

Role transition and hybridisation of the medical identity: The impact of leadership development on doctors in the UK National Health Service

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CONTENTS

	Page No
Contents	1
List of Tables.....	5
List of Figures.....	5
Introductory chapter	6
Chapter 1: Strategies to achieve a new medical professionalism.....	21
Introduction.....	21
1.1 Characteristics of the medical profession	22
1.2 NHS Organisations and doctors’ historical orientation towards their management.....	25
1.3 Scholarly views on organising according to professional values.....	26
1.4 Changing the conditions and ways in which doctors practice	28
1.4.1 The introduction of new practices and ways of working	29
1.4.2 The introduction of a new management cadre and other structural changes	30
1.5 An emerging discourse of clinical leadership	33
1.6 Developing doctors as leaders	37
1.6.1 The medical academy’s objectives for leadership development	40
1.6.2 The extent of development to date	42
1.7 The case for leadership development as a potential mechanism for change.....	44
1.7.1 Growing support within the profession for leadership development	44
1.7.2 Management has the potential to become more attractive	45
1.8 The case against leadership development as a potential mechanism for change.....	47
1.8.1 A hostile medical culture.....	48
1.8.2 A lack of incentives to take on leadership roles.....	49
1.8.3 The deeply embedded nature of medical professionalism.....	50
1.9 Conclusions and remaining questions.....	52
Chapter 2: Leadership Development for Doctors	53
Introduction.....	53
2.1 Existing frameworks for examining leadership development.....	54
2.2 Exploring leadership development through a framework of work role transitions	56
2.2.1 Nicholson’s theory and model of role transition	57
2.3 How might leadership development facilitate role transition?	65

2.3.1 Achieving the objectives: Training or development?	65
2.3.3.1. Potential problems in the process.....	73
2.4 Summary and emerging research questions.....	75
Chapter 3: Research Methodology.....	77
Introduction.....	77
3.1 Guiding perspective.....	77
3.2 The Research Strategy.....	79
3.2.1 Considerations in the study design	80
3.2.1.4 Minimising the possibility of selection bias.....	84
3.3 Conducting the research	86
3.3.1 Selection of an intervention	86
3.3.2. Selection of a cohort of participants	87
3.3.3 Collecting the data	90
3.3.3.2 Collection of secondary data sources.....	96
3.3.4 Analysing the data	98
3.4 Issues faced in the research process.....	100
3.5 Summary.....	101
Chapter 4: The Darzi Fellowship.....	102
Introduction.....	102
4.1 The Fellowship.....	102
4.2 The Background and Context of the Fellowship	103
4.3 Objectives of the Fellowship	105
4.4 Methods of Learning: The work based projects.....	107
4.4.1 A Service Development Project.....	107
4.4.2 A quality or safety improvement project	107
4.4.3 A project to enhance the capacity of Trusts to train and develop others	111
4.4.4 The educational leaders views of the projects.....	111
4.5 Methods of learning: The educational programme	112
4.5.1 The taught modules	113
4.5.2 Other learning and development opportunities	116
4.6 Principles underpinning the educational programme	116
4.7 Summary.....	120
Chapter 5: The 'Preparation' Stage for Role Transition	121
Introduction.....	121
5.1 The Recruitment process.....	122

5.2. The Selection process	125
5.3 Motivations for participating	126
5.3.1 Self development	126
5.3.2 Career development.....	127
5.3.2.1 The views of other doctors on the need for management experience	131
5.4 Factors influencing participation.....	134
5.5 The Fellows goals and expectations.....	137
5.6 The Fellows' concerns about participation	141
5.6.1 Ability to lead and make successful change.....	142
5.6.2 Potential impact on career and collegial relations.....	144
5.7 Prior experience of leading service development projects.....	145
5.8 Prior experience and attitudes towards clinical leaders & non-clinical managers.....	149
5.9 Attitudes of the comparison group towards non-clinical managers.....	151
5.10 Summary and reflections	154
Chapter 6: The 'Encounter' stage - Becoming a Darzi Fellow	157
Introduction.....	157
6.1 The change and contrast encountered in the new role	158
6.1.1 Job content.....	160
6.1.2 The Fellows' status	162
6.2 Surprises encountered by the Fellows	167
6.2.1 Surprises related to the role content	168
6.2.2 Surprises related to the work context.....	175
6.2.3 Surprises in relation to own self.....	181
6.3. How the Fellows interpreted and explained their experiences	185
6.3.1 The extent of support for a project across the Trust	186
6.3.2 Having the support of their mentors.....	188
6.3.2 The type of professionals the Fellows needed to engage.....	191
6.3.3 The organisational context.....	192
6.3.4 The impact of not working clinically.....	194
6.3.5 Self attributions.....	195
6.4 How the Fellows made sense of conflict.....	196
6.5 Summary.....	199
Chapter 7: The Adjustment and Stabilization stages	202
Introduction.....	202
7.1 Adjustment through role innovation.....	203

7.1.3 Re-shaping projects and designing new ones	204
7.2 Adjustment through personal change.....	208
7.2.1 New attitudes towards the management of organisations	210
7.2.2 New attitudes towards medical leadership	214
7.2.3 New attitudes towards non-clinical managers.....	219
7.2.4 New attitudes to working with other health professionals and patients	223
7.2.5 Alterations in the Fellows sense of self	227
7.3 The Stabilization stage.....	230
7.3.1 Maintaining aspects of the Fellowship role	230
7.3.2 The Fellows orientations towards being a future leader	232
7.3.3 Attitudes and orientations in the longer term	236
7.4 Summary and reflections	241
Chapter 8: Conclusions, contributions and implications.....	243
Introduction.....	243
8.1 Overall research conclusions.....	244
8.2 Three contributions to knowledge	246
8.3 Contribution 1: An emerging model of role transition and identity transformation	247
8. 3.1 The emergence of three new types of professionalism	252
8. 4. Contribution 2 Potential new ways of working within public organisations	261
8.5. Contribution 3: Recommendations for policy and practice	265
8.6. Limitations and opportunities for future research.....	267
8.7 Summary.....	269
Bibliography.....	271-304
Appendices.....	305-319
Appendix A.....	306-309
Item A1 Interview Guide Fellows Stage 1.....	307-308
Item A2 Interview Guide Fellows Stage 2.....	309
Appendix B.....	301-323
Item B1 A priori themes in tree nodes.....	311
Item B2 Initial free nodes (stage 1 interviews).....	312
Item B3 Themes emerging at first and second refinement.....	313-316
Item B4 The final template showing hierarchy of themes.....	317-319

