagues, and you're trying to sort this out. Not really to bother the boss, because he's too busy. Is that something you would do on a regular basis, or do you feel that's being disloyal to Colin, because you're discussing this amongst the group?**

*Judy: No, I think we do discuss things, and we sort things out amongst ourselves, unless it becomes a bigger issue that I think, 'Actually.'*

*Colin: No, you do. I know you do. They make me eventually aware of it, but usually when it's resolved, which is fine.*

**CAE: You have one of those, strategic places round your practice.**

*Martha: The loos.*

**CAE: So, do you then have a spokesperson, or do you take it in turns?**

*Sally: I don't think we ever escalate things that much.*

*Judy: Sometimes I'll say to Colin.*

**CAE: It is like a family though, isn't it? It sounds like a family.**

During a working group session, the Northby participants were asked to describe how they work together.

*Holly (DF dentist): We're in a really good practice.*

*Denise: It's a very organised practice.*

*Denise: Yes, and our practice manager's been there for 35, 40 years.*

**CAE: So, she drives it, then, does she, really?**

*Holly: Yes, 100%.*

*Denise: I think she's got a bit of a back-seat role, but if a nurse is stood talking, and she walks past, you stop and carry on with-, you're sort of at the old Headteacher kind of-*

**CAE: So, like a Matron, almost?**

*Denise: Basically, yes. But I've worked in other practices, and she might not be the best people person. But her skills as a Practice Manager are far better than anyone I've ever worked under.*

*Natalie: I think she does it right.*

*Denise: That's the thing. She sees it as her practice, I think.*

These next extracts give an opportunity for reflexive thought.

*Sandra and I discuss the challenges involved in managing staff and maintaining these high standards. She describes to me a balance she tries to achieve between being supportive whilst keeping distance from others and being assertive.*

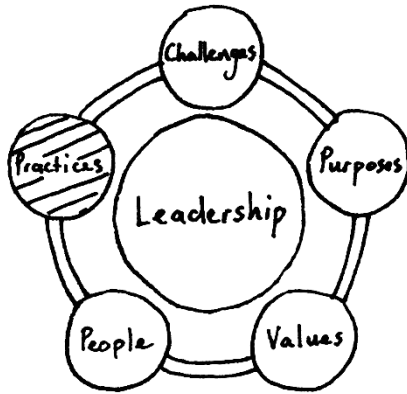
*At the end of the day on one of my visits, I have a discussion with Sandra. She asks me for feedback on how I think things are run. Rather than answering directly, I talk about different approaches to leadership and management. I mention approaches which give responsibility to others in decision making. Sandra is quick to respond to this: "this doesn't work". She tells me she has tried this before without success. She uses the words "tightening" and "sharpening" to explain what she is trying to do in addressing these issues.*

These extracts from my ethnographic accounts and the working group sessions tell of the contrasting experience of leadership in the two dental practices: those involved, their responsibilities, interests and concerns and the nature of relationships.

A summary mind-map of the key points found across the data in relation to 'People' is presented (figure 15).







#### 4.2.6 Leadership 'Practices'

*The actions/ activities which bring about leadership within a particular context. This includes routines and patterns of activity. It considers what people actually do, where this happens and how.*

In this area, there is considerable potential for overlap with the four areas already considered. Practices are the means by which purposes and values are brought about, how challenges are dealt with and people are needed to enact them. The aim is to be specific in relation to 'practices' as discrete matters for identification and discussion.

**The interviews**

| Sub themes                            | Representative data   |
|---------------------------------------|---|
| <p>1. Communication as a practice</p> | <p>Principal Dentist: <i>Communication that's really important, you have to be able to talk to people, you have to be able to speak to people when they've done things wrong, you have to know how to do that in the correct way and you know you have to understand how people perceive you.</i></p> <p>Practice Manager: <i>Definitely patience, definitely listening skills.</i></p>   |
| <p>2. Where leadership happens</p>    | <p>Orthodontic Therapist: <i>I try to maintain consistency, so they always know where they are and I try and just given them plenty of warning about what I want to do and just guide them sort of how I expect them to go, yes I think on a low level there is some leadership in my job.</i></p> <p>Dental Nurse: <i>It's surprising actually, I never really classed my role as having any managerial role really but actually when you think about it you do manage certain things everyday really, so I think that's a challenge just like with the diaries and just making sure everybody's complying really together as a team.</i></p>  |
| <p>3. 'Putting on a show'</p>         | <p>Practice Manager: <i>You have to put on an act and be strong for the rest of the team.</i></p> <p>Principal Dentist: <i>Well the first thing is 'show time' when you walk in the door you are positive, you smile, you remember everybody's name, you try to talk to all the staff.</i></p> <p>Orthodontic Therapist: <i>I just need to learn to stay calm [laugh] which I'm not very good at [laugh], I'm getting better, I'm a lot better now, but you just have to learn to deal with these situations a bit better.</i></p>  |
| <p>4. Involving the team</p>          | <p>Dental Nurse: <i>You've got to give guidance to your team or staff and there's leadership in all kinds of roles, be diplomatic, there's all sorts of things really.</i></p> <p>Dental Nurse: <i>He's willing to give people the flexibility to work in their own way as long as it's pulling in the same direction.</i></p> <p>Principal Dentist: <i>We have a staff meeting before the clinic starts, we have something called a huddle, ten minutes where issues of the day are discussed and in a way you know what's said is irrelevant the main thing is that everybody is in there together so that everybody sees everybody else because otherwise you know you can just be stuck away, you could be stuck in your surgery and never see anybody so you know who is in and then you see the other people and then you can engage with them a little bit, that creates a good feeling.</i></p> |

|                                 |  |
|---------------------------------|--|
| <p>5. In relation to others</p> | <p>Dental Nurse: <i>We're all you know pretty friendly and we all have a little bit of friendly banter when it's appropriate and occasionally we go and have a meal together, so we socialise, so I think that's probably the best way to keep morale up.</i></p> <p>Practice Manager: <i>I think you just generally need to be a quite caring person, with a good outlook.</i></p> <p>Principal Dentist: <i>Trying not to put people down but guiding them.</i></p> <p>DF1 Dentist: <i>He's got an open relationship if anyone wants to talk to him about anything obviously they've got that opportunity, he's never, oh no I can't talk about that now, he'll always make time.</i></p> |
| <p>6. Working well</p>          | <p>Practice Manager: <i>You want it to run smoothly as you can for patients and staff and it is just learning to look at what triggers a problem.</i></p> <p>Principal Dentist: <i>Sort of taking control a little bit, not being controlling but taking control of a situation that's going pear shaped in anything you do and being able to be nice when everyone else is being cross or sorting out an argument and getting everybody to calm down.</i></p>   |

**Table 16.** Interview data in relation to leadership Practices.

### **The ethnographic accounts**

In looking at how practices are incorporated everyday work, this next ethnographic account describes the activities in Westby on a routine Monday morning between 8.45 and 10.30am. In the collaborative working group session, this scenario was used specifically for discussion and was titled: 'Just another manic Monday' (Appendix A). Here it is used to illustrate the practices that bring about leadership within the dental practice context.

*The phone in the reception area is ringing. This can be heard all over the practice. Patients are phoning up asking for emergency appointments – it is Monday morning and this is a routine challenge.*

*Patients are also arriving into the waiting room needing attention from reception. A patient arrives for a booked appointment, but they are not found on the computer booking system. This means there is an overbooking with the DFT dentist.*

*The phone keeps ringing.*

*Nicola is on reception initially, she needs to manage multiple things at once. She speaks with patients on the phone to ask triage questions. She then steps into Colin's surgery to tell him what is going on – the door is already open so there is no need to knock or to ask permission to go in. She tells Colin about the patients in pain and the overbooking. She speaks quickly (one of the patients comments on this) and the information is passed on clearly, and succinctly. Colin listens and repeats back what he has heard. He can see the overbooked patient for the DFT dentist. Nicola and Colin agree this will be arranged.*

*Meanwhile Tracy, the receptionist arrives. She starts at 9am. She needs to get up to speed quickly on what is happening. It is the first time I have met Tracy. We don't get a chance to say a proper hello as it's too busy and I know I need to stay out of her way. She takes over from Nicola and they both work together managing the patients who are arriving and those who are on the phone.*

*There are 'toothache' slots held open in Colin's diary. Decisions have to be made about which patients to fit in and whether more patients can also be fitted in- they need to prioritise patients. There is communication between them all – a recap of the information is given so that everyone understands. Tracy knows that she needs Colin to tell her how long certain pain*

*appointments are likely to take, and which patients are the priority for today. There is honesty by Colin about what can be achieved, and he is realistic. They don't want to over promise. They need to come up with solutions and they jointly discuss options. Decisions are made and confirmation is sought as to whether these are right: "is that fair, do you agree?"*

*Colin runs upstairs to check on Sally before he starts with his own patients. Back downstairs Colin takes in the first patient and his surgery door closes. Reception still have queries however and Tracy goes straight through into the surgery and asks a specific question – this is not a problem for Colin and it happens throughout the day. A clear, brief answer is given and she comes back to reception. In between patients, Colin keeps the door open. Tracy and Colin converse through from reception into the surgery – they are not quite shouting but they can speak to each other through the door whilst they are both busy doing something. Tracy will have the phone held to her neck as she taps on the computer whilst calling through to Colin next door – they are still sorting out appointments for this morning. Nicola takes the role of greeting patients (by name) who are arriving and informs them about how long they are likely to wait. Everyone is busy.*

*At one point,*

*Tracy asks Nicola- "have you lost something?"*

*"Just my mind" is the response.*

*There is an assessment of how they are doing with the time and patient appointments. They are running behind but Colin is calm and reassures the team. There is no sense of panic, they get on with what they need to do. Colin calls through a patient into his surgery but according to Tracy there is another patient who should have been called first. There are some mutterings, but they acknowledge it has been a difficult morning and they apologise to the patient – they reassure the rest of the patients and there is no problem – they can see Colin is busy.*

*Sally comes down to reception with her patients throughout the morning.*

*She tells me that Colin has encouraged her to do this so that she can interact with Tracy and help to confirm arrangements. This is useful as she is able to answer any queries easily and it adds to the care and attention her patients receive.*

*There is therefore a lot of movement of the team throughout the practice, throughout the day. It is unusual for any one of them to be in the same*

*place for a long time. Even Colin is constantly out of his surgery in reception or upstairs helping Sally.*

*At about 10am everything starts to calm down. The patient appointments are now steady, and they are back to running on time. The phone calls stop for a while and they know which patients are coming in for emergency appointments.*

*There is a chance to take a deep breath. I feel that too as I have been trying to take note of all of the activity. There is a lot to take in.*

*The kettle is put on. This is a collective event and the coffee break is an opportunity to reflect together as a team. There is joint acknowledgement of the intensity and stress of the beginning of the day and relief that it is now sorted out. There are some sarcastic comments: "sense and this place don't go together". Colin joins in and I can see that he is relieved. He says to me "it's all done with a smile". They ask whether they made the right decisions – they reassure themselves that they did what they could. Onto the next thing...*

Here, the Westby participants of the working group, alongside the Clinical Academic Educators discuss this ethnographic account scenario.

***Clinical Academic Educator (CAE): It seems like every Monday's-***

*Martha (Dental nurse): We love Mondays!*

*Colin: Mondays in 'Westby', you know!*

*Colin: Can anybody remember what had happened? Something most unusual had happened that morning, that caused us to have-, I don't know whether it was a family, or two new patients who arrived? Can you remember?*

*Martha: I remember. It was two new patients, and they hadn't been put in the diary, had they?*

*Nicola (Westby dental nurse): Oh, I remember, yes.*

*Martha: They hadn't been put in the diary, but they were brand new patients to the surgery.*

*Colin: So, there were two new patients, to see Sally, which of course-,*

*Nicola: Threw us out.*

**CAE: So, it could have gone badly wrong, this day, couldn't it?**

*Colin: We had a number of options, and one of the options, we could have probably apologised to the new patients and sent them on their way. But that wouldn't have seemed very welcoming for a new patient.*

*Martha: It's not a good first impression, is it, really? Let's face it.*

**CAE: It seems, reading it, it seems as much about team working and communication. And the way that you must have seemed like a family that these patients were coming into, and you were all working together.**

**CAE: That had this positive effect on the day, really.**

*Nicola: I think it's important, as well, because we're a small practice, not to stress, let patients know that you're stressed, and just get on with it.*

**CAE: Because not one person took leadership of this. Everybody, sort of, knew that they were able to do that, and that's important, I think, to learn from. It isn't just one person that leads, that everybody's got a leadership responsibility. And that's what it sounds like, reading this, is what happened. Everybody stepped up, didn't they?**

*Nicola: We all do it together.*

*Colin: Well, we had a brief discussion, and the decision we reached was that we felt that I could see the new patients, if they were prepared to just give us a little bit of time. Not a lot of time, but just a little bit of time, I could*

*see the new patients and triage them, really, rather than do a comprehensive, you know, full charting.*

**CAE: *Why was that important?***

**CAE: *Well, the success will matter to the patient.***

**CAE: *But it will also matter for the staff, because you stepped up to the mark. You know, you did what you could on the day, and because it was positive, that'll enable you. Again, if a similar situation happens, it'll make you feel, 'I can do this. I'm able to make certain decisions. I know what I'm doing, I know what my role is,' and lead your area, then.***

*Colin: Well, I would say that every single member in the practice that day did their own little bit, did their job, with a smile on their face, calmly, to achieve that within an hour and fifteen minutes, everybody had been seen. Everybody had had done what they were booked in to do, and everybody left satisfied, and strong communication. But because we're a small building, we've got to have good communication.*

*Nicola: As the morning went on, we were a little bit, like, 'running behind, like, what are we going to do?' But we all just stayed calm. I think the most important thing is just not to let patients know that you're stressed. It's not a good look.*

**CAE: *But sometimes, something like that brings the team really close together, you've got a feel for what each other are going through, and that's really nice.***

Reflection on this scenario by the Westby dental practice staff is aided by the comments of the clinical academic educators. Collective leadership is recognised to have occurred. It is also recognised that the importance of their actions is not just about the effect on their patients, it also affects their own behaviour as a staff group; it has an enabling effect and brings the team closer together.



In looking back across the ethnographic accounts, contrasts can be found in relation to 'practices' between Westby and Northby and these are illustrated in the following precis descriptions:

In **Westby**, the approach to leadership was participative and collaborative. The activities of leadership were shared (though not intentionally distributed) between the practice principal/ owner and rest of the staff group. The practice principal/ owner took a very hands-on approach. There was continuous relational interaction between them throughout the course of the day. The compact nature of the Practice building layout and their movement within it helped to facilitate this. There was active engagement of staff in providing patient-centred care and in supporting staff well-being. Both aspects were seen to be of equitable value. These values were implicitly understood, and people were self-motivated to uphold and enact these. Leadership was emergent. Nurses felt able to hold the practice principal/ owner to account, using ethical principles to inform their arguments. They therefore demonstrated autonomous action and independent, conscious thought. The practices of reflexivity and joint reflection were important to the work of the group; this particularly benefitted the practice principle/ owner. This was done unconsciously and a key opportunity for this to take place was the coffee break: a collective event. Much of the activity within the practice took place 'on the hoof' and the team demonstrated in-situ, practical-coping. Experience had established this coping capacity and there was an assurance in this ability, despite the multiple mini-challenges which were faced on a day-day basis. They faced these challenges together as a Practice team. There was a willingness to be adaptable and to try different approaches. Overall, there was a fundamentally hopeful and optimistic attitude.

In **Northby**, the approach to leadership was compliance driven. The practice principal/ owner took a hands-off approach. Staff members were dependent on the practice manager to prompt and to guide them in their activity. There was a concentration of leadership activity in this one individual. She took on day-day responsibility and was key to the efficient and organised way that the practice ran. She had learned her work through experience. There was seen to be a need to keep staff 'on their toes' to prevent a deterioration in standards and her routine 'walk-about' were a way for her to do this. The large size of the building layout was not helpful in encouraging interaction or collective activity. Communication was transactional. External validation of quality was an important marker of

success and was used to promote the practice. Leadership activity was driven by the desire to uphold standards and to continue a legacy of the past.

A summary mind-map of the key points found across the data in relation to 'Practices' is presented (figure 16).



#### 4.2.7 Findings Summary

The accounts of Westby and Northby give an insight into leadership as it is found in the dental practice context; where, when, how and why this happens. The meta theorising framework provides a structure by which to consider these aspects and reveals the leadership needs in everyday, frontline dentistry, and allows the construction of a theoretical framework specifically for dentistry (figure 17).

The accounts reveal that leadership is shaped by the culture found within the dental practice organisation which, in the case of Westby and Northby, had been established over many years. Similarities and contrasts were found between them. Both faced the same broad challenges, espoused similar values and were driven by common purposes, however, there were differences in the 'people' and 'practices' areas of the framework and these are reflective of culture.

The 'People' area of the framework, in particular, revealed much about the complexity of human relationships and how people work together (or not) to achieve leadership and this theme was also found to be embedded throughout the other areas of the framework. The findings demonstrate how the 'People' aspect of leadership is one which reveals difficulties, tensions and ambiguities.