LIST of TABLES

TABLE	TITLE OF TABLE	PAGE NO
A	Profile of the Fellows	89
B	Profile of the Doctors in the comparison group	90
C	Overview of the interviews conducted	91
D	Secondary data sources collected	97
E	The Fellows service development and quality improvement projects	109-110
F	The 5 key principles of whole system working	118
G	Ways in which the Fellows heard about the Fellowship	122
H	Views of the comparison group regarding the value of management experience	132
J	The Fellows goals for the year	138
K	The Fellows prior leadership experience	147
L	The fellows attitudes towards non-clinical managers on entry	150
M	Attitudes of the comparison group towards non-clinical managers	152
N	Differences in job content and status in the new role	159
P	Attributions made in relation to ability to progress the projects	186
Q	Attributed ways in which mentors helped influence progress	188

LIST of FIGURES

FIGURE	TITLE of FIGURE	PAGE NO
1	The Nicholson (1984) model of work role transitions	58
2	An emerging model of role transition and identity transformation	248

Introductory chapter

Professionals are a group of workers who have attracted scholarly interest for many years. More recently, interest has stemmed from the fact that their professional identity and traditional ways of working have been challenged, by changes in the environment in which they work, including the internationalisation of markets and the introduction of new policies and legislation at a national level (Evetts, 2011; Muzio and Kirkpatrick, 2011; Waring and Bishop, 2011; Hinings, 2005; Powell, Brock and Hinings, 1999). The professional identity of workers such as lawyers, doctors, accountants, social workers and teachers is argued to be deeply embedded (Ackroyd, 1996; Bloor and Dawson, 1994; Freidson, 1970), with attitudes and values being more in line with those of the profession and its associations than the employing organisation (Raelin, 1985; Gouldner, 1957). Traditionally, professionals have enjoyed considerable discretion over how they carry out their work, and have focused on delivering their service to their individual clients, rather than concern themselves to any great extent with clients in a collective sense and the management of their organisations (Evetts, 2003; Freidson, 1989; Raelin, 1985). This was enabled by management practices based on collegial decision making and informal processes, (Cooper et al, 1996; Greenwood and Hinings, 1993; Ackroyd, Hughes and Soothill, 1989; Mintzberg, 1979). The 1980s, however, saw a departure from this type of management practice. New, managerialist cultures were introduced in the public sector by policymakers, with certain private sector style practices such as management by objectives, performance indicators and outcome measures (O'Reilly and Reed, 2010; Hunter, 2008) being prioritised. Similar managerial change also evolved within professional service firms in the private sector (Ackroyd and Muzio, 2007; Sokol, 2007; Brock, 2006; Hinings, 2005).

As a result, debates have emerged as to how far these changing environments have impacted on and begun to re-shape professionals (Evetts, 2009; Pickard, 2009; Adler, Kwon and Heckscher, 2008; Faulconbridge and Muzio, 2008; Ackroyd and Muzio, 2007; Noordegraaf, 2007; Jacobs, 2005), in terms of leading them to adopt more managerial values and priorities and accept greater responsibility for the functioning of organisations. This thesis sits within the stream of literature interested in *whether* and *how* the attitudes, values and orientations of

professionals might be changed (Noordegraaf, 2011; Waring and Currie, 2009; Hinings, 2005; Powell, Brock and Hinings, 1999; Exworthy and Halford, 1999; Reed, 1996). Specifically, it is interested in the recent focus on training professionals in the public sector in leadership and management, in a bid to turn them into people who can and will lead the organisational reform which policymakers currently desire (O'Reilly and Reed, 2010; Ham and Dickinson, 2008; Lawler, 2007; Glatter, 2004). Such a strategy has potential implications for established notions of professionalism, or the professional identity, in that it requires these professionals to work in new ways and with different groups of people. This is of academic interest but also wider policy and societal concern, owing to the level of investment being made in this area, particularly in areas such as health and education, and the lack of clarity as to whether this strategy is actually capable of achieving such change in this type of worker.

Doubts exist as to whether the attitudes and orientations of professionals are capable of undergoing change. Whilst those working in the public sector may be categorised as 'organisational professionals' (Muzio, Ackroyd and Chanlat, 2007; Noordegraaf, 2007), in that they are in the employ of publicly funded organisations, particular forms of management and orientations to management have historically existed in institutions where such professionals work (Scott, 1965; Mintzberg, 1979; Greenwood and Hinings, 1993; Freidson, 2001). Hospitals, schools and universities have been termed 'heteronomous professional organisations' (Scott, 1965) and 'professional bureaucracies' (Mintzberg, 1979), in recognition of the fact that they are subject to external control from policymakers and have elements of bureaucracy, but professional values established outside the organisation dominate the way in which things are done. Indeed, the orientation of many 'organisational professionals' in the public sector has been found to be similar to that of professionals in professionally owned organisations, such as law and accountancy firms, where particular attitudes to strategic, financial and operational management have been found (Cooper et al, 1990).