In all, the accounts reveal that leadership is deeply embedded in the nitty-gritty, mundane occurrences of everyday working life. A working group participant reflected on leadership in dentistry and where it is found:

*"I think often, people think of leadership in terms of political. Especially in Dentistry, they think of people who are willing to lead, LDCs, or BDAs<sup>10</sup>, when you have to be seen. And actually, that's not what most of it's about, is it, really?"*

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<sup>10</sup> LDC- Local Dental Committee, BDA – British Dental Association

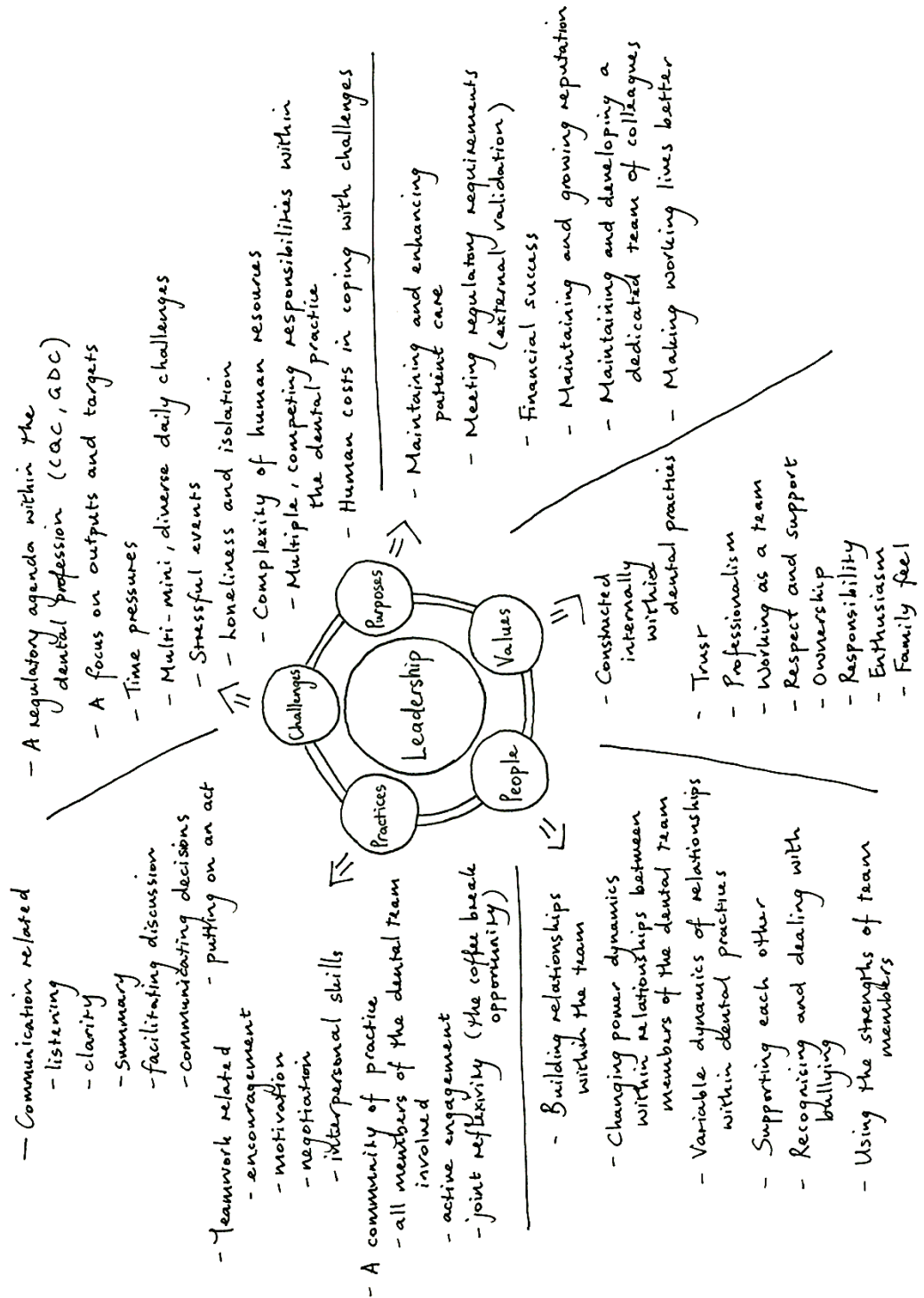


Figure 13. Summary of constructed theoretical framework for Dentistry (examples for each area of the framework).

### 4.3 Exploring Leadership Education for Dentistry

This part of the Findings chapter focuses specifically on the education dimension of leadership as set out previously. Findings are presented in relation to the following research aim:

**Leadership Education:** to explore the needs of leadership education for dentistry, specifically in relation to what leadership development outcomes and approaches are relevant to dentistry.

This chapter combines findings from the preliminary stage semi-structured interviews and the substantive stage collaborative working groups. As highlighted in the Methodology and Methods chapter (3.7), the working groups involved collaborative discussions between Westby and Northby dental practice research participants and clinical academic educators. In working together, they were able to bring different practice and academic based perspectives to discussions and to combine insights and experience. They additionally served to translate the findings of the ethnographic accounts into leadership development needs for the profession.

The findings are presented thematically, having been analysed through a series of six category order levels (table 17). Frameworks which illustrate chosen educational approaches are also presented along with a final 'mind-map' summary of key findings in relation to this educational dimension.

| Theme                                  | Category   | Representative Data  |
|--|--|--|
| 1. The Value of Leadership Development | 1.1 The needs of a modern profession                   | <i>It's at multi-levels, leadership, and it goes in both directions. It's a skillset across the dental profession.</i>   |
|  | 1.2 Can leadership be taught?                          | <i>I think some if it's natural, I would imagine. I don't think you could teach it. You could prepare for it, and maybe give them an insight and guide them.</i>   |
| 2. Educational Philosophy              | 2.1 Knowledge and experience                           | <i>You know, you're not sitting down having a lecture, saying, 'well, this is what you should do'. It's growing.</i>   |
|  | 2.2 Prescribed or emergent learning                    | <i>It's not just a tick box thing, you are actually getting value out of it.</i>   |
| 3. Educational Outcomes                | 3.1 Awareness  | <i>You know the ones who will always think they're doing a really good job, and actually, won't get on with anyone in the practice. And they will have a career like that, and they probably won't even notice.</i>  |
|  | 3.2 Empowerment and engagement                         | <i>Everybody's got a role in leadership.</i>   |
|  | 3.3 Ownership and influence                            | <i>Start and take ownership of your surgery, your equipment, your patients everything you do, and you know then that's starting that process of leadership and management and then of course they are encouraged.</i>  |
|  | 3.4 Communication and relationships                    | <i>I think people management is a good thing to have.</i>  |
|  | 3.5 Teamwork   | <i>I think a student should leave appreciating the value that everybody brings.</i>  |
| 4. Educational Methods                 | 4.1 The value of clinically-based (practice) education | <i>Somehow, we have to bring that environment into the education arena. Because it's such a rich environment that it's so difficult to replicate.</i>  |
|  | 4.2 The value of outreach-based experience             | <i>I think the more you can make it real. I mean, that's the thing that the kids like about Outreach, because it's more like the real thing.</i>   |
|  | 4.3 Community of learning                              | <i>I think it's important to have them (nurses) involved. So, when you're nursing, you're actually involved. I remember standing in a corner, watching, when you don't know what's going on.</i>   |
|  | 4.4 Scenario-based learning                            | <i>I think the use of these sorts of scenarios in education would be great because that's showing a real-life situation. And as we've had to think about it this evening, it would be good for undergraduates to think about it.</i>   |
|  | 4.5 Experiential and continued learning                | <i>You grow as you go through, and you begin to do different stuff through dental school. And suddenly, you're taking on a little bit more of a leadership role.</i>   |
| 5. Assessment                          | 5.1 Can leadership be assessed?                        | <i>That's why it's hard to assess and teach, because it's not a black and white thing.</i>   |
|  | 5.2 Assessment methods                                 | <i>Reflective logs and a written reflective log are a good way of reading if someone has actually taken any learning from a process.</i>   |
| 6. Educational Challenges              | 6.1 Overloaded curriculum                              | <i>Pressure of time on the learning of everybody because everybody's timetables are fairly tight, they struggle for clinical sessions and all the rest of it, you certainly don't want to lose clinical time.</i>  |
|  | 6.2 Planning and logistics                             | <i>It's the logistics of having the greater numbers from our educational delivery point of view, we are taking the whole team of one hundred odd people into the lecture theatre, so it actually won't embed as much perhaps if you were delivering it in a different way.</i> |

**Table 17.** Exploring leadership education for dentistry data structure.

### 4.3.1 The Value of Leadership Development

Leadership education is recognised by the research participants as being valuable in preparing students to become successful in contemporary dental practice.

*In my general experience I think that there is very little training given to dentists about leadership and management and I think that would be a good thing, without a doubt. (Orthodontic Therapist)*

This recognition comes from past experience of inadequacies in the profession such as the poor relationship between dentists and nurses and the lack of empowerment of some members of the dental team. There is seen to be a need to change this and to encourage a different approach to leadership within dental teams.

#### 1.1 The needs of a modern profession

The dental profession is evolving and what it chooses to value and the interaction between its members is changing. There is a perceived need to move away from the approaches of the past. An experienced Dental Nurse talked about her experiences at the beginning of her career:

*When we started dental nursing that's what it was, a hierarchy; the dentist didn't have a relationship with you, we didn't have conversations while we were working.*

Now there is a recognition that things are different; the traditional hierarchical leadership approach is changing towards more collective and distributed approaches and the involvement of all members of the dental team. A Principal Dentist commented:

*It's at multi-levels, leadership, and it goes in both directions. It's a skillset across the dental profession.*

Leadership development is therefore relevant for the whole dental team and at all levels. However more sceptical views in relation for the need for leadership development were expressed among some in the younger generation of dentists. They were concerned of a loss of educational focus on building basic clinical skills:



*I would much prefer that they sent me out as a technically competent dentist than necessarily one who can lead a team and not do any dentistry because I think you can learn those skills on the job.*

For those who have gone through the experience of learning leadership on the job, there is reflection that leadership skills are useful from the beginning:

*I suppose with all these things you wish you had done these things sooner, you wish you had developed these things earlier in your career.*

*(Experienced Principal Dentist)*

### 1.2 Can leadership be taught?

Two solutions are suggested in relation to this question: selection of students who already have leadership type skills and the teaching of leadership within the curriculum.

*They do say don't they that great leaders are born not made, they do say that, that's a common quote. I think even if, there are some people who are naturally, they've got naturally a force of personality which means they can put their point across and at the same time they are naturally psychologically gifted enough to be able to do it just the right way and they have the happy knack of getting different people to agree with what they wanna do, other people have to learn to do it that way and I don't think there is anybody who couldn't be taught. (Associate Dentist)*

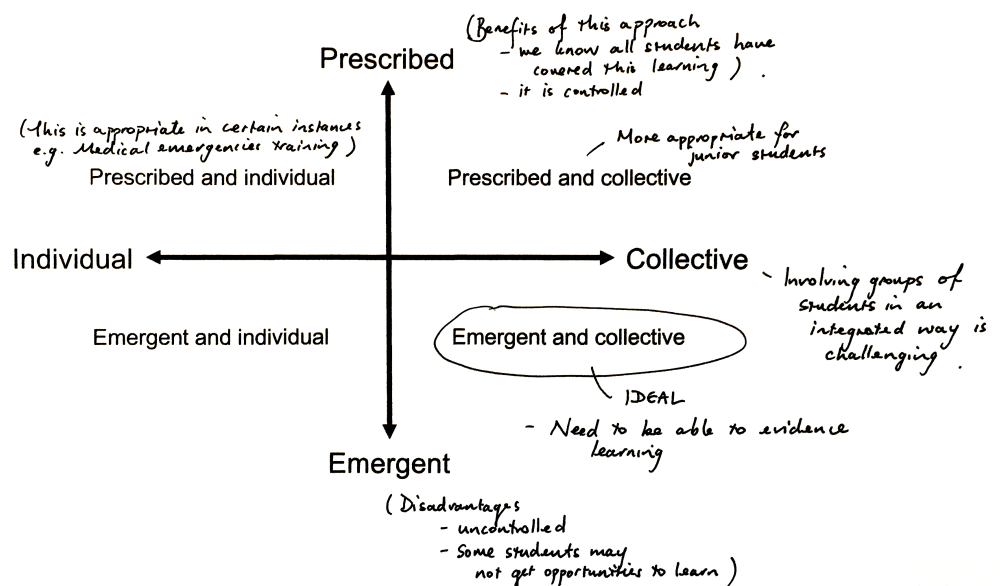
The key issues are whether some individuals are born with natural, innate ability and that they should be selected and nurtured as leaders, or that everyone has potential to develop leadership ability and if given the right guidance and encouragement can become successful leaders. The above view is that leadership can be taught. There is doubt however:

*I think some if it's natural, I would imagine. I don't think you could teach it. You could prepare for it, and maybe give them an insight and guide them. (Dental Nurse)*

Here the issue of what it means to 'be taught' is brought out and this leads on to thinking about educational philosophy and questions as to how to approach leadership development.

### 4.3.2 Educational Philosophy

Fundamental questions as to the approaches to leadership development were considered.



**Figure 14.** A framework for leadership development and chosen approaches.

This illustrated framework diagram (figure 18) shows that 'emergent' and 'collective' approaches were favoured and thought to be ideal. It was recognised however that there were very real challenges involved in managing this type of development approach. Engaging students in collective learning was felt to be difficult but this could be best encouraged within the 'practice' environment where students were already engaged in joint learning activity. Emergent learning opportunities were also more likely to be found in the practice environment. A strong disadvantage of emergent approaches was their uncontrollable nature. The provision of equitable learning could not be assured. Being able to record and to evidence collective and emergent learning was felt to be problematic, especially in relation to regulatory educational requirements.

It was recognised that some types of learning may be appropriate at different stages of student development and for specific learning events. For example, prescribed and collective learning opportunities may be suitable for junior students so that whilst they learn with others, their learning outcomes are controlled. An example of medical emergencies training where individual leadership skills need to be demonstrated was thought to be an example of where prescribed and individual approaches were appropriate.

### 2.1 Knowledge and Experience

The distinction between knowledge-based learning and experience-based learning was recognised. Learning leadership through experience was felt to be more effective. Adding more to an already overwhelmed knowledge base was not appropriate and learning in the real practice setting was key.

*You know, you're not sitting down having a lecture, saying, 'well, this is what you should do. It's growing. (Dental Nurse)*

*Being stuffed with knowledge, absolutely bursting with information. (Clinical Academic Educator- CAE)*

*Just in terms of watching and observing you actually learn as much, instead of being told things. You just pick up like how computers run, and people interact. (DF Dentist)*

*I think some things you can only learn once you're actually in a practice environment. (DF Dentist)*

### 2.2 Prescribed or Emergent Learning

There is recognition that learning leadership goes beyond a pre-prescribed set of learning outcomes. The competency approach is what is being referred to as a 'tick box'. Leadership learning does not stop once a tick in a box has been achieved. There needs to be scope for emergent learning.

*It's not just a tick box thing, you are actually getting value out of it. (CAE)*

*You can't have learning objectives for the whole of your f...g life. Trying to structure it with endless tick boxes would probably be burdensome.*

*(Associate Dentist)*

#### **4.3.3 Educational Outcomes**

Identifying specific leadership development outcomes was challenging and this reflects the difficulties in agreeing a definition of leadership and perceptions about the scope of leadership. In relation to this, one of the clinical academic educators commented:

*If you read the GDC learning outcomes, under Leadership and Management, some of those outcomes, without that title, you wouldn't think were leadership.*

Research participants recognise that even the regulator's (the General Dental Council) learning outcomes are not necessarily exclusive to leadership. There is significant cross-over between different learning outcome domains; communication skills and teamwork. Another educator recognises that:

*Lots of the skills we need for leadership are the same as the skills that we generally need to practice dentistry. Concepts like consent – they then translate to leadership. Those aspects of coming up with a plan. Is that another demonstration of leadership in action?*

#### **3.1 Awareness**

Concern was expressed that some students go out into practice with little awareness of how they performing or how they are perceived by others.

*You look across the profile of students, you just know the ones who are going to go out into practice and fly. And you know the ones who will always think they are doing a really good job, and actually, probably, won't get on with everybody in the practice. And they will have a career like that, and they probably won't even notice. (CAE)*

A lack of awareness (lack of questioning or meaningful reflection) could result in dysfunctional leadership. Helping students to learn how to be conscious in their work is important in helping them to recognise issues and then to take action in resolving them.

### 3.2 Empowerment and Engagement

An educator talked about the lack of empowerment and engagement found in student dental nurses. Traditionally, they had not been meaningfully involved in working with dental and dental hygiene and therapy students as they were treating patients. These dental nurses could not see the value in their work and this meant that they didn't feel they were a key part of the team.

*They're not empowered, because they don't see the value of them actually being there. What are they bringing to the team? That's not developing anybody's leadership. (CAE)*

Empowerment and engagement in leadership across the dental team were therefore recognised as key learning outcomes.

*That everybody's got a role in leadership. (CAE)*

*It's that aspect that they want to engage and want to improve. (CAE)*

### 3.3 Ownership and Influence

It was recognised that from an early stage, developing ownership and the ability to influence were key learning outcomes. This might involve students starting to demonstrate these abilities within their own area of responsibility.

*Start and take ownership of your surgery, your equipment, your patients everything you do, and you know then that's starting that process of leadership and management and then of course they are encouraged. (Principal Dentist)*

*There's that thing they talk about, 'circle of influence'. Often people underestimate their ability to influence. (CAE)*

### 3.4 Communication and Relationships

This was found to be one of the most crucial areas in relation to leadership in dental practice. Communication in relation to leadership is about how people within a team interact.

*Communication, that's really important, you have to be able to talk to people, you have to be able to speak to people when they've done things wrong, you have to know how to do that in the correct way and you know you have to understand how people perceive you. (Principal Dentist)*

*I think people management is a good thing to have. (Orthodontic Therapist)*

Multiple aspects are brought out here: confidence, tact, insight and perception. Again, a recently qualified DF Dentist recognised the importance of this and how it this was encouraged in her development:

*What I would class as leadership skills? You need to be able to communicate, you need to have some confidence without being I would say arrogant but having confidence, assertiveness to be able to talk to patients, talk to people and say we're not doing this or we are doing that so again it's probably not one where I would say oh that was definitely leadership cause it's kind of all the communications and kind of the practical things we do throughout Uni help to build those skills which make a good leader I think. (DF Dentist)*

Communication goes both ways and the need to listen to others as a skill was recognised:

*I think it's really vital. We all have to be, as clinicians, good listeners. For leadership you've got to be a really good listener. Whatever level that is, from the very top of leadership to the very bottom, if you're a good listener. I think one of the values that they have to have is being able to listen. (Principal Dentist)*

*You have to ...let yourself be managed sometimes. You have to be willing to do that, willing to take criticism. I think that's something important people*

*should leave with as students. It's not good to be defensive about things.  
(DF1 Dentist)*

One very simple and overlooked aspect of communication was the use of peoples' names. This was an issue that resonated particularly with the dental nurse participants who had experienced situations where even this most basic aspect of respectful communication had been missing.

*It's just the basic thing, if you're working with someone, it would be, 'Hi, my name's, you know. It would be interesting to know how many of the students actually introduced themselves, rather than just say, 'Can I have someone to come and help me?'' (Dental Nurse)*

There was discussion about how, in a dental school environment where there were large clinical areas, students often get unintentionally siloed into their dental professional groups (dentists, dental nurses) with little meaningful interaction between them.

*You've got your Hygiene and Therapy, you've got your dental students, you've got your nursing staff, you've got your qualified nursing staff, then you've got your people that work behind the dispensaries. They're all just their own little camps, there's no integration at all. (CAE)*

The need to encourage interaction and the building of relationships in this setting was recognised as important in promoting the value of joint working from the beginning of a career in dentistry.

### 3.5 Teamwork

The need for teamwork as a leadership development outcome comes along with the needs of communication and relationships.

*One of them is definitely teamwork isn't it and how to value other members of the dental team. (CAE)*

*I think a student should leave appreciating the value that everybody brings.  
(Principal Dentist)*

Students can be individualistic in their approach to clinical work, not recognising the value of working with others as a team. They need to be encouraged to take a team working approach.

*You kind of have a very tunnel vision of why you are there, and you don't realise the importance of a team. It's when you are then more experienced in doing things that you actually realise the benefit of having a lot of people around you to help you get the job done. (Associate Dentist)*

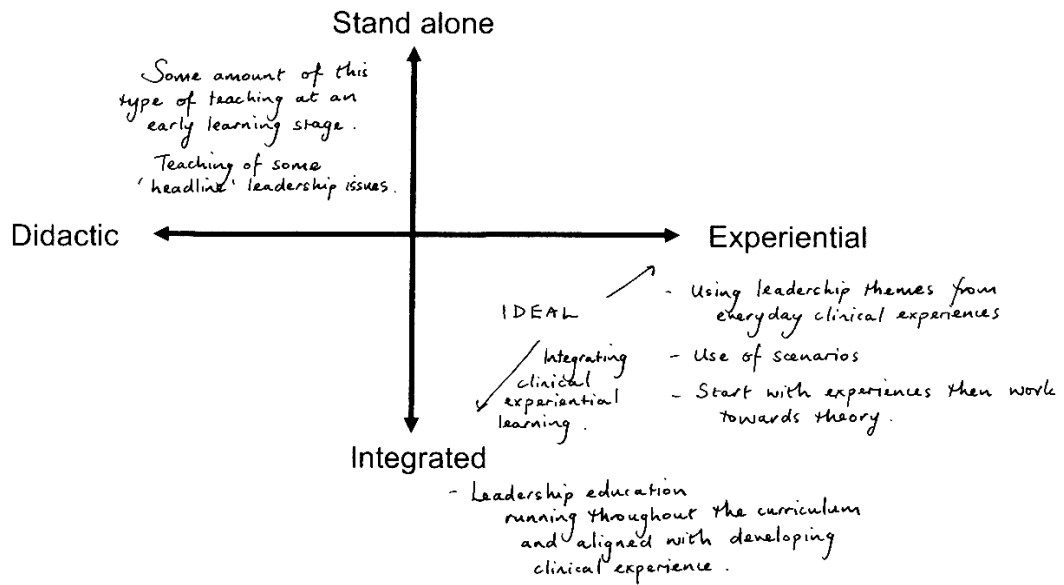
*Learn to respect that working within their surgery, working within their little unit at the Dental Institute, it should be a team situation, it's not just them dictating what happens, it should be that they work and somehow learn that you have to be a team. (Principal Dentist)*

#### **4.3.4 Educational Methods**

This theme considers what leadership development methods are most appropriate in relation to the dental education context. The findings indicate that an approach which integrates leadership development throughout the curriculum and which is experiential in character is thought to be ideal.

This framework demonstrates divergent approaches to leadership development. The chosen approaches are illustrated in figure 19.





**Figure 15.** A framework of leadership development methods and chosen approaches.

#### 4.1 The value of clinically- based (practice) education

Clinically-based leadership development was thought to be key.

*Somehow, we have to bring that environment into the education arena. Because it's such a rich environment that it's so difficult to replicate. (CAE)*

*People (students) don't know what practice is about, really. So, when they're put into a scenario, and you say, 'How are you going to deal with it?' They automatically escalate it, in totally inappropriate ways, because they don't understand the practice structure. So actually, maybe, thing about practice visit, end of fourth year, so that they then have a bit more idea when you say, 'Okay, so in a practice there's likely to be, maybe, a Practice Manager.' (CAE)*

#### 4.2 The value of outreach-based experience

Outreach teaching involves regular work placements within dedicated, small, community-based clinical dental teaching units, away from the central Dental School premises. In this way, students are given the opportunity to provide holistic dental care in an environment outside a large teaching hospital. The outreach experience is therefore more akin to General Dental Practice and the findings of

this research recognise it as an ideal setting in which to gain leadership experience to prepare students for their future working life.

*I think the more you can make it real. I mean, that's the thing that the kids like about Outreach, because it's more like the real thing. (CAE)*

*I found outreach helped me lots because it gives you an inkling of how things actually are in practice. (DF Dentist)*

It is recognised that dental students get the opportunity to work with dental nurses more closely and as a team. They are therefore able to learn from each other.

*You get that leadership from an established nurse when you get to outreach. (CAE)*

*Maybe that's the place to do it, at the end of an outreach session, they pick a nurse that they worked with and have some sort of reflection and feedback. (CAE)*

#### 4.3 Community of learning

The importance of learning collectively rather than individually was identified earlier. Establishing a community of learning, so that all student members of the dental team can learn together is recognised here as key. This is a change from past experiences where students were encouraged to keep a separation between them.

*We were advised (as students) not to interact with the dentists (dental students) out of clinic, which I thought was terrible. I think it's really bad that we didn't have any interaction whatsoever. We'd come onto clinic, and we'd all stand in a little circle, and it would be like, 'Oh you go there, you go there.' Like you say, no-one knew each other's names. (Dental Nurse)*

*You've got your Hygiene and Therapy, you've got your dental students, you've got your nursing staff, you've got your qualified nursing staff, then you've got your people that work behind the dispensaries. They're all just their own little camps, there's no integration at all. (CAE)*

When students are brought together, joint, or 'peer to peer' learning provides opportunities across groups of students:

*As fifth-years we had our third years nurse for us... and we got used to having that communication. But then again, we were also teaching them, so, like my third year relied a lot on me for her to learn. It was great, like, I think it's a really useful set-up. (DF Dentist)*

*I think it would be good to get feedback from the nurses on just interpersonal skills, because, like, I think that really affects leadership. (DF Dentist)*

#### 4.4 Scenario-based learning

It is suggested that outside of the clinical environment, the use of scenario-based learning could be used to engage students in leadership learning.

*I think the use of these sorts of scenarios in education would be great because that's showing a real-life situation. And as we've had to think about it this evening, it would be good for undergraduates to think about it. (CAE)*

Reference is made to the scenarios used by participants in the working group research sessions. These gave examples of how leadership was found in everyday dental practice.

Scenarios, in the form of situational judgement tests are used to 'assess' students as part of the Dental Foundation training recruitment process (the first year in in practice as a qualified dentist). Here a DF1 dentist raises a concern in relation to the way that leadership and management often highlight deficiencies, and do not emphasise success.

*All the scenarios that you see in the Dental Foundation leadership and management tend to be more negative. Why are they negative? (DF1 Dentist)*

Consideration is therefore needed in relation to the nature and design of scenarios for use in leadership development.

#### 4.5 Experiential and continued learning

Experiential learning was identified in the framework illustration to be ideal, rather than a didactic approach. Experience had been crucial in developing the leadership abilities of the research participants through their careers:

*If I've got leadership skills at all, I think has just come, has been acquired over a long practicing career. (Principal Dentist)*

*You learn by your mistakes, I've certainly made plenty of them. (Principal Dentist)*

At Dental School, leadership is also learned through experience students are not necessarily consciously aware that this is happening; it is hidden in the curriculum:

*You grow as you go through, and you begin to do different stuff through dental school. And suddenly, you're taking on a little bit more of a leadership role. (DF Dentist)*

*Sometimes you don't even see these things as leadership, do you? Sometimes just people being willing to do the little things mount up to the big things, and actually they probably don't realise they're taking that leadership role. (CAE)*

The need to encourage continued development after Dental School was also highlighted:

*One of the most important things that we should leave University asking, or questioning, is what else you can do to make yourself better. I don't think you should leave there thinking, 'Okay, well that's it. I've been at University, I now know everything'. I don't think it's that at all. I think that we should be taught to go out there, and then carry on asking what it is that's going to make us better. (Associate Dentist)*

This raises the question, at what point can we say that leadership development has been completed. Here the answer is that it is never complete, it starts in Dental

School where there is preparation for development, and then continues through foundation training and into a career in dentistry.

#### **4.3.5 Assessment**

Earlier, the ability to evidence development in leadership was identified as being important within a profession such as dentistry. This is a requirement at undergraduate, postgraduate and continuing professional level. There is however a fundamental question as to whether leadership itself can be assessed. If leadership is to be assessed, attention is needed as to what form of assessment is most meaningful. Suggestions for specific assessment types are provided.

#### 5.1 Can leadership be assessed?

Difficulties in assessing leadership are identified, especially by the Clinical Academic Educators.

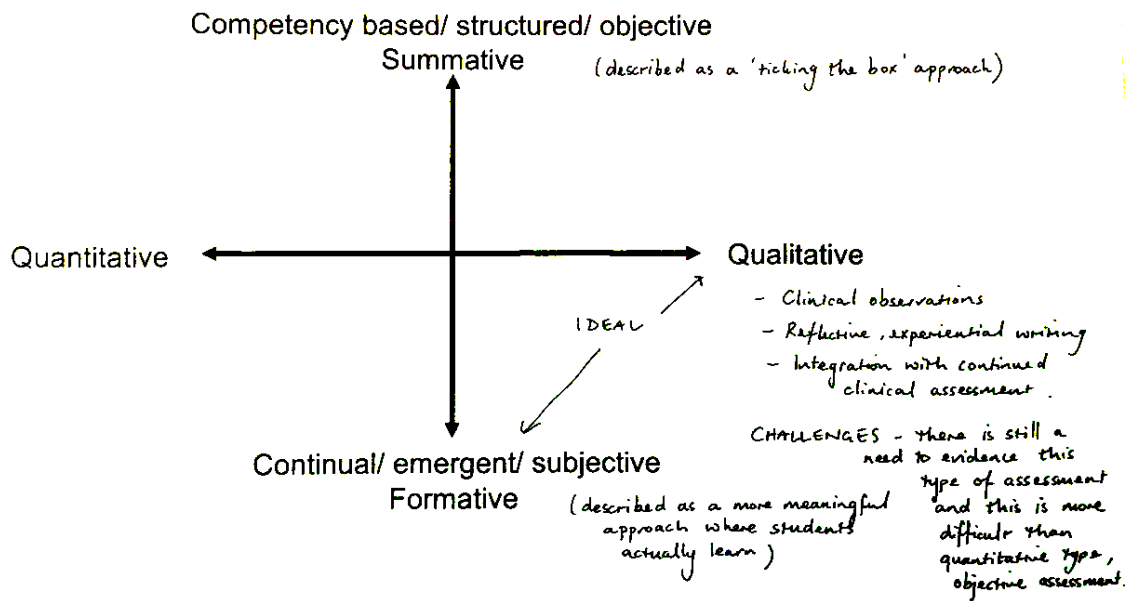
*That's why it's hard to assess and teach, because it's not a black and white thing. (CAE)*

*If you were going to apply it to a sort of teaching environment the thing is if you are doing that you've got to be able to measure it haven't you, you've got to be able to assess that you are achieving. (CAE)*

*It's not a technical assessment is it? (CAE)*

#### 5.2 Assessment methods

A framework illustrates the chosen, most appropriate approach to the assessment of leadership within the dental context (figure 20).



**Figure 16.** A framework of leadership development assessment and chosen approaches.

This highlights a move away from approaches which take a quantitative and competency type approach. Although qualitative and continual assessments are thought to be ideal, they do come with challenges which relate to the ability to record and to evidence leadership assessment. In this case, quantitative and competency have an advantage.

Suggestions were made in relation to specific assessment methods. One of these is the use of OSCE (Objective, Structured, Clinical Examination). These are used as a key clinical assessment in medical and dental education.

*We've got the OSCE situation where you could observe how somebody relates to a staff member as well. (CAE)*

The very name 'OSCE' indicates that these assessments form part of the competency / quantitative quadrant of the framework therefore it is surprising that this is suggested. It is recognised that pre-determining what should be included in an 'tick box' assessment scheme does not allow for examiners scope to use their subjective judgements, which in the case of leadership, is crucial.

*This last time we ran OSCE, we had the markers giving written feedback comments and one of them, there was a particular student who, the attitude and the way they were behaving and speaking to the simulated patient and their colleagues was something that was commented on, and we don't have anything in the assessment scheme to pick that up, it was just that one of the assessors has thought that was an important aspect to put down so maybe we so need something extra, it's an extra dimension to bring in somewhere. (CAE)*

Another key suggestion related to the use of reflective type assessments. These could be based on events experienced in relation to clinical practice:

*Some sort of incident you're supposed to reflect on, how you dealt with it and what you would do differently. (DF Dentist)*

*Reflective logs and a written reflective log are a good way of reading if someone has actually taken any learning from a process. (Principal Dentist)*

#### **4.3.6 Educational Challenges**

This theme acknowledges the real and practical challenges involved in providing leadership development in a dental education. Firstly, there is the issue of an already crowded and packed curriculum. Previously the findings told of students being 'stuffed' with knowledge, so much so there is little scope or appetite for more. An integrated approach to leadership development as part of clinically-based experiential learning has been suggested as a way to develop leadership skills without further burdening the curriculum. This however also brings practical challenges. These ideas are expanded in the following quotes:

#### **6.1 Overloaded curriculum**

*They're just ready to get out of that whole wanting to learn more. Because they've been so saturated with it at the moment. (Associate Dentist)*

There is a warning against the loss of clinical experience in order to fit in more to the curriculum. Students are so focussed on their clinical work that, if taken away from it, they would not see the value or relevance in this 'other' teaching.

*Pressure of time on the learning of everybody because everybody's timetables are fairly tight, they struggle for clinical sessions and all the rest of it, you certainly don't want to lose clinical time. (Principal Dentist)*

*I know dental students get so stressed out with totals and cases and all those things, if you were to take them off for two weeks they'd be thinking, I'm not going to....I just want to get away from this. (DF Dentist)*

## 6.2 Planning and Logistics

With large cohorts of student groups, it is challenging to introduce what might be considered as ideal leadership learning opportunities, especially in the clinical environment. Didactic, lecture-based teaching is one solution to this problem; however, it is acknowledged that this is not the best way for students to be engaged in leadership learning.

*I think it's just the volume, more than 90 students in every year. (CAE)*

*It's balancing that utopia with the clinical reality of patients isn't it? (CAE)*

*It's the logistics of having the greater numbers from our educational delivery point of view, we are taking the whole team of one hundred odd people into the lecture theatre, so it actually won't embed as much perhaps if you were delivering it in a different way. (CAE)*

A summary mind-map of the key points found across the data in relation to Education Design is presented (figure 21).