Traditionally, the focus of professionals has been on providing a good service to their clients. In professional service firms it has traditionally been professionally qualified partners have owned and managed the firm, whilst also providing the service. Collectively the partners have taken responsibility and accountability for the service provided and the financial viability of the firm, also controlling the scheduling of work and budgetary processes, with little investment into formal management practices such as marketing or human resource management

systems (Greenwood and Hinings, 1990, 1993). In the public sector, in professional bureaucracies such as hospitals, a 'consensus management' approach was well established (Harrison and Pollitt, 1994). This involved a team of professionals, dominated by doctors, who made decisions about how the organisation operated, supported by administrators who facilitated rather than controlled their work. Services were planned and budgets allocated on an incremental basis (Harrison and Pollitt, 1994). In others areas of the public sector, such as local government, Greenwood and Hinings (1988) reported the existence of both a professional bureaucracy model and a corporate bureaucracy model in the organisations they studied between 1967 and 1983. Whilst in the corporate bureaucracy model there was emphasis on general management competence, with rewards being commensurate with this, in the professional bureaucracy model it was the professionals who took up the departmental head roles. Here, appraisal of performance was based on professional activities and, as in the NHS, there was an incremental form of budgeting. In these professional bureaucracies, control occurred not through enforcement of rules by managers, but because the professionals adhered to certain occupational norms and values, or a guiding framework of professionalism, instilled during their initial training (Hafferty, 2009; Van Maanen and Schein, 1979; Freidson, 1970, 2001).

Such ways of organising and managing attracted policymakers' attention in the late 1970s, as the welfare sector faced increased demand for services due to rising unemployment, an ageing population and new treatments in healthcare becoming available. This rendered such services increasingly expensive to run at a time of economic crisis, and in 1979 a conservative government came into power armed with new ideas about how the economy and organisations ought to be managed (Kirkpatrick, Ackroyd and Walker, 2005; Dent, 2003). Welfare professionals were perceived as the underlying cause of many problems (Ackroyd, Hughes and Soothill, 1989; Ferlie et al, 1996; Foster and Wilding, 2000). For example, social workers were seen as creating a culture of dependency amongst their clients (Foster and Wilding, 2000) and doctors were perceived as overly dominant, resistant to change and the root cause of failure to control costs in the NHS, due to a lack of line management (Dopson, 2009; Hunter, 2008; Fitzgerald and Ferlie, 2000). Existing structures and management systems within many professional organisations were considered a barrier to efficiency, as well as flexible and integrated responses to social issues (Greenwood and Hinings, 1993). As a result, new practices were introduced in an attempt to alter professionals' ways of thinking and behaving, which the next section moves on to discuss.

New management practices and the emerging discourse of leadership

Following the election of a conservative government in 1979, the 1980s saw the introduction of management practices associated with 'New Public Management' (NPM) across public services. Whilst a 'loose term' (Hood, 1991, p.3) NPM reflects a move to a new set of beliefs, with accompanying practices, that public services needed to be more efficient, business-like and market oriented. Whilst these changes were ostensibly aimed at improving organisational efficiency and effectiveness (Flynn, 1999), they have also been an attempt to control professionals (Dopson, 2009; Evetts, 2006; Dent, 2003; Foster and Wilding, 2000) and to alter traditional notions of professionalism, or established ways of thinking and behaving. Put bluntly, professionals have come under pressure to alter their ways of thinking and behaving, and to concern themselves with the organisational aspects of how their service is delivered (Noordegraaf, 2007; Hinings, 2005; Dent, 2003; Hanlon, 1999; Reed, 1996; Freidson, 1994).

Two common themes have emerged with the move to a NPM type philosophy. Firstly, professionals have faced the introduction of new management practices. These include such things as a new cadre of managers in the NHS with a mandate to take decisions and make change, and more generally the introduction of centrally defined objectives, targets and measures designed to focus activity and improve service delivery, costs and outcomes. An internal or quasi market was also introduced in the 1990s, in a bid to create an element of competition amongst professionals and motivate them to improve their performance (McMurray, 2010; Dopson, 2009; Dent, 2003; Ferlie et al, 1996). As such, a number of services are now put out to tender, with public and private sector providers able to bid for the contracts, meaning that some professionals have had to come to terms with the need to compete for contracts with their peers and to attract customers (Dopson, 2009; Hunter, 2008; Ferlie et al, 1996). In a bid to reduce variations in practice, such things as a national curriculum within education (Foster and Wilding, 2000) and clinical protocols and guidelines within healthcare have been introduced (Dent, 2003, 2007; Carey, 2003).

Secondly, there has been an attempt in the public sector to turn professionals into managers. This has been through the devolving of greater managerial responsibility to those professionals already in administrative/managerial roles, such as head teachers and social worker managers (Carey, 2003). It has also been through the creation of new 'hybrid,' professional-manager

roles (Fitzgerald et al, 2006; Llewellyn, 2001; Exworthy and Halford, 1999; Ferlie et al, 1996) in professions such as medicine. These hybrids, or professional-managers, are required to straddle both professional and managerial worlds and to manage devolved budgets, deal with staff issues, work to targets and to develop their service (Giordano, 2010; Berg et al, 2008; Carey, 2003; Farrell and Morris, 2003; Kirkpatrick, Ackroyd and Walker, 2005; Kitchener, 2000; Ferlie et al, 1996; Dawson et al, 1995).