#### **4.3.7 Findings Summary**

These findings explore leadership education for dentistry. Practitioners, involving all members of the dental team, and clinical academic educators considered how leadership education could be designed to be relevant and meaningful for the needs of the dental profession specifically.

The findings indicate that leadership development is relevant to all members of the dental team and at all levels of the profession. One key finding is that leadership has to be continually developed from the beginning to the end of a career; it is not something that once acquired, is static – it is an ongoing and evolving process of development. Experienced practitioners recognise this particularly.

At an early stage students needed to be prepared, rather than taught, for leadership. A set of leadership development outcome themes and approaches were agreed:

Outcomes themes:

- Awareness;
- Empowerment and engagement;
- Ownership and influence;
- Communication and relationships;
- Teamwork.

Approaches:

- Emergent, collective, integrated and experiential learning;
- Qualitative, formative, subjective and continual assessment.

The most meaningful opportunities to develop leadership were thought to be within the clinical, practicing environment, especially within the outreach teaching setting. Here students are already engaged in a community of learning with student members of the dental team working and learning together. There are opportunities for students to recognise the value of collective approaches to leadership; to see how it improves patient care and their working lives; in all to experience the relevance of leadership. This approach would help to overcome the problem of adding to an already overloaded dental curriculum where there is little scope to add to the volume of theoretical learning content.

## **4.4 Findings – Closing Notes**

This chapter has provided a series of empirical exploratory findings on which to base a rethinking of leadership for dentistry. It has combined the semi-structured interview, ethnographic observation and collaborative working group data to allow a consideration of different perspectives.

The findings address the thesis aims in relation to leadership theory, practice, research methodology and education. The ethnographic accounts from Westby and Northby tell resonant stories of the lived experiences leadership in General Dental Practice and the theorising framework help to provide an understanding the leadership needs in this context. Examples of scenarios taken from ethnographic observations were used in the collaborative working groups to help participants explore the leadership needs of dental practice and to translate these into educational outcomes and approaches that are relevant in preparing for practice.

The next chapter goes on to discuss the findings in relation to the literature and a final reflexive account is given.

## **5. Discussion**

### **5.1 Discussion - Opening Notes**

The overall aim of the thesis was to provide an opportunity to rethink leadership for dentistry.

Having taken a critical approach to reviewing the dentistry and leadership studies literature and an exploratory approach in undertaking empirical research, an alternative 'practice and contextual' thinking of leadership for dentistry is discussed.

The dimensions of leadership theory, practice, research methodology (this includes the limitations of the research) and education are used to structure this discussion and it is acknowledged that these dimensions are inherently interlinked and interdependent, and that there will be areas of overlapping discussion.

## 5.2 Leadership Theory

The aim in relation to leadership theory was to construct a theoretical framework of leadership for dentistry.

The Critical Literature Review (2.1) explained how the dentistry literature is engaging in a consideration of leadership theory and that there is a call for dentistry to develop its own theory or model of leadership (Willcocks, 2016), with a need for dentistry specific leadership traits and behaviours to be defined (Brocklehurst et al., 2013a). There is therefore an eagerness in dentistry for definition and theory in relation to leadership. The perspective given from the leadership studies field reveals that this is not a straightforward endeavour with concepts of leadership being “highly contested” (Grint, 2005b). Thinking in relation to leadership theory is moving away from heroic and individual versions of leadership towards more collective and critical approaches and this presents an opportunity to rethink how leadership is theorised in dentistry.

This thesis used a ‘practice and contextual’ theorising of leadership to construct a theoretical framework through which to understand leadership. This moved away from essentialist, romanticist and dualist characteristics of heroic leadership (Collinson, 2011; Ford, 2015a; Sinclair, 2007; Tourish, 2013) towards a more collective and critical understanding (Crevani et al., 2007; Ospina et al., 2020; Ford et al., 2008; Ford, 2010; Collinson, 2011; Harding et al., 2011; Sutherland, 2015; Learmonth and Morrell, 2019). This section discusses the value of the ‘practice’ approach in helping to revitalise leadership (Wilson et al., 2018) for dentistry such that it becomes meaningful and useful in everyday practice, in leadership research methodology and in leadership development.

### The purpose of leadership theory

An important question when considering leadership is to ask, what is the purpose of theory? Theory helps to develop abstract, conceptual thinking, understanding and definition. Theories also provide a basis for models of application and educational development. In leadership, theories often provide prescriptions for application (e.g. situational leadership, Hersey and Blanchard, 1969) with the view that these will be universally workable and effective (Wilson et al., 2018).

There are two main difficulties with these conventional views, firstly an assumption that abstract theory is useful in the practice environment and secondly, that

universal approaches will be applicable to specific contexts. In relation to theory and practice, the Critical Literature Review (2.1.2) considered how these domains are intricately linked. The 'practice' philosophy argues for the primacy of practice, putting it before the domain of theory arguing that it is only through 'being-in-the-world' (Heidegger, 1962; Dreyfus, 1991) and engaging in practice, that theoretical understanding can then follow. Theory cannot be brought about by shutting oneself off from the world, as academic theorists often do.

In relation to universalism, the assumption that 'one size fits all' does not take into account the inherently complex and contextual nature of leadership where a diversity of different challenges, purposes and values are found.

Leadership therefore needs to be practically and contextually useful. These arguments drove and informed the approach taken in this thesis and the approach to 'contextualised theorising' (Leadership-As-Practice-In-Context) (Raelin, 2016b; Wilson et al., 2018). In putting a practice perspective first and observing the everyday practice environment (in this case General Dental Practice) and engaging with practitioners (in this case dental care professionals), a specific theorising of leadership for dentistry was constructed.

In considering the value of this, whether or not this theorising might become practically useful beyond the work of this thesis depends on its acceptance within the dental profession itself. This is a challenge when it does not offer a clear definition or a neat prescription for action. Its purpose, rather, is to develop the understanding and interpretation of leadership in General Dental Practice and to aid in a preparation for practice.

#### What the contextualised theorising framework reveals about leadership

The meta-framework was designed to consider the areas of 'challenges', 'purposes', 'values', 'people', and 'practices'. In modifying the framework from Wilson et al.'s, (2018) version, the focus on leader/ follower individuals and leader/ follower relationships was replaced with 'people' and the area of 'practices' replaced the 'domains of leadership activity'. The Methodology and Methods chapter (3.5) explained the rationale for these changes: to address dualist and heroic notions of leadership and to bring more attention to Leadership-As-Practice. The mind-maps presented in the Findings chapter help to illustrate what constitute these areas within the dental context and give examples. The 'People' area was the richest in terms of what is revealed. There are multiple issues and some which revealed deep seated, historical, personal experiences recognising the need to give particular attention to the relational aspect of leadership in dentistry and the move

away from a hierarchical notion of leadership. The inclusion of this area within a leadership framework for use in dentistry is therefore crucial in understanding leadership. This will be considered further in the next section of this chapter (5.2). In relation to the 'Practices' area of the framework, the mind-map illustrates the multiple and varied examples found in the research. It was however, difficult to separate out 'practices' from the other areas of the framework and examples of practices can be found in the other areas (as seen in the mind-maps). This raises the question as to whether 'practices' should be considered as a distinct area of the framework or integrated within the other areas. The advantage of including 'practices' in its own area of the framework, is that it brings attention to particular and specific practices and "what people do" (Whittington, 2006) and how leadership is enacted. This was explained in the Critical Literature Review (2.1.2) within a consideration of the thinking and philosophy behind 'practice' and 'practices'. The inclusion of the 'Practices' area may also be of potential benefit if the framework is used as an educational tool to aid the understanding of how leadership is brought about in everyday practice.

This is what Wittgenstein (1980) argues for:

How could human behaviour be described? Surely only by showing the actions of a variety of humans, as they are all mixed up together. Not what one man is doing now, but the whole hurly-burly, is the background against which we see an action, and it determines our judgement, our concepts and our reactions.

Wittgenstein, 1980, p.108.

Overlap between other areas of the framework were also found, demonstrating their inherently interlinked and interdependent nature. Separation of these areas could be criticised as being artificial. The argument against this is that considering these areas brings attention to areas which may be neglected otherwise, such as the 'People' area.

#### Using theories to understand leadership in dental practice

The findings of this thesis demonstrate the usefulness of the Leadership-As-Practice-in-Context theoretical framework (in all its constituent areas) in understanding and making sense of leadership in dentistry and this was illustrated in the accounts of leadership as it was found in Westby and Northby. Table 18 gives a summary of similarities and contrasts between them:

| Leadership 'Areas' | Westby   | Northby   |
|--------------------|--|---|
| Challenges         | <ul style="list-style-type: none"> <li>• Multi-mini challenges</li> <li>• Human resources challenges</li> <li>• Compliance with regulations</li> </ul>                                   | <ul style="list-style-type: none"> <li>• On-going challenges</li> <li>• Human resources challenges</li> <li>• Compliance with regulations</li> </ul>  |
| Purposes           | <ul style="list-style-type: none"> <li>• High quality patient care</li> <li>• Financial success</li> <li>• Internal validation as a source of worth</li> </ul>                           | <ul style="list-style-type: none"> <li>• High quality patient care</li> <li>• Financial success</li> <li>• External validation as a source of worth</li> </ul>  |
| Values             | <ul style="list-style-type: none"> <li>• Hopeful and optimistic attitude</li> <li>• Connect between values and practices</li> </ul>  | <ul style="list-style-type: none"> <li>• Driven attitude</li> <li>• Examples of misaligned values and practices</li> </ul>  |
| People             | <ul style="list-style-type: none"> <li>• Collaborative</li> <li>• Participative</li> <li>• Shared</li> <li>• Relational interaction</li> <li>• Active engagement of staff</li> </ul>     | <ul style="list-style-type: none"> <li>• Hierarchical and heroic</li> <li>• Compliance driven</li> <li>• Concentrated leadership in one individual</li> <li>• Isolated</li> <li>• Dependency</li> </ul> |
| Practices          | <ul style="list-style-type: none"> <li>• Emergent</li> <li>• Hands-on approach by dental practice principal</li> <li>• Joint reflexivity</li> <li>• In-situ, practical coping</li> </ul> | <ul style="list-style-type: none"> <li>• Controlled</li> <li>• Hands-off approach by dental practice principal</li> <li>• Constant checking of compliance</li> <li>• Planning and execution</li> </ul>  |

**Table 18.** Summary comparison of leadership as it was found in Westby and Northby.

Both dental practices faced broadly similar challenges and purpose and although Westby and Northby espoused similar values, there were differences in how these values were then used to inform their leadership practices. Contrasts between Westby and Northby also reveal heroic and collaborative versions of leadership. General Dental Practice is therefore a context in which an abundance of leadership is found and the theorising framework helps to reveal and provide interpretation of this.

### Summary

In using a Leadership-As-Practice-In-Context lens to guide the approach to theorising leadership, a tailored and dentistry-specific understanding of leadership was constructed. This moved away from the essentialist, romanticist and dualist characteristics of heroic versions of leadership, towards more collective and critical approaches and was based on the everyday, routine practices found in the General Dental Practice environment. In considering its value, it brought attention to the



importance of the 'People' area of the leadership framework and this recognises a need to emphasise a future focus on the relational aspects of leadership within the dental profession. Instead of defining a set of specific traits and behaviours, it focuses on the practices by which leadership is brought about thereby replacing an emphasis on the 'who' of leadership with the 'how' of leadership.

The theoretical framework of leadership for dentistry constructed in this thesis does not offer a neat prescription for action but it has value in understanding and making sense of leadership and in informing how leadership is practised, researched and developed specifically within the dentistry context.

### **5.3 Leadership Practice**

The aim in relation to leadership practice was to understand leadership from within dentistry: where, when, how and why leadership takes place.

The Critical Literature Review explored how talk of leadership has become ubiquitous within healthcare policy in the UK and how the dental profession is catching up in recognising how leadership applies within its own context as a solution to dealing with multiple challenges found within the profession – leadership is seen as an attractive answer. Initiatives which promote the development of leadership in dentistry are being driven at the national policy level (Advancing Dental Care Review, HEE, 2018). A critical and sceptical view of this type of leadership promotion is found in the leadership studies field (Ford, 2015) which questions the assumptions this makes; about where leadership is found, when it happens, how and why (Raelin, 2016a).

The exploratory research undertaken in this thesis brings attention to General Dental Practice and reveals how leadership is found within this context. This section discusses the findings and how these tell a story of how leadership is experienced within the dental profession, in everyday practice.

The areas within the meta-theorising framework for leadership are used to structure the discussion.

#### Challenges

The findings of the research undertaken in this thesis indicated that ‘challenges’ related to the need for compliance with externally imposed regulatory requirements, a focus on output and targets, the complexity of human relations, and the scope and variety of responsibilities that were faced on a daily basis within the practicing environment. There was a human cost in coping with these sustained challenges, experienced in feelings of isolation, loneliness and stress.

The accounts of challenges found in Westby and Northby give insight into these. They tell of quite mundane and everyday issues such as a broken operating light and an autoclave, and minor tension between dental nurses (In Westby) and in Northby, frustrations in working with others and trying to engage colleagues in ensuring that equipment is maintained. In putting these challenges together over the course of just one day, in practice, they become significant. Those involved in

dealing with these challenges did so using practical coping abilities; they had learned this ability through experience and needed to sustain this effort every day. There was no external source of support for these dental practices and as independent organisations, they were responsible for their own success. This is a heavy burden. It is worth reflecting on the fact that the General Dental Practice context, responsible for delivering the majority of dental care provision in the UK, is led and managed in this way and this indicates that perhaps better support for General Dental Practice is needed.

### Purposes

In General Dental Practice, it was found that leadership needs to achieve success in maintaining and enhancing patient care, meeting regulatory requirements and running a financially profitable business. The Northby dental practice in particular, was driven by the need to maintain its reputation for providing high quality dental care. Evidence for this high quality came in achieving external validation such as the CQC report and the BDA 'Good Practice' award and these were used for promotion purposes. Competition with other dental practices in the local area was seen to be important. Compliance with quality markers drove much of the leadership work in Northby and staff were encouraged and expected to achieve these. The Clinical Nurse Manager spent most of her full-time position dedicated to this purpose. There was also focus on being efficient and effective; maximising the efforts of the receptionist team (through observation and remote monitoring), monitoring the fullness of appointment books and auditing equipment and materials. Efficiency margins were important.

It is worth reflecting on the findings of the Francis Report (2013) which had a profound effect on emphasising how the culture within healthcare settings can impact significantly on patient care. In the Mid-Staffordshire NHS Trust case, the culture had focused on reaching targets and on achieving financial balance and foundation trust status. It should be remembered that the purposes that leadership takes part in must be balanced and that, in some contexts, there are purposes which over-ride others in their significance; in the healthcare context, the quality of patient care. Dentistry must take care in remembering this lesson.

### Values

The Francis Report (2013) also highlighted a need to re-emphasise a commitment to values in healthcare. It is interesting to think about how values are constructed, how they are kept alive or why they might be lost in the practising environment.

The personal histories of the Westby and Northby participants give an insight into the origin of the values found within the dental practices. Values had been passed on through generations of dental professionals and had been forged through experience; wanting to improve the future experiences of others.

Values were found to be both implicit and explicit in their use. For example, in Westby, the work of the participants was embedded within values, but these were not talked about or brought to attention specifically. Every day, they held each other to account (including the dental practice principal), pointing out where something might not be appropriate and helping each other to make value-based decisions. Together they supported each other in maintaining their values and they discussed ethical issues to share their views, sometimes keenly. In Northby, the practice manager constantly reinforced the need to maintain the values of hard work and dedication. When, for example, two trainee dental nurses fell below the expected standards, they were immediately held to account. Mentoring of generations of dental nurses also helped to pass on values within the practice and they talked about how this was what they had 'grown up with'.

The newspaper extract included within the ethnographic account illustrates the way that values are explicitly promoted within healthcare and how this can appear to be patronising in the language used and the naivety that it assumes. Values are not externally driven, but constructed within teams of practitioners, over time and lived in everyday practice.

### People

This area of the contextualised theorising framework brings attention to perhaps the most important and revealing aspect of leadership as it was found in the General Dental Practice context. The preliminary interviews gave an initial indication that this was an area which had a particularly poor reputation within the dental profession.

A consideration of 'People' was found to be integral across all aspects of the framework, for example:

**Challenges:** human relations challenges were identified as one of the most difficult in leadership.

**Purposes:** leadership has a purpose in helping to make working lives better and to support colleagues and teams.

**Values:** values are maintained through mutual support and are embedded in personal experience. The values of trust, empowerment, inclusivity (as examples) key parts of relational leadership.

**Practices:** many of the practices identified relate to the way leadership is brought about: setting an example, listening, negotiation and teamwork.

A recent qualitative study (using interviews) of the perceptions of dental associates in relation to their working environment raised the issues of autonomy and internal conflict within General Dental Practice (O'Selmo et al., 2019). Internal conflict issues often related to the relationship between the associate and the practice principal or manager. Where the relationship was poor, issues raised by associates were "lost or ignored" and there was felt to be a need for "self-preservation" in not raising challenging or difficult issues if it might cause conflict (O'Selmo et al., 2019, p.960).

The ethnographic accounts of Westby and Northby reveal different and contrasting experiences of leadership and give an insight into variations in the leadership culture found within General Dental Practices. In Westby, a collaborative approach with constant discussions and sharing of challenges was found. It was a community of practice and demonstrated a family style culture (as recognised by one of the working group clinical academic educators). In Northby, the presence of a practice manager was crucial to the leadership effectiveness and the CQC report was evidence of this. However, as the Northby dental practice meeting illustrated, the leadership approach that had operated for many years, had resulted in passivity among the rest of the staff. There was very little active participation or real learning that took place and there was no sharing of experience or the healthy critical analysis of points of view – an example of self-preservation by members of the meeting group.

Poor communication, cynicism and poor teamwork are recognised as barriers in relation to effective clinical management (Daly et al., 2014). From a critical leadership studies perspective, the 'fig leaf' description of leadership becomes pertinent here (Martin and Learmonth, 2012).

The dental practice accounts also raise the issues of power and gender in the relationships between people. For example, the surfacing of an underlying power and hierarchy relationship between the Northby dental practice principal and

practice manager with the rest of the dental team. There also appeared to be some gendered division of roles, with the practice manager (female) being largely responsible for people management and day-to-day management whereas the practice principal (male) dealt with more strategic issues. In Westby, the issue of gender in leadership relationships can be illustrated by the absolute respect given to the dental practice principal as the only male member of the team. Although not elaborated on specifically within the findings presented in this thesis, there is an opportunity for further analysis in relation to these issues.

In all, the given accounts raise issues such as passive and active involvement in leadership, interdependency and dependency, and collaboration and autocracy. Leadership is brought about through people and is inherently relational and collaborative (Cunliffe and Eriksen, 2011; Crevani et al., 2007; Fredrich et al., 2009; Ospina et al., 2020). The dental profession needs to consider how teams within dental practices can be encouraged to take an active, participatory role in leadership and how it judges leadership to be effective.

### Practices

In this thesis, practices were considered as the actions / activities which bring about leadership. When asking the dental practice participants about how they were involved in leadership activities some were unsure. On asking them what they did as part of their routine work however they did reflect on the way that their activities were contributing to leadership even, on what one described as “a low level”. All members of the dental team were found to be involved in leadership and a focus on practices, rather than their position, allowed this to be revealed.

Examples of practices were revealed in the mundane and everyday events within the two dental practices and the particular scenario (‘Just another manic Monday’) which was used within the Findings chapter illustrates this. Practices were, for example, communication related: listening, the need for clarity, summary and repetition of decisions; teamworking related: trust, encouragement, motivation, negotiation; reflection related: reflexivity as the event proceeded and joint reflection after the event. The scenario illustrates how leadership happens in what might be called ‘critical events’ within everyday working life as well as within coffee breaks and lunchtimes, and on more formal occasions such as meetings. Leadership in these settings often not a planned activity but it comes about unconsciously (an example of Heidegger’s dwelling mode).

A focus on the 'how' of leadership could help dentistry to develop its understanding and practice of leadership and to reduce its dependency on heroic individuals. In doing this there is an opportunity to engage all members of the profession, rather than, "identifying and supporting high-calibre individuals to maximise their potential" (Advancing Dental Care Review, HEE, 2018). As Spillane (2004, p.19) argues:

Leadership practice takes shape in the interactions of people in their situation, rather than from the actions of an individual leader.

### Summary

A focus on leadership as it is found in practice demonstrates the complexity involved within real workplaces and organisations. Leadership is embedded and engaged in challenges, purposes, values, history, legacy, people, experiences and is enacted through practices.

The Findings tell of the real stories and lived experiences of leadership within the dental profession, in ordinary General Dental Practices, at the front line of patient care. It is interesting to think about how Westby and Northby might react to the Advancing Dental Care (HEE, 2018) self-help pack "designed to help dental teams assess their current level of efficiency and effective working practices".

Leadership is not just about the talk, it is about the doing – the practice, and its complexity within the practice environment needs to be understood and appreciated.

## 5.4 Leadership Research Methodology

The aim in relation to leadership research methodology is to explore the use and value of innovative approaches to qualitative research to make sense of leadership in dentistry.

The Critical Literature Review (2.3) exposed assumptions in relation to approaches taken to leadership research in both the dentistry and leadership studies literature. Questions were raised in relation to the focus of inquiry (contexts and those who are chosen as participants), and the approaches taken to research itself. It was explained that these choices were intricately linked with, and informed by, theories of leadership and these reflect deep philosophical differences.

The approach and methods explored and used in this thesis give an opportunity to consider their value in making sense of leadership. In this section, the areas of research philosophy and methodology, strategy and methods, reflexivity and ethics as well as an integrated identification of research quality indicators (Tracy, 2010) are used to guide discussion. There is also a consideration of the limitations of the research undertaken in this thesis and a final reflexive account.

### Research Philosophy and Methodology

This thesis was based on an understanding of leadership as a complex, socially constructed and contextual concept. The chosen research approaches had to align with this understanding and therefore an interpretivist and subjectivist philosophical position was crucial in informing the methodology and methods used in this thesis. This was a move away from positivist and objectivist approaches which were presented in the example of leadership research methodology in used in dentistry (Hill and Brocklehurst, 2015) and that, reportedly, dominate the leadership studies literature. The use of this unconventional approach however brought challenges. Although the contrasts between different research philosophical positions are well known within the social sciences field, in healthcare sciences (including dentistry) this understanding is not as well developed (as explained in the Methodology and Methods chapter). In this thesis, a particular challenge was found at the ethical approval stage of the research process, particularly at the substantive research stage. The exploratory nature of the research, the sampling strategy and the unpredictable, non-generalisable nature of the outcomes were examples of issues that needed to be defended. As explained in the Methodology and Methods



chapter (3.1), markers of qualitative research quality and how these are distinct from markers of quantitative research, are starting to become more well-defined by the health sciences community (Noyes et al., 2018). It is hoped that by undertaking research which takes a non-conventional qualitative approach, and which reflects deeply the interpretivist and subjectivist philosophy, presenting research which is worthy, rich in rigor, sincere, resonant and which makes a significant contribution (Tracy, 2010), the value of this approach will be recognised within the healthcare and dentistry specific fields.

### Research Strategy and Methods

In choosing the research strategy and methods used throughout the research process, it was important to maintain alignment and coherence (as described by Tracy, 2010) with the research aims and the chosen interpretivist epistemology and subjectivist ontology. The exploratory and inductive strategy allowed each research phase to be informed and developed as the research progressed, responding to the findings of the previous stage. This helped to ensure the relevance of the findings. This approach is however, unpredictable and uncertain and these can be considered as disadvantages. For example, the outcomes are not necessarily clear from the outset. This affects the ability to plan and to ensure the efficiency of the process and can create practical challenges in gaining approval and funding for the research.

The choice of the Leadership-As-Practice-In-Context theoretical framework and the ethnographic observation and collaborative working group methods were informed by the findings of the semi-structured interviews used in the preliminary research phase and this was the main purpose of this phase. There were limitations in the usefulness of the semi-structured interview process and the data obtained. For example, the number of participants was limited, however by taking a purposive sampling approach, all members of the dental team were included, and this was felt to be more important. It gave a voice to those members of the team who had not been included in previous leadership research in dentistry. Another limitation was the difficulty in gaining the participant's lived experiences of leadership, in some cases, because they gave clichéd descriptions of leadership, and in others, because they were unsure what 'leadership' meant and what to talk about – using the 'leadership' word was actually a limitation in the research. Asking open questions about their experiences in dental practice was more revealing. In some cases, participants used the opportunity to open up about their experiences and the

difficulties they were facing at the time or had faced throughout their careers. These often involved cultural and relational issues and so it was important that the next phase of the research was able to capture this in more detail.

### Research Context and Recruitment

From the outset, the research engaged with General Dental Practice and its participants. This was a deliberate choice; the rationale being that the majority of the profession practice in this context. The view taken by one research paper author, described in the Critical Literature Review (2.2.1), was that “the vast bulk of our profession don’t really get exposed to the opportunity to become a leader” (Morison and McMullen, 2013, p.3). The research in this thesis sought to challenge this assumption. The ethnographic observations undertaken in Westby and Northby demonstrate the richness of leadership practice undertaken by all members of the dental team in General Dental Practice.

Westby and Northby are examples of independently owned General Dental Practices providing a mix of NHS and private dental care. They don’t therefore represent the growing corporate ownership and management of General Dental Practices in the UK and the involvement of this type of dental practice would have added to the relevance of the research. Although recruitment of this type of dental practice was sought, it was not successful. One such dental practice explained that involvement in research was not a priority and this demonstrates the significant recruitment challenge.

What the research undertaken in this thesis also does not consider is leadership outside of the General Dental Practice context and the links between the different contexts and levels found in the dental profession such as community practice, secondary care, Local Dental Networks, Health Education England, the Office of the Chief Dental Officer and NHS England. As described in the Critical Literature Review, the perception is that leadership needs at these levels are “quite different” (Brocklehurst et al., 2013a, p.246) from those needed within a dental practice environment. A wider consideration of leadership in dentistry was outside the scope of this thesis.

This research focuses on revealing the everyday nature of leadership practice in dentistry and how it makes a difference directly to patient care and, importantly the working lives of those in the profession, an aspect which is frequently absent from considerations of the purpose of leadership considered in the healthcare professions (worthy topics, as described by Tracy, 2010). The recruitment of dental

practices was a key challenge and the outcome of this research owes a great deal to the participants involved.

### Crafting the Research

The substantive research phase offered the opportunity to craft (Cunliffe, 2011) and to tailor the methods used to achieve the research aims set out following the preliminary phase and went well beyond the capabilities of the interview method.

In relation to the ethnographic observations, this afforded the opportunity to collect different types of data using a range of approaches:

- Interviews to reveal individual, personal narratives and dental practice narratives, which gave an insight into values as well as historical aspects and how leadership culture within the dental practices had been constructed, over time, through these;
- Observed events which illustrated the ways in which the layout of the practices had an effect on how leadership was enacted and experienced;
- Observation of meetings which allowed social relationships, roles and responsibilities and hierarchy to be revealed;
- Written recording of interactions which allowed attention to discourse and language;
- Comparative analysis between the two dental practices which allowed particular leadership styles to be highlighted and seen to be different.

These reflect areas of interest that were recently identified by Sutherland et al. (2020) in their call for greater attention to 'place' in leadership research. The ethnographic observations were therefore able to reveal a relevant, rich and diverse range of data and help to achieve resonance (as described by Tracy, 2010). This is essential in exploring and exposing the complex nature of leadership.

There are, however, potential limitations that can be identified in the ethnographic observations undertaken in this thesis. For example, ethnography is an intensely immersive research experience and it might be argued that the length of time spent within the two dental practices was limited in terms of what is considered true ethnography (this is why the description 'ethnographic observation' is used in this thesis). In undertaking ethnographic research, a significant time commitment is required, not only in being immersed within the field but in analysing and translating

a vast quantity of data. Ethnography is not therefore an easily applied method. In crafting this ethnography, the research visits took place over a long period of time (10 months), but in short bursts. This allowed a gradual understanding of the context to emerge and the ability to see how various issues had 'played out' over time. Importantly, the long-time span gave time for more in depth reflexivity and analysis of data between visits. It also did not burden the dental practices with intense scrutiny or the 'hosting' of a researcher (Gill, 2011).

In relation to the collaborative working groups, this method was crafted by combining aspects of focus groups, appreciative inquiry and the use of practice-based scenarios. This brought challenge in both the design and conduct of the working group sessions. Firstly, in relation to the focus group approach, this relied heavily on the attendance and engagement of the participants, in particular the dental practice participants. This was not assured and was largely dependent on how the participants perceived the process and the value of the research. The researcher (*my*) interaction with them also had an effect on this. Holding the sessions in evenings and the need for travel were also limitations. The two-hour time period which included a break also meant that fitting in all the elements of discussion was challenging. Despite this, the transcripts that resulted were rich with data.

Secondly, the design of the sessions using appreciative inquiry and the practice-based scenarios had to be planned carefully. It was clear that the dental practice participants would scrutinise the scenarios as they had come directly from their practice. Even when attempting to use an appreciative inquiry approach, and focussing on positive aspects, inevitably there will be perceived areas of criticism and negativity. The involvement of the clinical academic educator participants in the scenario-based discussions, helped to facilitate a positive appreciation of their practice. This 'external' view point was important in helping the dental practice participants recognise the leadership that they were practising and its positivity. It also helped them to reflect and to explain the rationale for their actions and activities. This had benefits to the research outcomes as the level of insight given in these reflections, in some instances, revealed more than the ethnographic observations had identified. Combining these methods where ethnographic observations are then supplemented with related working groups is therefore one way to add to the credibility of the data: through multivocality, crystallisation and member checking (as described by Tracy, 2010).

In relation to the educational translation purpose of the collaborative working group sessions, a limitation of the approach used was that it did not initially result in a defined outcome. The third working group session which was held with the clinical academic educators helped them to focus their thinking in relation to educational outcomes and approaches and to use the findings of the previous collaborative group sessions which had been analysed in advance. The use of the illustrative educational frameworks (Rodgers et al., 2003) was helpful in allowing them to identify contrasts in educational philosophy, methodology and assessment and how this related to what they had been asked to consider. Whilst the clinical academic educators were able to choose specific educational methods and assessments, their awareness of underlying philosophical positions was not as obvious. These experiences raise the question as to how educational planning and development is best conducted. There are examples of highly structured approaches such as the Delphi method, involving a sequential series of rounds of questionnaires given to a selected group of panellists whereby a consensus outcome is agreed (Green, 2014; Tonni and Oliver, 2013) but this method involves panel members working individually, responding to questionnaires; there is no chance for discussion and interaction. In this thesis, the collaborative working group method aligned with the interpretive, subjectivist and social constructionist research philosophy and demonstrates how practitioners and academic educators can combine their experience and expertise by working together in person to discuss and to exchange ideas in producing practice-based (taking into account challenges, purposes, values, people and practices) and relevant outcomes.

#### Reflexivity and Ethical Issues

It is said that ethnography is a research method that can only be learned through experience (Yanow et al., 2012). Much of ethnographic research practice lies in the immersive nature of the process where decisions are made “in-situ” (Chia, 2004, p.33) and “on the hoof” (Chia and Holt, 2006, p.643), much like the practice of leadership itself (Carroll et al., 2008). Reflexivity was a key part of the ethnographic research experience and, to a lesser extent, as part of the collaborative working groups and helped to achieve sincerity in the work (as described by Tracy, 2010). A number of different issues arose throughout the ethnographic observations which prompted reflexive considerations:

- **The effect of the researcher (*my*) presence;**

*This manifested in different ways in the two settings. In Westby, I was conscious of space and the proximity of my position as I observed. It was difficult not to get in the way. I felt the need spend time in the upstairs waiting area to give those working downstairs some space. This did however afford me the opportunity to write up notes which was difficult to do when in front of participants. In the Northby practice I was aware of being managed and directed. There were instances where I saw things that I wondered whether or not they were put on for show or to purposefully demonstrate a point.*

- **Being a member of the dental profession (being perceived as an insider);**

*I was aware of an initial degree of suspicion as to my motivation for visiting the dental practices. I had to work hard to gain trust, particularly with nurses and receptionists, I wasn't for example a 'regulator' and was not there to judge them. I had genuine interest in them, their views and experiences – in some cases this was a novelty. At the same time, I was accepted as a member of the profession and was able to understand the challenges they faced.*

- **Establishing trust and rapport in the relationship with the research participants;**

*Over time conversations became easier and more relaxed. I found my ethnographic visits to the practices over a period of months helped me to establish a relationship with them and to gain their trust. The participants of Westby, in particular, were engaged in the aims of the research and wanted to contribute their thoughts and experiences. They were also keen to hear about my findings, especially the scenarios I had chosen for the working group sessions.*

- **Being judged;**

*I was aware of being judged in relation to my own character and my own leadership abilities. I was told in one situation: "you come across as being very calm, but you don't necessarily have the strength needed". On reflection, I felt this revealed a view that leadership is about overtly demonstrating one's strength to others.*

- **Being asked for feedback on leadership capabilities;**

*Participants, particularly the dental practice principals, asked me for feedback on their leadership skills and were curious about the other dental practice involved in the research. Comparison seemed to be important.*

- **A desire to defend and support dental practice participants;**

*There were times when I wanted to help participants by suggesting ways of handling situations or even to defend them in front of others. Some instances surprised me. For example, the description given of receptionists as they appeared on the live CCTV images. These were an examples of where I took advice from my supervisors outside of the research setting in order to reflect on these events and to work through what they meant in relation to my work. For the purposes of the research it was important to understand why the camera images were used and I when I encountered these types of situations, my strategy was to ask 'why' type questions in order to understand the participant's perspectives and intentions.*

- **Outsider differences;**

*For me, the main reflexivity issue I encountered related to autonomy. As an academic who values autonomy I found it difficult to relate to issues of control, hierarchy and the lack of opportunity for members staff, particularly nurses and receptionists to question ways of working or to use their responsibilities to the full. This is where my 'outsider' differences became most evident.*

- **Engagement of participants in the research;**

*The collaborative working groups presented a particular challenge in relation to the engagement of the dental practice participants due to the additional time needed outside of the working day. In Westby, most of the ethnographic 'characters' attended. The manner by which they went about making arrangements to attend the session (they would travel together) was illustrative of the collective and participative approach that I had described in the ethnography. In Northby, engagement in this aspect of my research was not as evident. Natalie, Holly and Resham had not featured in my ethnographic accounts but their perspective was valuable in providing triangulation to my findings. I was particularly interested in their views.*

*I reflected on the reasons for the difference in the engagement between the two practices. In the smaller and more cohesive Westby practice, establishing a relationship had been easier. There was genuine interest in my work and I had more opportunity to discuss this with them during the course of my visits. In the larger and less cohesive staff group at Northby, this had been difficult. I had been asked not to disturb the normal routines of activity and staff members were busy concentrating on their work.*

*Between the first and second working group sessions, my ethnographic visits to both practices continued. In Westby, the staff group had started to reflect more about their work and often referenced the working group discussion. They told me that they had found it helpful: "Seeing the scenario on paper has made me feel more confident in the way we cope in a difficult situation as a team and highlights our strengths and weaknesses." "It has been interesting to listen to people's views/ opinions from a different perspective, and for them to challenge your views/ opinions." In Northby, the individuals who had attended found it interesting and insightful.*

- **Possible bias in the different perceptions in relation to the two dental practices and their participants; Westby and Northby.**

*I needed to consider whether I had established a biased view of Westby and of Northby, through my ethnographic observation experience, which could have influenced the research findings. Certainly, my experiences at Westby and Northby were different and I had achieved more engagement from the Westby participants. The involvement of the clinical academic educators to give a detached perspective was important as part of the working group sessions. I did not take part in the working group discussions and the groups were self-led, using the prompt questions that I had given in the introductory presentation (Appendix B). The interpretations of the discussion transcripts however were my own.*

Ethical issues were also integral there were examples where my ethical practice was tested. There was a need to maintain the confidentiality of some dental practice participants within the dental practice, and in relation to the dental practice management. This was an example of ethics-in-practice (Guillemin and Gillam, 2004), in addition to the procedural ethics approval that was gained prior to the research. Again Tracy (2010) includes 'ethical' in list of quality criteria for



qualitative research and this required active consideration throughout the research process.