Over time, successive governments have introduced modifications to this culture of managerialism in the public sector. For instance, New Labour introduced more complex governance arrangements. These included new networks designed to tackle inter-related issues such as health and social care problems, through greater collaboration across professional organisations and the increased involvement of service users, in terms of client/patient input into decisions (Dopson, 2009; Dent et al, 2007). However, alongside this, more centrally imposed standards, benchmarks, guidelines, targets and forms of quality assessment were also introduced (Kuhlmann et al, 2009). Since coming into power in 2010 the current coalition government has removed some of these targets but seeks further structural change (Brookes, 2011). New academies to deliver education are being encouraged and major structural change is underway in the NHS. However, when it comes to the role and behaviour of professionals in the public sector, the coalition government is continuing with the policy begun by previous conservative and Labour governments. This involves a shift in policy focus and discourse, from one in which new professional-manager roles are created and managerial responsibilities devolved, to one which advocates the need for professionals to be involved in leading public services. The concept of leadership, in contrast to management, has come to the fore, with leadership by professionals being heavily promoted in relation to service reform and organisational development (Spurgeon, Clark and Ham, 2011; O'Reilly and Reed, 2010; Lawler, 2007).

The reason for this shift from management to leadership is the source of some debate. Some writers feel that it is based on a recognition that 'terror by target' (Hunter, 2008, p.39) has not worked, and that other ways to engage professionals with the efficient running of services must be found. Brookes (2011) argues that there is some recognition that the introduction of NPM type practices led to what is measured being what gets done, with a detrimental effect on both service development and public confidence. There is certainly some evidence within

the health sector that professionals in management roles can champion change that leads to service improvement (Fitzgerald et al, 2006; Ham, 2003; O'Sheaff et al, 2003; McNulty and Ferlie, 2002) and there are signs that having more doctors in management (Goodall, 2011) and on hospital boards (Veronesi, Kirkpatrick and Vallascas, 2012) positively relates to higher rankings and quality outcomes respectively. This implies a need for the likes of health professionals to be involved, if improvement in the way services are provided is to be achieved. Some writers on leadership also argue that leadership, associated as it is with relational skills such as influence and persuasion, in contrast to the command and control mode of operating associated with management, is increasingly necessary owing to the complexity of providing public services (Hartley, 2008, 2010; Valle, 2006). For instance, leadership at an individual, team, organisational and system level is argued to be necessary for the provision of effective contemporary health care (Mohapel and Dickinson, 2007).

In contrast, other writers argue that the policy discourse of leadership is simply another tactic aimed at furthering the managerial agenda, through positioning professionals as champions of service reform, but reform in line with government ideas (Bolton et al, 2011; Wallace, Tomlinson and O'Reilly, 2011; O'Reilly and Reed, 2010; Ackroyd and Muzio, 2007; Thrupp, 2005). For example, 'Lean' service re-design practices are popular with NHS managers, but they require leadership by clinical professionals in order to be implemented (Waring and Bishop, 2010). In other words, leadership is another strategy through which policymakers seek to control professionals and alter their professional identity, or traditional sense of professionalism. The implication of this is that previous attempts to re-shape professionals have been less successful than hoped. While the changes introduced have had an impact on the individual level of autonomy professionals enjoy, and have created a need for them to engage with managerial issues (Waring and Currie, 2009; Lawler, 2007; Dent, 2003; Freidson, 2001; Harrison and Ahmad, 2000), there is a fair amount of support for the idea that the collective autonomy of professionals has not been severely dented (Dent, 2008; Ackroyd, Kirkpatrick and Walker, 2007; Kirkpatrick, Ackroyd and Walker, 2005; Hunter, 2008; Freidson, 1994). A number of writers also argue that traditional notions of professionalism, in terms of attitudes, values and orientations to work, have proved difficult to erode (Wallace, Tomlinson and O'Reilly, 2011 Kirkpatrick et al, 2009; Kippist and Fitzgerald, 2009; Carey, 2008).

Irrespective of what policy intentions may be, the discourse of leadership has been accompanied by considerable investment in efforts to champion and develop leadership skills in professionals (Wallace, Tomlinson and O'Reilly, 2011; Lawler, 2007; Glatter, 2004). The education and health sectors have received particular attention. For example, a National College for School Leadership (NCSL) was established in 2000, to champion the development of future and existing school leaders as well as a National Leadership Centre with similar aims in the NHS in 2001. The latter was followed with a National Leadership Council, which in 2012 evolved into the NHS Leadership Academy. The propensity of leadership development to alter the attitudes, beliefs and practices of professionals is therefore of great interest and the next section looks at the extent of our current knowledge regarding this.

The impact of leadership development: limitations to our current understanding

Leadership development for professionals has varied, in terms of the extent of opportunities available and the focus, duration, intensity and extent of evaluation of interventions. For instance, in the health care sector some management development programmes for clinical directors in the 1990s ran over several months and underwent evaluation (Allen, 1995; Cowling and Newman, 1994; Fitzgerald, 1994; Harrison and Miller, 1993; Lorbiecki et al, 1992). These early evaluations tended to focus on the capacity of programmes to enhance doctors business and management skills, but offer some suggestion that certain attitudes were developed through participation. For example, Cowling and Newman (1994) found participants were able to draw up plans for their directorate, owing to their improved knowledge of finance, marketing, IT and organisational behaviour. Fitzgerald (1994) reported that on entry clinical directors demonstrated little understanding of the strategic side of management, but that by the end the cohort viewed operational management and finance as important and recognised the need to be more outward looking and focused on the organisation's competitors, customers and suppliers.

Since the shift from management to clinical leadership, a mixture of short courses as well as more intensive programmes has occurred. Some early programmes for medical leaders, such as those at Keele University, were of a short duration and evaluated mainly for formative purposes (see for example Russell, 2004). However, more intensive evaluations have since occurred. For example, an eighteen month programme for medical leaders in Ireland which

focused on the group's personal development as well as their impact on service improvement through project work was evaluated (Hardacre and Keep, 2003). Increases in participants' confidence, as well as self and political awareness were reported. Intensive interventions have been run for nursing leaders in England (Cunningham and Kitson, 2000) and Ireland (Lunn et al, 2008), focused on personal development. These evaluations reported increases in confidence as a leader, greater self-awareness and greater ability to understand others' perspectives. In contrast, an advanced leadership programme for medical leaders which was evaluated by Edmonstone (2009) in terms of whether or not it met participants' and commissioners' objectives, found that participants wanted a greater focus on personal development, with some confusion evident amongst trainers regarding the precise objectives of the programme.