Even preparation in relation to ethnographic research and potential ethical issues – reading textbooks, papers and examples did little to prepare for the lived experience of it. It was an emotional and affecting experience, as Cunliffe (2010, p.227) describes so well in quoting Van Maanen (1988, p.2):

Much of our academic training prepares us to be disciplined, structured, and “objective” in our intellectual pursuits rather than preparing us to “move among strangers while holding [ourselves] in readiness for episodes of embarrassment, affection, misfortune, partial or vague revelation, deceit, confusion, isolation, warmth, adventure, fear, concealment, pleasure, surprise, insult and always possible deportation.

Cunliffe (2010, p.227) goes on to argue that it is only by exposing ourselves to these experiences that ethnography can “reveal and explore the intricacies, challenges, tensions, and choices of life in organisations.” It also makes the research experience more engaging and fulfilling.

### Summary

The approaches to research undertaken in this thesis presented significant challenges and difficulties, and success in achieving the research aims was not guaranteed. It is therefore important to ask a fundamental question: whether the challenge and difficulty is worth it, especially when there are other, more controlled and straightforward approaches which do guarantee an output (usually positivist and objectivist approaches).

In choosing to embrace the complex, socially constructed and contextual nature of leadership and to move away from heroic, individualistic theories of leadership, the chosen research approaches had to align with this; an interpretivist and subjectivist research philosophy, a qualitative methodology, and the individual semi-structured interviews, ethnographic observations and collaborative working groups.

In exploring these approaches, this thesis has demonstrated their value in making sense of leadership in dental practice. They were able to involve the whole dental

team (where previously some had been overlooked), they were able to tell individual and dental practice narrative stories and to show how history and values are inherent in how the culture of leadership in General Dental Practice is constructed. They also reveal Leadership-As-Practice-In-Context; the everyday activities and actions by which leadership plays out and is experienced, by the “vast bulk of the profession.”

## 5.5 Leadership Education

The aim in relation to leadership education is to explore the needs of leadership education for dentistry, specifically in relation to what leadership development outcomes and approaches are relevant to dentistry.

The Critical Literature Review (2.4) highlighted a need to question assumptions made in relation to the purpose and practice of leadership education in dentistry. Bolden (2011, p.6) argues that “leadership development should be aligned with the organisational culture, context and objectives.” The opportunity to translate the findings of the ethnographic observations of leadership in practice into educational outcomes and approaches therefore allowed for a consideration of how this alignment might be designed. There is an opportunity to do what Collinson and Tourish (2015, p.577) argue for: to “rethink and revitalise leadership pedagogy.”

In this section, the themes identified in the Findings chapter in relation to leadership education are used to guide discussion.

### The Value of Leadership Education

The findings of this thesis emphasise the evolving nature of the dental profession and the need for leadership to reflect this. There was seen to be a need to move away from hierarchical leadership towards the view that leadership is a collective endeavor requiring the engagement of the whole dental team. The rhetoric found in the literature however, reveals a ‘leader-centric’, individualistic thinking of leadership development (Jackson and Parry, 2011), highlighting the distinction between leader and leadership development (Day, 2000). The description used by the ‘Advancing Dental Care Review’ is an example of this:

Leadership development aims to help shape people’s knowledge, skills and behaviours to help them become outstanding leaders.  
Health Education England, 2019a.

The emphasis on knowledge, skills and behaviours and the choice of ‘outstanding’ as a description is also characteristic of the ‘heroic’ versions of leadership theory. An alternative thinking might replace knowledge, skills and behaviours with ‘practice’. This would be based on a Leadership-As-Practice theory of leadership.

Leadership was found to be practised by all members of the dental teams observed in this research and was embedded in the everyday practice of dentistry.

One of the questions raised by the working group participants asked what it means to prepare students for leadership. Is it something that can be taught? There were different views. There is a deeper question of what it means to be taught and the transactional versus transformational distinction described in the Critical Literature Review chapter is useful here. Teaching could be described as transactional whereas education could be considered as transformational: Fromm's (1976) *'Having'* and *'Being'* modes.

From a critical perspective, leadership skills, it is argued, are not "neutral vehicles for achieving unproblematic ends" (Collinson and Tourish, 2015, p.591) and therefore, leadership is a concept that cannot be learned or achieved through being taught.

One working group participant gave their view that students could be prepared for leadership by giving them insight and guidance. This recognises that this is all leadership education can do – in giving opportunities for insight through experience. As Klenke (1993, p.119) describes, this is about giving students "the freedom to pursue the ambiguities and paradoxes inherent in the study of leadership."

### Educational Philosophy

In relation to educational philosophy, the Critical Literature Review (2.4.2) had identified examples of individual and prescribed approaches to leadership education within dentistry (Victoroff et al., 2009; Kalenderian et al., 2013; Roig Jornet and Kalenderian, 2017). There was seen to be a need to follow other areas of healthcare in the use of the competencies (Willcocks, 2016). Competencies were seen as a necessary step in guiding outcomes and enhancing quality (Smith et al., 2016). Within the leadership studies field there are strong arguments against the use of competencies and the functionalism that these are characteristic of (Bolden and Gosling, 2006; Carroll et al., 2008; Huotari and Carroll, 2019). Care is needed here in the terminology used in relation to distinctions between competencies and learning outcomes (O'Brien et al., 2018). These terms should not be used interchangeably with learning outcomes being used as a broader outline of what a student should be able to know, understand, synthesise or demonstrate (as examples). Learning outcomes are not bound by a particular educational philosophy such as functionalism. Competencies are "an integration of knowledge, skills and attitudes indicating a capability to perform professional tasks

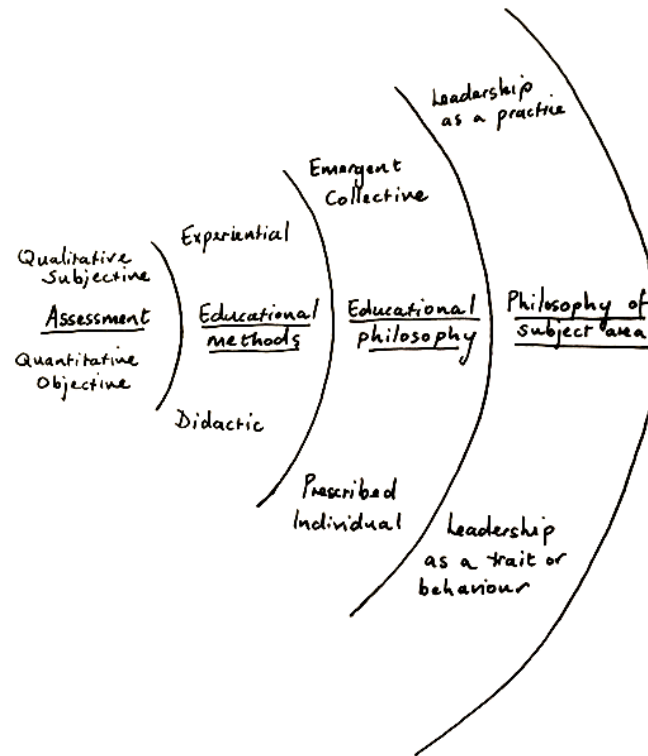
safely and ethically” (Chuenjitwongsa et al., 2018, p.1). They are more prescriptive in relation to what is expected in relation to set standards.

The philosophical approach advocated by the findings of the research in this thesis was ‘emergent’ and ‘collective’ and this takes a more critical educational philosophical approach. A difficulty in this is the expectations set by professional regulators in relation to the need for evidence of learning and meeting certain prescribed learning outcomes. The use of prescribed and individual approaches, with competency-based assessments allows easy demonstration of student learning. The scope for freedom in learning is to a large extent sacrificed to allow this.

Competencies are used across dental education and have become the conventional approach. It is assumed that this approach can apply in the same way across different subject areas. In relation to a subject such as leadership, however, this assumption needs to be questioned, especially when the nature of leadership itself is highly contested as an objective or as a subjective, socially constructed concept (Bresnen, 1995). Advocating for the use of competencies without first understanding the underlying philosophy of a subject such as leadership, goes against the principles of constructive alignment.

Biggs and Tang (2011) describe how assessment and learning methods should be aligned to intended learning outcomes. Outcomes are decided first and learning methods and assessment design follow. Even the principles of constructive alignment, however, do not allow scope for emergent learning with Biggs (2003, p.2) describing how “the learner is, in a sense, trapped and finds it difficult to escape without learning what he or she is intended to learn.” This goes against the critical philosophy of learning and Friere’s (1972) consideration of education as the ‘practice of freedom’. It could be argued that there is something deeper and more fundamental about leadership education which requires attention to the philosophy behind a subject area before considering an educational plan or system.

This could be considered as being similar to the principles of the ‘research onion’ (Saunders et al., 2019) where research philosophy is considered before the methodology and specific methods are chosen for a particular research project. An interpretation of this in relation to education might take the following form of an ‘education onion’ (figure 22) with the layers representing aspects of the design of a system of education. The idea of starting from the outside layer and working inwards helps to illustrate how alignment can be ensured in the design process.



**Figure 18.** 'Education Onion'.

#### Leadership Outcomes: Preparing for Practice?

The examples of leadership outcomes set by dental profession regulators in different countries demonstrate the wide range of interpretations as to what leadership education should include (e.g. compliance with professional regulations, communication skills and risk management). One of the working group participants was of the view that without the heading 'leadership and management', many of these learning outcomes were not necessarily attributable to leadership. One interpretation of this situation is that 'leadership and management' has become an overarching, nebulous heading under which to gather a set of learning outcomes which cannot be placed elsewhere – 'the rest'. In this case, leadership as a concept in itself, loses its own meaning and value. Highly detailed and prescribed and compliance-driven outcomes also do little to encourage engagement in leadership, as described in this thesis. There is also a question of what it means to 'prepare for practice' (General Dental Council, 2015).

The findings of the working groups identify four main areas in relation to leadership learning:

- Awareness – recognises the need for individuals and teams to be conscious of their leadership practice. A critical reflexivity approach, as suggested by the leadership studies development literature, could be valuable here (Sinclair, 2007; Cunliffe, 2009), which would encourage ongoing critical thinking, challenge of assumptions, questioning, and trying to make sense of experiences;
- Empowerment and engagement – recognises the need for all members of the dental team to be involved in leadership. One of the most fundamental outcomes is the need to engage in leadership activities at any level. Without this, learned helplessness and passivity becomes the norm and nothing changes or has the potential to improve;
- Ownership and influence – recognises the need to take responsibility and to act if there is felt to be a need to change things and how to do this effectively through influence;
- Communication, relationships and teamwork– the ‘People’ aspect of the leadership model was found to be key. Communication skills in relation to direct patient interaction is already well covered by most modern dental curricula. However, the importance of communicating with colleagues, listening and building working relationships is not something that receives equal emphasis.

The ethnographic findings themselves, and the constructed leadership theoretical framework, can also help to inform leadership education for dentistry, so that there can be alignment with the relevant “culture, context and objectives” (Bolden, 2011, p.6) of dentistry. Each area of the theoretical framework; challenges, purposes, values, people and practices, can be used as a guide for learning. For example, in being aware of ‘Purposes’ in dental practice, attention can be given to leading the delivery of high-quality patient care, compliance with regulations, and making working lives better. Insight into some of the actions and activities which bring about leadership (the ‘Practices’ area of the framework) can also be used in helping students to observe these in others and to enact and try out for themselves. A focus on the ‘People’ area could also help education to bring attention to the importance of relational leadership.

### Educational Methods

Most of the discussion within the literature in relation to leadership education in dentistry focuses on the need for it and what content it should include. There is

little consideration in relation to the methods that could be used. As the Critical Literature Review outlined, some examples can be found from the US (Kalenderian, 2013). These use, for example, active learning approaches, panel discussions with role models, personal vision planning, lectures, issuing of textbooks and 360° feedback competency. The approach can also involve short, classroom-based learning as seen from the post-graduate leadership course example.

The findings of this thesis emphasised the need for integrated and experiential learning methods. Integrated means opportunities for learning are given throughout the curriculum, at progressive stages. Experiential learning especially through clinically-based education was thought to be key. This is based on a 'practice' approach to education, embedded within the context in which students are actually preparing to work in. Outreach clinics were seen as the most beneficial context for practice-based learning in dentistry. In this environment, student teaching clinics are run in a way which tries as far as possible to replicate the context of General Dental Practice. Student members of the dental team work more closely together to manage and to treat patients. This provides an opportunity for a community of practice and of learning. This aligns with the Leadership-As-Practice perspective on leadership development which highlights the everyday, emergent, relational and contextual aspects of leadership and leadership learning (Raelin, 2016b).

In dentistry, undergraduate students are heavily involved in patient care, sometimes from an early stage. They are, for example, involved in arranging patient appointments, organising their time, liaising with the dental laboratory and working with colleagues (student peers and qualified staff). These are all leadership learning opportunities which emerge from the experience of being within the clinical environment. Students have to learn to cope with unforeseen challenges and are encouraged to reflect on their experiences. This is an example of the Leadership-As-Practice, "scene of everyday action" (Chia, 2004, p.30) and "in-situ, practical coping" (Chia, 2004, p.33), 'dwelling mode' (Heidegger, 1971).

In other healthcare professions, this level of involvement in practice, or the opportunities it brings is not always possible. Learning opportunities often have to be engineered such that students come into contact with patients and work in a team. This means that leadership challenges are not readily experienced, and students can perceive the process as being artificial, as described by one of the working group participants.



### Assessment

As with leadership education methods in dentistry, little attention has been given as to how to assess leadership development. The example of the multiple-choice questions used as part of the post-graduate leadership course in dentistry which were given in the Critical Literature Review (Roig Jornet and Kalenderian, 2017) represent a quantitative, objective approach. The findings of this thesis were that the opposite of this type of approach should be used: qualitative, continual and subjective assessment. It was also found that formative rather than summative assessment should be used. Examples such as reflective assessments based on real, clinical events could encourage students to engage in critical thinking and reflection. The disadvantage of these, however, is that this critical thinking and reflection actually occurs well after the event, at a time set by the teacher with a set deadline. Students are therefore not encouraged to engage in critical reflexivity which occurs more contemporaneously, alongside their practical experience. One way to encourage this would be to utilise systems which are already in place to allow student reflection. In dentistry, online systems (Examples: CAFS – Clinical Assessment and Feedback System and LiftUpp) allow students to record their work experience – what clinical work they have completed as well as their own reflection on the process. Students could be encouraged to reflect not only on their clinical procedural work but also on their leadership, teamworking and communication skills. There is an opportunity to design a set of leadership related critical reflexivity prompts to encourage engagement in this.

A challenge in using formative assessments is that students often don't attach the same significance to them as they do summative assessments. Students often value what they need to do to pass or to get a good grade. There is, however, a growing professional need for students to demonstrate their development via the use of Personal Development Plans (PDPs). Including leadership experience would give students more experience to develop and demonstrate their learning and critical reflexive abilities.

The use of OSCE (objective, structured, clinical examination) to assess leadership was proposed by working group participants. This is traditionally used as a highly controlled, summative type assessment. It may be that its format – where students move round a series of stations interacting with simulated patients or engaging in technical tasks, could be adapted. It could, for example, become a formative type assessment (F-OSCE) (Harrod and Gomes, 2017; Bernard et al., 2017) with students being given feedback immediately following each station and it could

include leadership scenarios where instead of managing patient-related communication issues, relational issues involving members of staff could be designed. This is still an example of prescribed and controlled learning, however it could have benefits in the undergraduate dental curriculum.