In terms of other professionals targeted by policymakers for leadership development, there have been programmes aimed at developing both existing and future school leaders since the 1990s. However, Glatter (2004) notes that there has been a neglect of research into their impact. To date, suggestions are that interventions have not been as successful as hoped in terms of making teachers more managerially oriented (Brown, Boyle and Boyle, 2002; Guskey, 2000). A recent review (Wallace, Tomlinson and O'Reilly, 2011) of a programme run by the National College for existing school leaders, aimed at developing participants as change agents and leaders of reform, found that they internalised the promoted view of themselves as transformational leaders. However, the authors also noted that, "our school leaders had harnessed their power to mediate the government's acculturation effort by holding hard to their professional culture as educators, and continuing to use their authority to express these educational values as far as they perceived was feasible" (Wallace, Tomlinson and O'Reilly, 2011, p.277). In higher education, an evaluation of a pilot leadership intervention for established and new academic programme co-ordinators in Australia (Ladyschewsky and Flavell, 2011) found some impact on attitudes, to the extent that participants began to realise that they could mobilise people to do things and to recognise the responsibilities of the role.

In sum, evaluation of previous leadership development programmes for professionals suggests that participation may alter some attitudes and orientations to leading and managing organisations. However, they provide mixed and partial evidence, with limited insight into how the process of change unfolds from the participants' perspective. In addition, they have largely been aimed at those already established in formal leadership roles, which has been

criticised in relation to medical professionals, with such interventions being described by Simpson and Calman (2000) as remedial, or aimed predominantly at plugging existing skills gaps. Indeed, Simpson and Calman (2000) suggest that the postgraduate or specialist trainee (usually referred to as Registrar) stage is potentially the best time to train doctors, ahead of their becoming consultants, a view supported by some clinical directors (Dopson, 1996). While programmes for specialist trainees exist, run by NHS Trusts in some cases as well as universities and external training companies, these are generally short, being of around four or five days duration, which Edwards (2005) has suggested is insufficient a time to prepare doctors for what leadership and organisational involvement entails. A recent survey of junior doctors also found that of qualified doctors from foundation year onwards only 25% had received any leadership training (PMETB, 2007).

An international review of management and leadership education for doctors (Ham and Dickinson, 2008) found that more intensive development interventions are fragmented at the postgraduate stage, with initiatives tending to be localised and in their infancy. This is certainly the case in the UK, where a limited number of more intensive interventions have been piloted in recent years. These include a management programme of six months duration for specialist trainees in psychiatry, instigated in London in 2007 to prepare trainees for consultant posts. Those facilitating the programme noted some signs of attitude change amongst the trainees. Participants reportedly gained a better understanding of management processes and structures and began to see that service delivery should involve both clinicians and managers (Fellow-Smith et al, 2004). A leadership mentoring programme, 'Prepare to Lead' launched in London in 2008, placing twenty Registrars in management and change alongside senior leaders working on organisational development projects. Reports on this have focused on the success of the mentoring arrangements, rather than on any attitudinal and behaviour change amongst participants (Warren, Humphris and Bicknell, 2008).

A number of evaluations of leadership development interventions for professionals have highlighted that the context in which they occur and their design can have an impact on how effective they are able to be. For instance, the need for more support within the workplace to enable health and social care professionals to implement change was noted on one programme (Rounce et al, 2007). In higher education workload and time pressures have been found to limit the time needed for reflection and thought about how leadership may be

implemented in practice (Stigmar, 2008; Trowbridge and Bates, 2008). The introduction of interventions in a bureaucratic, top down fashion has been suggested as one reason why they have failed to inspire teachers' interest in managerial issues (Guskey, 2000). Brown, Boyle and Boyle (2002) also advocated that initiatives for school leaders adopt a whole systems perspective, so that teachers can start to understand and consider how their work and role fits into that of the school as a whole. These authors also suggested that within the education sector there has been an over reliance on formal teaching methods, rather than on methods which are grounded in the work context which they suggest are more likely to enable teachers to deal with the complexity and ambiguity that exists within the school environment. The use of more work-based and informal methods to enable learning and behaviour change amongst professionals (Warren, Humphris and Bicknell 2008; Brown-Muth and Ferrigno; 2004; Glatter, 2004) and adult learning in general (Raelin, 2006; Lave and Wenger, 1991; Schon, 1987) is now widely supported. In addition, the importance of having supportive professional mentors in the workplace has been raised (Warren, Humphris and Bicknell, 2008; Fellows-Smith et al, 2004), with calls for a greater number of positive mentors and role models (Coulehan, 2005; Brown-Muth and Ferrigno, 2004), particularly when the objective is to develop a new sense of professionalism amongst participants.

All of this raises the question of what conclusions might be drawn about the potential for leadership development interventions to alter the attitudes and orientations of professionals with regard to organisational issues and involvement. Existing empirical data suggests that the self-awareness and confidence to lead of participants can be improved, and that a wider perspective on how services are provided and managed can emerge. This suggests that there is potential for leadership development to impact on both the take up of leadership roles and also established notions of professionalism. However, what is missing within the literature is a detailed, longitudinal examination of the way in which an intervention, which is focused on personal change and adopts the methods advocated within the literature, impacts on the attitudes, beliefs, practices and leadership motivations of professionals not yet in any formal leadership role. In addition, an understanding of how the process of change occurs and is experienced by those participating in leadership development is needed. This research begins to address this gap, through a detailed study of postgraduate level doctors (Registrars) undergoing an intensive leadership development programme. The next section considers the rationale for studying medicine.

The rationale for studying medicine

Medicine was selected as the professional group to study for a number of reasons. It is one of the archetypal professions (McDonald, 1995; Freidson, 1970; Larson, 1990; Murphy, 1990), with members perceived as having a particularly embedded sense of professional identity (Hafferty, 2009; Bloor and Dawson, 1994; Raelin, 1985; Freidson, 1970) and as being largely resistant to ongoing efforts by policymakers to engage them in the management of the NHS (Kings Fund, 2011; Ham and Dickinson, 2008; Kitchener, 2000). However, there has been a change in stance on the part of the medical academy in recent years, which now supports the development of management and leadership competency amongst doctors. In 2005 the Royal College of Physicians re-defined medical professionalism, such that doctors are now required to show corporate responsibility and work in partnership with managers and other professionals (Royal College of Physicians, 2005). The college argued that a degree of management and leadership competence will be needed if doctors are to enact this new sense of professionalism. High profile figures within the profession also support this move, including Sir John Tooke, who conducted a review into 'Modernising Medical Careers', the move to a shorter postgraduate training programme (Tooke, 2008), and Sir Ara Darzi who led a review of the NHS for the last Labour government. Lord Darzi called for doctors (and other clinicians) to take a lead in improving and designing services (Department of Health, 2008). The dual objective, of altering competencies and notions of professionalism, makes doctors a professional group worthy of study.

Looked at from an individual perspective, the new medical professionalism outlined by the Royal College of Physicians requires that doctors work with new groups of professionals in new ways, such that they are effectively being required to undergo intra-role transition (Louis, 1980a), that is to change their orientation to their current role. Ibarra, Snook and Guillém Ramo (2008) recently suggested that leadership development be considered a process involving role transition and potential identity transformation.

As such, this research explores the process and impact of participating in a leadership development intervention from this new perspective, by examining these issues through a lens of role transition (Nicholson, 1984; Nicholson and West, 1988). Role transition theory (Ashford and Taylor, 1990; Nicholson and West, 1988; Nicholson, 1984; Louis, 1980;) suggests that any

role transition will involve a complex internal process and that adjustment to these new role requirements may involve any of the following: a personal change in attitudes and behaviours; a re-shaping of the role to suit oneself; personal change and a re-shaping of the role or no change (Nicholson, 1984). Looking at how and whether role transition occurs amongst doctors as a result of participating in leadership development is therefore a useful way of looking at whether leadership development may be a suitable mechanism for re-shaping professional identities. This raises two particular research questions:

1. Will leadership development be able to act as a mechanism for role transition, in the form of personal change, amongst doctors not in a formal leadership role?
2. Under what conditions might it do so? That is to say, if role transition is seen to occur, how might leadership development have facilitated it? If role transition is not seen to occur, what factors might have hindered transition?

This research focused on a group of specialist trainees (Registrars) participating in a high profile, pilot intervention, known as a Darzi Fellowship, which ran over twelve months. Participants predominantly ceased clinical work and took up a newly created role leading live service development projects within sponsoring NHS Trusts. An educational programme comprised of formal and informal methods, including taught modules, action learning, participation in communities of practice and individual coaching, supported them throughout. A qualitative, case study approach was adopted, with primary data collected longitudinally via semi structured interviews, along with secondary data sources including podcasts and written reports from participants and other key informants. Training and planning documents were also collected and analysed. In addition, data was collected via interviews from a comparison group (Glaser and Strauss, 1967) of specialist trainees who were not participating in leadership development. This was in order to enable more robust conclusions to be drawn as to the ways in which the Fellowship impacted on attitudes (Miles and Huberman, 1994), to determine how representative the Fellows were of the wider population of Registrars (Gomm, Hammersley and Foster, 2000) and to corroborate certain findings (Fetterman, 2010; Sayer, 2000).

In terms of its wider academic contribution, the thesis sheds light on current issues of concern, including the way in which leadership development might lead to new forms of professionalism, in terms of orientations towards the management of organisations, and the

potential emergence of more collaborative, inter-professional forms of community (Adler, Kwon and Heckscher, 2008). Role transition theory is also developed, in terms of its application within longitudinal leadership development processes and professional contexts, and the findings support the idea that leadership development be considered a process of role transition linked with identity transformation (Ibarra, Snook and Guillém Ramo, 2008).

The thesis is structured as follows: Chapter 1 'Strategies to develop a new medical professionalism' begins by looking at the traditional characteristics associated with the medical profession and their orientation to management. It then considers the introduction of new public management in the NHS and the gradual emergence of a discourse of clinical leadership, including the limited progress made to date in developing leadership competency in doctors.

Chapter 2, 'Leadership development for doctors', begins by considering existing evaluative frameworks which might be used to examine the ability of leadership development to engender a change in doctors' attitudes, beliefs and practices. The appropriateness of using traditional evaluative frameworks is called into question, with the recent proposal that the process of becoming a leader be considered a process of role transition and identity change outlined. Role transition theory and the model of work role transitions (Nicholson, 1984) which consists of four stages - preparation, encounter, adjustment and stabilization – and offers a potentially more appropriate framework for examining the issue is outlined, incorporating the potential process of identity transformation at each stage (Ibarra, Snook and Guillém Ramo, 2008; (Ibarra, 2007). The chapter then moves on to consider what type of approach to leadership development the literature suggests is likely to have most chance of achieving transition in the form of personal change amongst doctors. It reviews the learning process, including theories of learning and possible methods that may be used and the pros and cons of each. It concludes that an intervention utilising a mix of formal and informal methods, including work based experience, and which focuses on personal development and building capacity for the longer term, has the most chance of achieving change and is worthy of study. The research questions emerging from the review of the literature are then outlined.