### Challenges

Many of the challenges reported in relation to the provision of undergraduate level leadership education relate to the already heavily packed curriculum and the difficulty of adding more. There was seen to be a need to take something out of the curriculum in order to put leadership in (Smith et al., 2016). The working group participants did not want to see clinical time being lost. The use of clinical, practice-based leadership education would address this problem. Leadership learning is embedded within the clinical experience, it is not separate to it and therefore, a specific additional course in leadership is not necessarily needed. Students could be prompted to read about various leadership theories and practices and to use these in their own critical reflexive accounts.

### Summary

The educational philosopher John Dewey argued that the design of systems of education (methods and assessments) indicate to students what the system itself values (Biesta and Burbules, 2003). Even if a system of education is efficient and effective, if it does not reflect the values that are important to a subject or a profession, the system should not be advocated. The construction of a set of specific leadership competencies has been argued for in the dental education literature. This thesis does not provide such an outcome.

The design of a system of leadership education for dentistry needs to ensure that it reflects the values found within the dental profession. Care and thought are therefore needed in the design of education. Dewey described this as making education more 'intelligent' (Biesta and Burbules, 2003). He argued against the use of educational prescriptions and universal approaches. In arguing for competency type approaches for leadership in dentistry, the risk is that conformity and prescription will result. Dental educators must be critical thinkers too. In following the path taken by other healthcare professions, dental education, in relation to leadership, would effectively be hiding behind convention.

This thesis has argued for a rethinking of leadership education for dentistry so that it can more meaningfully prepare students for their careers in dental practice and

encourage them to engage in leadership for the benefit of the dental profession. A practice and contextual approach to leadership and leadership education is offered as an alternative to conventional approaches.

## **5.6 Discussion – Closing Notes**

This chapter has discussed a rethinking of leadership for dentistry and has brought together the literature and the findings of the exploratory research. The discussion makes suggestions for ways in which the dental profession might develop its thinking in relation to leadership by taking a ‘practice and contextual’ theoretical approach to the interconnected dimensions of leadership: theory, practice, research methodology and education.

In the following, final chapter a set of conclusions are presented in relation to the aims of the thesis.

## 6. Conclusions and Contributions

This final chapter presents the conclusions and contributions of the thesis in relation to an overall rethinking of leadership for dentistry and makes recommendations for further research and policy direction.

This thesis has provided an opportunity to develop the thinking in relation to leadership in dentistry, as called for in the dentistry literature. The UK national policy agenda for leadership in the dental profession (especially in relation to the dimensions of 'practice' and 'education') has emerged rapidly over very recent years and the extent to which this has been based on a specific, contextual understanding of leadership in dentistry, rather than a simple replication of policy developments found in other areas of healthcare is unclear. It is clear however that leadership is seen as important to dentistry.

The findings of this thesis are therefore both timely and relevant. They demonstrate how academics situated within universities (in dentistry and the wider leadership studies field) can develop thinking and produce research which has the potential to influence policy and practice and which is worth paying attention to.

### 6.1 Core Contributions

This thesis makes core contributions in relation to the areas of leadership theory, practice, research methodology and education and demonstrates how these are interlinked and aligned.

#### Leadership Theory

- Surfaces and questions assumptions in leadership thinking in dentistry by taking a critical perspective in relation to leadership theory and how this influences approaches to practice, research methodology and education;
- Extends the Leadership-As-Practice and Leadership-Practice-In-Context theoretical approaches in relation to the importance of a contextually specific understanding which recognises the dimensions of 'Challenges', 'Purposes', 'Values', 'People' and 'Practices';

- Modifies a meta-theorising framework for leadership which can be used to help to understand and make sense of leadership needs across different contexts.

#### Leadership Practice

- Presents an alternative thinking of leadership for dentistry based on empirical, exploratory research which engages deeply in the world of practice and the experience of practitioners using a Leadership-As-Practice-in-Context lens;
- Revitalises leadership thinking for the specific context of General Dental Practice which is at the frontline of patient care delivery; acknowledging its complex, embodied, relational and sustained nature.

#### Leadership Research Methodology

- Presents a rare example of practice-based research which uses innovative and crafted ethnographic observation and collaborative academic – practitioner involved methods which helps to illustrate the value of interpretivist, subjectivist and qualitative research.

#### Leadership Education

- Presents a rethinking of leadership education for dentistry which recommends the use of a 'practice' approach to education which reflects the culture, context and objectives of the dental profession, specifically;
- Suggests a way to inform the alignment of subject related philosophy with educational philosophy, methodology, methods and assessments – the 'Education Onion'. This can help to ensure that a subject such as leadership is not treated in the same way as a technical skills subject.

## 6.2 Conclusions

In relation to the dimensions of leadership used to structure this thesis, conclusions are made.

### Leadership Theory:

- A move away from the essentialist, romanticist and dualist characteristics of heroic leadership towards more collective and critical concepts of leadership is advocated;
- A 'practice' perspective on leadership (Leadership-As-Practice-in-Context) helps to demystify leadership to understand where, when, how and why leadership is done (Raelin, 2016a, p.134) in the everyday dental practice context and demonstrates how this is more useful and valuable than a focus on abstract theory or on heroic individuals;
- A tailored theoretical framework for understanding leadership for dentistry has been constructed which helps to make sense of what areas leadership needs to be involved in and what it needs to do: challenges, purposes, values, people and practices;
- It is suggested that the theoretical framework be used for educational purposes in helping students (at whatever level) to make sense of leadership within their own scope of practice.

### Leadership Practice:

- The work of this thesis brings back a focus on leadership within the everyday, frontline practising environment, where the 'vast bulk of the profession' are situated and gives a voice to those in the profession who, traditionally, might not be perceived as having a leadership role;
- Leadership within General Dental Practice happens in everyday, mundane and unheroic routine work; it is often 'on the hoof' and improvised. This is demanding, and more support is needed for practitioners to help them make sense of this;

- The socially constructed nature of leadership as a lived experience is demonstrated. Insight is given into how leadership in the General Dental Practice context can be experienced in different ways: as participative, collaborative and distributed or as autocratic and compliance driven;
- The challenge of relational leadership and a focus on 'People' is particularly pertinent to the dental profession. The purpose of leadership is not just about achieving efficiency and effectiveness, but in helping to improve the working lives of members of the profession. More attention and support are needed in this area;
- Values are constructed and maintained inter-relationally and are embedded in personal experience;
- The practices involved in leadership in General Dental Practice are revealed and these are undertaken by all members of the dental team;
- Judgements in relation to the effectiveness of leadership found within General Dental Practice often focus on compliance with regulations and the efficiency of the organisation. These judgements can be superficial and there is a danger that the lessons learned from the Francis Report, and other healthcare related inquiries are not meaningfully put into practice.

#### Leadership Research Methodology:

- Crafting of research (process and methods) can reveal a more nuanced and resonant account of leadership, which are specific to certain contexts;
- The ethnographic observation method has value in revealing the everyday nature of leadership practice and culture in dentistry with its complexities, tensions, contradictions and ambiguities;
- Comparative ethnography helps to highlight contrasts in leadership styles;
- The value of collaborative Practitioner - Academic research is demonstrated in generating practice-relevant findings in relation to leadership as it is found in dentistry;

- Despite the challenges involved, ambitious research which moves away from conventional approaches is achievable within the healthcare context;

Leadership Education:

- The alignment of educational philosophy with the philosophy behind a subject area is key in designing a system of education which is meaningful, for example, the socially constructed nature of leadership and emergent and collective approaches to learning;
- Suggested learning outcomes are informed by the findings of the ethnographic observations in General Dental Practice and on the insights of practitioners. These highlight the areas of awareness, empowerment and engagement, ownership and influence and communication, relationships and teamwork. In this way they align with the culture, context and objectives of the dental profession which requires active engagement in leadership across its members. The value of critical reflexivity as a leadership education outcome is advocated;
- An emergent and collective educational philosophy is advocated, this is opposed to a prescribed and individual approach and moves away from competency-based education;
- Experiential and integrated methods and continual, subjective and formative, qualitative assessment types are advocated;
- In the dental education context, outreach-based learning is seen as an ideal opportunity for students to engage in leadership learning and development through a community of practice within a clinical practice-based environment. This is an example of a Leadership-As-Practice perspective on development;
- Many of the challenges reported in relation to the provision of leadership education in dentistry can be overcome by its integration within current clinical practice learning experiences.



## **6.3 Recommendations for Further Research and Policy**

### **Direction**

There are opportunities for both dentistry and leadership studies to develop the thinking presented in this thesis in relation to theory, practice, research methodology and education.

#### For dentistry:

In relation to further research, there is an opportunity to:

- Conduct further empirical research in relation to leadership in dentistry to inform policy developments;
- Extend the scope of research context in dentistry in relation to leadership – to explore leadership across the profession (e.g. in community practice, secondary care, Local Dental Networks, Health Education England, the Office of the Chief Dental Officer and NHS England) – its challenges, purposes, values, people and practices;
- Extend the focus of enquiry to include the critical leadership issues of power and hierarchy as well as gender relationships within dental teams;
- Extend the use of a variety of qualitative methods to explore leadership in dentistry and to extend the involvement of practitioners in the design and participation in research;
- Conduct further research which uses qualitative research methodology and interpretivist research philosophy and to demonstrate the value and of this for dentistry;
- Engage with educational stakeholders across the dental profession (dental nursing education, undergraduate, postgraduate, specialist and continuing professional development providers) to research and develop leadership education approaches specifically for dentistry.

In relation to further policy developments:

- A greater liaison between academic researchers, practitioners and policy makers within the profession is needed to ensure that policy developments are evidence based and relevant;
- A more critical approach is needed to challenge assumptions made within the profession about leadership: where, when, how and why it happens;
- The dental profession needs to move away from a focus on identifying and training heroic individuals towards a commitment to the whole dental team within everyday dentistry, and to particularly value the leadership work of dental nurses;
- There is a need for better understanding and the acceptance of research philosophy and methodology within the dental profession and the dental research community. More explanatory literature and high quality examples are needed;
- Educational policy makers need to engage in the leadership studies and leadership development literature to better understand the particular issues involved in leadership education. This needs to involve a critical approach to education.

For leadership studies there is an opportunity to:

- Engage further with professions to make sense of leadership by providing an academic base and a critical perspective;
- To apply the meta-theoretical framework to help different professions or organisations to help them to make sense of leadership within their own specific contexts;
- Conduct more empirical, co-produced and practice-based research to build an evidence-base by which professions can inform their leadership practice and development;

- To undertake further research studies which use a Leadership-As-Practice-In-Context perspective and which can be used as examples to illustrate its value.

## **6.4 Final Remark**

The overall aim of this thesis is to provide an opportunity to rethink leadership for dentistry. In any rethinking, a commitment to critical thinking and exploration is essential. It is often uncomfortable and unsettling. However, what emerges from this process can be enlightening and revitalising and helps to make thinking more conscious and intelligent - and practically useful. It is hoped that this way of thinking will set an example.

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## **Appendix A: Collaborative Working Group Session Scenarios**

### **Collaborative Working Group 1**

#### **Practice 1: Westby**

##### **Telling the story:**

##### **How everyday work contributes towards achieving a strategic goal**

#### **High patient satisfaction levels and established reputation of the practice**

Monday morning, start of the day.

Radio on, fish fed, answer machine switched off.

The phone starts to ring. Multiple patients are asking for emergency appointments.

Nurse checks the patient list while cleaning down the surgery ready for the first patient. There is a problem – an overbooking.

Receptionist is quickly aware, dentist is informed. They will see the overbooked patients; it will mean a busy start to the morning - they all agree.

Receptionist is multi-tasking with patients arriving and phone conversations going on simultaneously. There are emergency slots in the book and appointments are checked with the dentist. Multiple patient needs must be considered and managed. Prioritising decisions need to be made, explanations to patients are given; communication between dentist and receptionist is essential.

Problem solving is done together – they think on their feet, in between patient consultations, and decisions are made- dentist asks “Is that fair?, do you agree?” – decisions are confirmed. Communication is direct- quick and clear: “right.....”. Summaries of decisions are given so everyone knows the situation. Everyone is focussed. The proximity of the

surgery and reception mean that communication is sometimes done without actually seeing each other. Receptionist doesn't mind pointing out things the dentist may not have considered and vice versa. Dentist gives advice and reassurance to the receptionist.

Dentist and nurse frequently go through to reception to check appointment bookings when free. Receptionist will also go through into the surgery. Much of the communication is done in front of patients, everyone is mindful of this.

It's busy, multiple patients come and go. Patients are greeted by their names, in many cases their first names. Patients also greet the dentist by his first name. There is reassurance, apology and explanation about appointment times.

Nurse on decon duties helps to greet patients, sorts out paper work so receptionist can concentrate on the phone and emergency appointments. Apologies for the waiting time are made. Patients are understanding.

Everyone knows the task, they work to ensure patients can be seen and make all efforts to fit patients in for emergency care.

10am back on track, quiet. Kettle on.

There is acknowledgement of the busy start: "that was full on!" It's Monday morning, this is usual. There is humour and philosophical relief "It's all done with a smile".

There is reflection about how the situation was managed, feedback is sought. Did they make the right decisions? Everyone inputs and there is reassurance that they did all they could.

Dentist is constantly busy, onto the next thing. There are regular checks upstairs to see the new DF1 dentist to offer advice and support. An autoclave also needs to be looked at in-between patients.

Nurse: "xxxx does very well, he keeps calm: he's very good really. I hate to admit it.

## Practice 2: Northby

### **Telling the story: How everyday work contributes towards achieving a strategic goal**

#### **Successful outcome of a CQC inspection**

There are high standards to maintain. This is a legacy from the past, a culture that is maintained now. "It's what I grew up with" says the Clinical Manager. The aim is to go above and beyond the given regulations. "If the CQC came in we wouldn't need to panic but we don't rest on our laurels".

On the walls of the reception, the staff room and surgeries are reminders of policies, regulations and reporting mechanisms. It is usual to see the Practice Manager checking and updating these, it's part of the routine. "I am always on the BDA website to check for updates". There is obvious pride in fulfilling the regulations and enforcing high standards.

Regular checks are made. Spot checks are used, some explicit, but mostly there is ongoing awareness.

Nurse meeting notes 09/01/17

- When working in the decon room, full PPE needs to be worn in the dirty side, this is for your own safety. I'll be popping my head in every now and again.
- Expiry dates on pouches and materials must be checked weekly, found some LA cartridges in a surgery 3 years out of date!!!!!!

Decontamination and cross-infection compliance is a priority.

At an appraisal meeting there is reflection as to how to get others involved in maintaining and improving standards. The importance of positive reinforcement, acknowledging and prompting is discussed. It's not always easy to get others to change: "they get set in their ways". This is the challenge.

Patient satisfaction survey results need to be reported. Verbal comments made by patients are not recorded and included in the results. How can this be changed? A suggestion by reception staff that they record comments in a designated book is discussed with the Practice Manager.

A dentist reflects on their CPD activity: "Its easy to get in a rut with CPD, I did the very minimum but then I really caught up". At the staff meeting they discuss the topic of whistle blowing, this is an example of ongoing staff training. The Practice Manager facilitates the

training, members of the team are asked for their answers, they are all required to complete an online CPD course on this topic – the deadline is next week, there is a sheet pinned to the wall of the staff room which they must sign to record completion.

A dentist reflects: “here it is very well run, you know who is responsible”. The practice manager is very experienced. She has a proactive approach. She structures her day, but has to be flexible, she has a monthly plan and knows when the deadlines are: “It’s up here, it’s not written down”. “I like things to be organised”. There are regular conversations with the practice owner and the clinical manager. “Everyone looks up to her and wants to try to live up to her high standards” they agree.

“This is a tight ship” reflects a nurse.

“What audits shall we do next?” asks the clinical manager.

“The better the practice is run – we can invest more” the practice owner reminds.

## Collaborative Working Group 2

### Practice 1: Westby

#### Telling the story:

### How everyday work contributes towards achieving a strategic goal

## Creating a supportive working environment

Monday, reception.

Patient: "you just can't get the staff"

Nurse: "I heard that!"

Dentist: "you're right there....., only joking"

Patient reading 'The Times' Newspaper. Headline article:

The Times Newspaper Monday October 10 2016

Happiness is the best medicine, grumpy doctors and nurses told.

Doctors, nurses and other NHS staff need to be more positive at work, the new whistleblowing chief for the health service has said.

"If you bring a positive attitude to work with you then you start seeing all those benefits of working well as a team". Henrietta Hughes.

She said that "every single person" in the health service had to help to make it a happier place to work and end a culture of bullying and poor care.

Dr Hughes urged staff to "start living...the NHS that they want to work in".

Whistleblowers have criticised her 'utopian' approach.

Patient to nurse xxx: are you happy?

Nurse xxx has worked in the practice for 12 years.

Nurse xxx when interviewed: We're all you know pretty friendly and we all have a little bit of friendly banter when it's appropriate erm and occasionally we go and have a meal together so we socialise so I think that's probably the best way to keep morale up.