Chapter 3, 'Research methodology' begins by outlining the critical realist perspective that informs the research, the qualitative, case study design adopted and the factors taken into

account in the research design. It then moves on to look at how the process of research occurred, including the selection of a case, a sample of participants and a comparison group of doctors who were not participating in any intervention. The way in which the four stage model of role transition was operationalised and data collected, through longitudinal, semi-structured interviews, is discussed and the secondary data sources collected are outlined. Following this, the step-by-step process of analysing the data, through use of template analysis (King, 2004), a part deductive and part inductive way of thematically analysing qualitative data, is discussed.

Chapter 4 'The Darzi Fellowship' considers the background to the Fellowship, its subsequent design and the objectives underpinning it. The learning inputs are briefly outlined, in terms of the 'live' work based projects developed and the content of the educational programme. The principles of whole system working which were embedded in the educational programme are also discussed.

Chapters 5 to 7 present the findings in relation to the four stages of the role transition model (Nicholson, 1984). Chapter 5 looks at the first stage, that of preparation. Chapter six looks at the second stage, the encounter stage and chapter seven looks at the third and fourth stages, those of adjustment and stabilization.

Chapter 5 'The Preparation Stage' begins by presenting the findings that emerged from the first interviews. These focused on: how the Fellows were recruited and selected; their motivations for taking part in the Fellowship; factors that influenced their participation; the Fellows goals for the year; any concerns the Fellows had about participating and their prior experience of leading service development or other initiatives. The chapter then presents the attitudes found amongst the Fellows on entry to the Fellowship with regard to clinical leaders and NHS managers, followed by the attitudes found amongst Registrars in the comparison group.

Chapter 6, 'The Encounter Stage,' begins by depicting the extent of change and contrast found in the new role, compared with the usual clinical role. It then presents the findings on the

things that surprised the Fellows in their new role and the ways in which they made sense of their experiences.

Chapter 7, 'The Adjustment and Stabilization Stages,' is structured around three parts. The first part presents the findings as to how the Fellows adjusted to their new role, beginning with the extent to which they engaged in role innovation, through re-shaping the original projects they were given or designing new ones. The second part looks at reported changes in attitudes in relation to organisational involvement, working with non-clinical managers and other stakeholders. The third part of the chapter looks at the extent to which stabilization, which may or may not occur (Nicholson and West, 1988), actually occurred. Follow up data collected from four Fellows, twelve months post completion of the Fellowship, is presented in this section.

Chapter 8, 'Conclusions, Contributions and Implications' briefly summarises the conclusions drawn from the findings before looking at the three key contributions of the work. These are then presented in more detail, beginning with the emerging new model of role transition and identity transformation associated with leadership development. The model includes the potential contingencies associated with identity transformation and three new types of professionalism identified. Drawing on the contingencies highlighted within the model, possible explanations for these emerging new types of professionalism are then elaborated. The chapter then turns to the second main contribution of the thesis, related to what the findings suggest about the potential for new ways of professional working to emerge within public organisations, moving then to the third contribution of the thesis, the recommendations for policy and practice. Limitations of the work and opportunities for further research are then discussed before the chapter ends with a brief summary of what the thesis has achieved.

Chapter 1: Strategies to achieve a new medical professionalism

Introduction

The chapter sets out to highlight the extent of change the medical profession, in line with many professions, has faced over the last thirty years, with regard to their traditional ways of working. This is due to new forms of management being introduced by policymakers, along with strategies designed to control doctors and engender a greater sense of organisational responsibility and managerial involvement in them. In effect, policymakers have attempted to change the way in which doctors think and behave, or to transform their sense of professionalism, along similar lines as tried in other professions (Noordegraaf, 2007; Hinings, 2005; Dent, 2003; Hanlon, 1999; Reed, 1996; Freidson, 1994). This chapter traces the ways in which policymakers have sought to effect a change in doctors' orientation to the organisational and managerial aspects of how health services are delivered which have led to the latest strategy, that of training doctors in leadership and management, aspects which have traditionally been missing from their initial medical training (Edwards, Kornacki and Silversin, 2002; Smith, 2001). This strategy of developing doctors as leaders is discussed in detail, in terms of the current lack of clarity as to whether such a strategy might achieve the desired change and the extent of progress in this area to date.

The chapter is structured as follows: Section 1.1 considers the characteristics traditionally associated with the medical profession. In section 1.2, the way in which NHS organisations operated and were managed before the 1980s, including doctors' with, and orientation to, management is discussed. Section 1.3 considers scholarly views on the pros and cons of organisations operating in such a way. Section 1.4 considers the management changes introduced in the NHS since the 1980s, including the way senior doctors have increasingly been drawn into management roles. Section 1.5 considers the recent emergence of a strategy and discourse of clinical leadership, including the various scholarly views as to why there has been a shift from management to leadership. Section 1.6 then looks at the strategy to develop doctors as leaders in more detail, including the introduction of the medical leadership competency framework (MLCF) and the particular objectives of the medical academy. These include engendering new attitudes and orientations towards NHS organisations and their

management, or in other words a new sense of professionalism. This section also considers the limited progress made to date in developing leadership and management skills in doctors and engendering a change in their sense of professionalism. Sections 1.7 and 1.8 then look at arguments for and against leadership development acting as a mechanism for change in doctors' attitudes, beliefs and practices. Section 1.9 concludes that big questions remain as to whether leadership and management development is an appropriate strategy, capable of achieving the kind of change desired in doctors.