Nurse yyy is on reception, answering the phone, sorting out paperwork and making patient appointments. She had started in the practice only a few weeks ago to cover maternity leave, having been in a previous practice for over 15 years. "I like this practice because of the 'family' feel". The previous practice had multiple surgeries and a large staff group. Being on reception is difficult. There are different ways/ systems of doing things here that need to be learned and adapted to and she is coming into an already established group of staff.

Nurse xxx when interviewed:

I think we work more or less as a team, I mean the more experienced staff like myself I suppose have a little bit more responsibility to you know when new staff come in, to set an example so they obviously know what's expected, allowed and not allowed and a little bit of in-house training like the computer or things like that.

Nurse zzz when interviewed:

I was always mindful that to look after young people when they started because you know it's hard and they need help and support.

Nurse zzz has worked in the practice for 8 years but has been dental nursing since she was 17. She is mindful of her own experiences many years ago when she was starting out. She notices things, a sort of emotional intelligence and talks about the advice she has given to staff members in the past "sometimes you have to point out how people are feeling because when everyone is busy they don't always notice it". She has a calming influence on everyone and acts as a mediator and advocate.

Nurse zzz offers nurse yyy reassurance: "It's hard. Are you ok?"

Nurse zzz: I want people to be able to come to talk to me if things are not right or if you think that they could change or something you can see is not right.

Meanwhile, it's time for the kettle to go on – it's been another busy morning. Dentist 1 comes pops his head into the reception: ooh, can I have a cup of tea and a lie down?....I'll do a referral". He is thinking about what's next.

Later, towards the end of the day, there is acknowledgement and checking that everyone is ok before they leave: Dentist 1: "Well done today".

Dentist 2: "I feel, on the whole, they (nurses) kind of balance things between them and lead each other really, which in the absence of a head nurse I think here works very well".

Dentist 1: "We're actually a support group for each other, the dentistry sort of comes second!"



## **Practice 2: Northby**

### **Telling the story: How everyday work contributes towards achieving a strategic goal**

#### **Retention and development of staff within the practice over many years**

01/06/17 Practice Attendance Board

20 members of staff 'IN' today. All busy, 6 surgeries working.

There is a well established staff group including:

- The practice manager who has been working in the practice since she was 18 – starting as a trainee nurse – a 42 year career.
- The principal and practice owner started in the practice as a trainee dentist 14 years ago.
- Another dentist has been in the practice for 21 years.
- A receptionist has been working here for 14 years
- The clinical manager started as a trainee nurse, left to move to another practice and came back. "It's a different culture here. In the other practice the bottom line was money – just not personal." "I learned from xxx and the dentists here and that was what I grew up with".
- A clinical dental technician has been here for 35 years. He was encouraged and mentored to develop his role by the previous owner of the practice.

The practice manager recalls a Yorkshire saying: "I knew you when you ad'nowt." She's been here longest and knew the current principal when he was a trainee and now works for him. She is proud of the fact that many nurses in particular have stayed in the practice. There is an awareness of needing to be fair in her approach. "I wouldn't ask anyone to do anything I wouldn't do myself. In the past I've swept the pavement outside the practice and polished the brass plaque. I've done it all."

"xxx is always there for you" is the general feeling. "She runs it (the practice) with a reasonably firm hand but she listens to people and will bring stuff up that needs bringing up as well". Her office door is open throughout the day and she is frequently out and about in the practice.

A new generation of staff is also developing in the practice: 2 DF1 trainees and 2 apprentice dental nurses. "If we have the same people day in, day out doing the same menial tasks then you'll stagnate; there's no buzz in the practice". Maintaining motivation is seen as an important part of staff management and to keep up the momentum for training.

The dental technician offers feedback to the DF1 trainees on their work. He enjoys this aspect of his work and can see the importance of encouragement when developing

trainees. They see the practice manager regularly and freely ask questions in addition to working with their trainer.

“There’s things that you don’t know and if you just went ahead and did things as you think, you’d get them wrong and you would just look stupid. If there’s someone who’s been there and done it – you might as well use it” – DF1.

The clinical manager supports the trainee nurses giving feedback on their portfolios. A few months earlier, the practice manager had picked up the trainee nurses on feedback she had received on their progress.

One of the qualified nurses has a notebook with written lists of procedures and materials preferences for each dentist – she shows this to the apprentice nurses to help them out. There is a buddy system of mentoring. There is a trail of three nurses in the practice who have consecutively mentored the next trainee.

The clinical manager is also adapting to her new role as a manager. There is a chance to discuss this at her appraisal meeting. There are challenges but support is offered by the principal and the practice manager. She is asked “overall, are you getting satisfaction and enjoyment from it?”.

The practice manager reflects on her own experiences over the years. “Sometimes you need reassurance and acknowledgement for good work. We all have a breaking point though; I’m human too”.

“Both sides benefit from the fact we are a training practice. It keeps you on your toes”.

#### CQC report

There was a clearly defined management structure in place and all staff felt supported and appreciated in their own particular roles.

Staff hold us there was an open culture within the practice.

# Appendix B: Collaborative Working Group Presentations

## Collaborative Working Group 1 Presentation


School of Dentistry  
Faculty of Medicine & Health  
UNIVERSITY OF LEEDS

### Preparing for Practice: Leadership Education for Dentistry

Outline of Working Group Session

- 6.30pm Introduction and aims
- 6.40pm Discussion: Dental practice scenarios
- 7.15pm Dinner (Level 7)
- 7.45pm Discussion: Leadership education
- 8.30pm End

Jane Wardman  
Clinical Lecturer and PhD Researcher




School of Dentistry  
Faculty of Medicine & Health  
UNIVERSITY OF LEEDS

### Working Group Session

#### Preparing for Practice: Leadership Education for Dentistry

Jane Wardman  
Clinical Lecturer and PhD Researcher



School of Dentistry  
Faculty of Medicine & Health  
UNIVERSITY OF LEEDS

### Overall aim

To produce leadership education/ development approaches to prepare dental students for the everyday needs of practice

### The process

- A collaborative process – equal partners learning from and influencing each other
- Learning from practice
- Involving all members of the dental team
- A positive process



School of Dentistry  
Faculty of Medicine & Health  
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### Working groups

Aims of the session:

- To identify examples of the 'where', 'what', 'why' and 'how' of leadership in everyday general dental practice
- To consider our students, their future and how we best prepare them for leadership in practice

Focus of working group sessions:

Session 1: Leadership for Patient Benefit

Session 2: Leadership for Staff Benefit

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### Dentistry needs to be doing leadership!

Review of NHS Dental Services in England  
Stevenson Report, 2009

There is a deficit of leaders within the profession  
Marrison and McMichael, 2013

"There is a need to 'grow' more leaders"  
Marrison and McMichael, 2013

"The vast bulk of our profession don't really get exposed to the opportunity to become a leader."  
Marrison and McMichael, 2013

There is a need for dental professionals to "get out of the surgery and into the leadership academy"  
Ford, 2014



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### Dentistry doing leadership



How leadership emerges and unfolds through day-to-day experiences  
Carroll et al., 2008

Micro-practices and everyday routines. The nitty-gritty details  
Chia, 2004

The unheroic work of ordinary practitioners  
Whittington, 1996

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## An opportunity to rethink....

**Recent dental literature calls for:**

- A rethink of the role that leadership plays in dentistry
- A need to outline the leadership requirements for the profession
- A need to involve the whole dental team
- The development of new approaches to leadership
- A need to develop leadership education at all levels

*Clarification of the conceptualisation of leadership being used in any given setting is an important pre-requisite for effective leadership development.*  
Hartley and Bennington, 2010

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## Group work

Scenarios

- The collection of people's stories of something at its best
- Learning from scenarios where there was a positive outcome

Guidelines

- Respecting confidentiality of participants outside the group
- Respecting confidentiality of content – organisational, individual, educational
- Audio recording – purpose and use
- Note taking

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## Learning from Practice

### Leadership for patient benefit

Each practice group takes a scenario where there has been a positive outcome

- Why does this success matter to your organisation?
- What inspired you to become engaged in achieving this goal?
- Work through the scenario - what acts, activities and interactions were involved?
- What 'unheroic' work was involved?
- What difference did you make working together?
- Continue the story of how this success was achieved
- What themes appear from these scenarios that are worth others learning from?

*For individual participants in training positions:*

- How have you benefitted from being involved in these successes?
- What have you learned that you can apply to your future practice?

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## Scenarios from Practice

### Practice 1

High patient satisfaction levels and established reputation of the practice

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## Scenarios from Practice

### Practice 2

Successful outcome of a CQC inspection

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## Preparing for Practice

**Break -**  
Level 7 Airport Lounge

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**Leadership Education** School of Dentistry  
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Management and leadership should be embedded in training from the outset of their career  
General Dental Council, Preparing for Practice, 2015



**Preparing for practice**  
A forward thinking and innovative dental education syllabus.



**The School of Dentistry at Leeds**  
A forward thinking and innovative dental education syllabus.

Our forward-thinking syllabus focuses on the integration of science with clinical dentistry, personal and professional development and self-directed learning. Features include early clinic exposure in the first year of study; an emphasis on research, project management and critical thinking; and highlights the importance of communications and **leadership skills** while working as part of the dental team.

**Outcomes for dentists**

- Clinical
- Communication
- Professionalism
- Management and Leadership

**Growing leaders....** School of Dentistry  
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Many leadership programmes ... promise to turn students into inspirational leaders capable of impacting powerfully and positively on the world.  
Tourish et al., 2010

|             |   |
|-------------|---|
| Aims        | "to empower dental and dental hygiene students to envision and promote cultural changes.... those willing to wrestle with global issues facing the dental profession" |
| Admission   | Selective process   |
| Requirement | Optional and extra-curricular   |

Kalenderian et al., 2013, p.1511

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**Translation into leadership education**

- What leadership development / educational outcomes do we want to achieve?
- What values do we want to bring to leadership education?
- What are the best ways to engage / inspire our students in leadership issues?
- How can we use the curriculum to do this?
- What student transition points do we need to link to?

Those teaching leadership should themselves be reflexive about their purpose, values, assumptions and classroom practices.  
Collinson and Tourish, 2015

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**What next?**

- Further observation work in dental practices
- Second working group session – focusing on leadership for staff benefit
- Development of example educational materials and resources

## Collaborative Working Group 2 Presentation


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### Preparing for Practice: Leadership Education for Dentistry

Outline of Working Group Session

- 6.30pm Reflections on last session and aims
- 6.40pm Discussion: Dental practice scenarios
- 7.15pm Dinner
- 7.45pm Discussion: Leadership education
- 8.20pm Reflections on the process
- 8.30pm End

Jane Wardman  
Clinical Lecturer and PhD Researcher




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### Working Group Session

#### Preparing for Practice: Leadership Education for Dentistry

Jane Wardman  
Clinical Lecturer and PhD Researcher




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### Overall aim

To produce leadership education/ development approaches to prepare dental students for the everyday needs of practice

### The process

- A collaborative process – equal partners learning from and influencing each other
- Learning from practice
- Involving all members of the dental team
- A positive process



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### Working groups

**Aims of the session:**

- To identify examples of the 'where', 'what', 'why' and 'how' of leadership in everyday general dental practice
- To consider our students, their future and how we best prepare them for leadership in practice

**Guidelines**

- Respecting confidentiality of participants outside the group
- Respecting confidentiality of content – organisational, individual, educational
- Audio recording – purpose and use
- Note taking

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### Reflections on session 1

- Everyone has a leadership role to play
- Ordinary situations can reveal significant leadership issues
- Reflection is a useful process in helping to realise the significance of ordinary situations
- Leadership is a very practical process and it should be learned in a practice situation
- Embedding learning into clinical experience is essential
- There is a need for more interaction and joint learning between student members of the dental team

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### Learning from Practice

#### Leadership for staff benefit

Each practice group takes a scenario where there has been a positive outcome

- What main themes/ issues arise from the scenario?
- What acts, activities and interactions were involved?
- What moral, emotional and relational aspects, if any, were involved?
- How do you bring out the best from others working in your team?
- What makes working in your organisation feel fulfilling?
- Why does this matter in the success of your organisation?

*For individual participants in training positions:*

- How have you benefitted from being involved in these successes?
- What have you learned that you can apply to your future practice?

Scenarios from Practice

Practice 1

Creating a supportive working environment

7

Scenarios from Practice

Practice 2

Retention and development of staff within the practice over many years

8

Leadership Education

Management and leadership should be embedded in training from the outset of their career  
General Dental Council, Preparing for Practice, 2015



Outcomes for dentists

- Clinical
- Communication
- Professionalism
- Management and Leadership

9

Preparing for Practice

Translation into leadership education

- What themes appear from the scenario that are worth others learning from?
- What do we want our students to learn/ experience/ develop?
- What kinds of learning opportunities could be provided?
- How could the learning be assessed?

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Preparing for Practice

Discussion: Dental Education

Group A

Group B

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Preparing for Practice

Reflecting on the process

**Please complete on the sheets provided**

- What effect, if any, has reflection on the scenarios had on you personally or as a group?
- What have been your experiences of working with others (academics/ practitioners) in the group?
- What are your hopes for the next generation of dental professionals?

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## Working Group 3 Presentation


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### Preparing for Practice: Leadership Education for Dentistry

Outline of Working Group Session

- 4.30pm Welcome, aims of the session
- 4.40pm Outcomes of previous working groups
- 5.10pm Educational design principles
- 5.30pm Development of specific examples of leadership education activities
- 6.20pm Summary and outcomes

Jane Wardman  
Clinical Lecturer and PhD Researcher



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### Leadership Education

Management and leadership should be embedded in training from the outset of their career  
General Dental Council: Preparing for Practice, 2013

Outcomes for dentists

- Clinical
- Communication
- Professionalism
- Management and Leadership

Many of the learning outcomes in this domain are knowledge or principle based.

Where there is a requirement to demonstrate aspects of leadership and management in the team this may be at a limited level, related to the basic requirements of delivering care within the dental team.

There will be opportunities during clinics and outreach placement to demonstrate and reflect on the use of these skills.

Evidence may be collected in a portfolio, including simulation where an opportunity or scenario does not arise.




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### Overall aim

To produce leadership education/ development approaches to prepare dental students for the everyday needs of practice

### The process

- A collaborative process – equal partners learning from and influencing each other
- Learning from practice
- Involving all members of the dental team
- A positive process



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### Working groups

Aims of the session:

- To review the outcomes of previous working groups – Leadership-in-Practice-In-Context
- To discuss how educational design could be used to engage students in leadership
  - educational approaches
  - Methods
  - Assessment and evaluation
- To develop specific examples of leadership education activities

Guidelines


- Respecting confidentiality of participants outside the group
- Respecting confidentiality of content – organisational, individual, educational
- Note taking
- Photographs of paperwork

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### Leadership-In-Practice-In-Context

Leadership is only of value if it is shaped by, and responds to, the needs of a particular context.

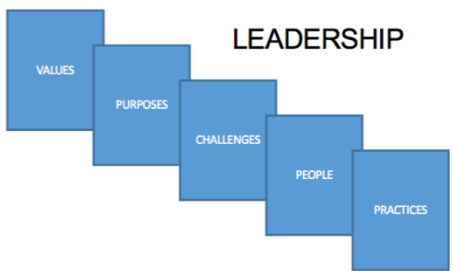
How does this apply to the dental context?



What leadership VALUES, PURPOSES, CHALLENGES, PEOPLE and PRACTICES are relevant in our context?

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### Outcomes of previous working groups





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### Outcomes of previous working groups




EDUCATIONAL DESIGN

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### Engaging students in leadership

How should our leadership education design be used to engage students in these VALUES, PURPOSES, CHALLENGES, PEOPLE and PRACTICES?



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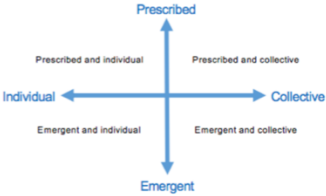
### Engaging students in leadership

How should our leadership education design be used to engage students in these VALUES, PURPOSES, CHALLENGES, PEOPLE and PRACTICES?

- What educational style would best suit this approach to leadership?
- What educational methods would best be used to give our students the opportunity to engage in this approach to leadership?
- How would we and our students know if they had engaged in leadership practices? What approaches to assessment and evaluation should be used?

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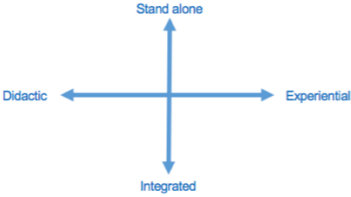
### A framework of leadership development



Rodgers et al (2003)

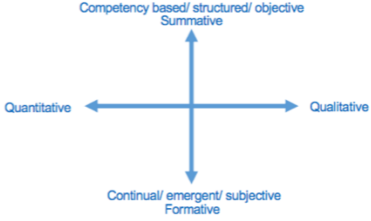
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### A framework of leadership development methods



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### A framework of leadership assessment and evaluation



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### Design of leadership education activities

Using our agreed educational principles, outline a leadership education activity  
e.g. for use in the early years of the programme  
e.g. for use in the clinical practice environment

```
graph TD; Values --- Leadership; Purpose --- Leadership; Challenge --- Leadership; People --- Leadership; Practice --- Leadership; Values --- Purpose; Purpose --- Challenge; Challenge --- People; People --- Practice; Practice --- Values;
```

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### Summary and outcomes