1.1 Characteristics of the medical profession

Whilst there is no fixed or universally agreed definition of a profession (Ellis, 2004; Freidson, 1974) they are generally viewed as a particular form of 'occupational community' (Van Maanen and Barley, 1984). As one of the archetypal professions, along with law, (Adler, Kwon and Heckscher, 2008; McDonald, 1995; Larson, 1977, Freidson, 1970) medicine is long established and has influenced the way in which other professions are perceived. What distinguishes medicine and professions in general from other occupations is that members are providers of a service and of a group that has been granted special privileges. Privileges include internal, or occupational, control over who enters the profession, the training and accreditation of members and the work they do (Freidson, 1989). As such, a form of occupational closure is said to exist (Murphy, 1988), on the basis that the profession controls who can enter and become accredited and so limit external competition for work, resulting in an effective monopoly over the provision of medical services (Larson, 1977). In order for occupational control to occur the state, in granting such rights, has to be convinced that the work requires a formal, abstract knowledge and discretionary judgment to implement this knowledge (Freidson, 1989) and that the work is so specialised that it can only be evaluated from within (McDonald, 1995; Freidson, 1994, Collins, 1990; Larson, 1977). The result is that doctors and other professionals have greater autonomy or discretion regarding the work that they do, and how they carry it out, compared with non-professional workers (Evetts, 2006).

Professional status also confers other privileges, in that occupational control tends to lead to professions dominating the division of labour and directing the work of other occupations, such as nurses in the case of medicine (Rueschemeyer, 1988; Freidson, 1970), and using their knowledge base to impose their definition of reality (Collins, 1971). Occupational control was

granted to medicine via the 1858 Medical Act and subsequent establishment of the General Medical Council as the regulatory body (Kirkpatrick, Ackroyd and Walker, 2005; McDonald, 1995). The profession has since gained legitimacy for a 'biomedical model' of health and tends to dominate health related discourses (Hunter, 2008). Having originally practiced on an independent basis in private practice (Reed, 1996) doctors had to be co-opted to work in NHS organisations when they were founded in 1948 (Kirkpatrick, Ackroyd and Walker, 2005). To gain their co-operation the state granted them continued autonomy over how they carried out their work (McDonald, 1995), although Dent (1995) argues that a responsible autonomy in which some freedom was granted in return for a degree of accountability was always the preferred option of the state.

Hence, medicine is a profession with a long history of occupational control over what it does, how it does it and the behaviour of its members. This occupational control of its members is asserted to be achieved through the instilling of a common language and a certain mindset, including a particular set of attitudes and values (Cruess, Cruess and Steinert, 2009; Hafferty, 2009; McDonald, 1995; Van Maanen and Schein, 1979; Freidson, 1970; Goode, 1957). These attitudes and values constitute a framework of medical professionalism which is encountered during initial training (Cruess and Cruess, 2009) and which acts as a disciplinary mechanism (Fournier, 1999), defining and conditioning how members think and behave. The next section looks at what medical professionalism has traditionally meant.

1.1.1 Medical Professionalism and orientations to clinical work

Displaying professionalism in what Noordegraaf (2007) refers to as the 'pure' sense (p.765), or traditional way, has meant displaying competency in the clinical body of knowledge by analysing specific cases, making inferences and taking decisions as to how to treat patients. It has also meant conducting oneself in an appropriate manner in relation to patients and clinical peers. In the case of the latter, doctors are expected to show commitment to their patients and their colleagues. The emphasis is on providing a sound clinical service, gaining the approval and respect of their peers and maintaining good collegial relations. Doctors compete to be recognised within the medical community for the quality of their work and their ability to deal with difficult cases, as opposed to their adherence to bureaucratic standards (Freidson, 1989). Relationships with colleagues and patients are based on trust, with trust in their doctor

essential for patients, who generally do not have the expertise to judge a doctor's capability (Calnan and Rowe, 2008). With regards to this relationship with patients, doctors have been found to have an individualist orientation (Degeling, Kennedy and Hill, 2001; Freidson, 1970) or a tendency to focus on their own set of patients, accompanied by a belief that they should be free to exercise their judgment, on the basis that they know what is best when it comes to caring for them. Degeling, Kennedy and Hill (2001), who surveyed doctors, doctors who were managers, nurses, nurse managers and lay managers found that this individual orientation of doctors was in contrast to that of nurses and non-clinical managers, who were more oriented towards patients as a collective. As Freidson (1990) notes, "physicians tend to have an individualistic conception of autonomous clinical judgment that leads them to resent examination, evaluation, and commentary on their work by anyone, even colleagues" (p.43).

A sense of etiquette pervades collegial relations, such that doctors tend not to interfere in the work of their peers (Ackroyd, 1996; Freidson, 1970). An example of this is that recommendations regarding prescribing are not made unless advice is sought (Armstrong and Ogden, 2006). They are typical of professionals who, when they must be managed, favour being managed from within, by managers who treat them as individuals, emphasise professional standards, take a laissez faire approach and who are preferably professionals themselves, or have a strong appreciation of the norms of their professional practice (Raelin, 1985; Mintzberg, 1979). For example, Xirasagar (2005) found that doctors are more likely to be influenced by medical leaders who seek to influence through their vision, charisma and powers of persuasion, rather than because they occupy a position of authority.

Since the inception of the NHS doctors have become 'organisational professionals' (Muzio, Ackroyd and Chanlat, 2007; Noordegraaf, 2007) in the sense that they are salaried employees who must work within the confines of state funded and controlled organisations. This is not unusual, however, as the majority of professionals now work within organisations under external control (Raelin, 1985), but does raise the question of how their professionalism and orientation to clinical work fits within such organisational boundaries. The next section looks at the particular form NHS organisations take, dominated as they are by a professional workforce, and at how doctors have traditionally viewed the management of these organisations.

1.2 NHS Organisations and doctors' historical orientation towards their management

As is the case in other large, professionally dominated institutions such as universities, particular forms of management and organisation have been found in the NHS, particularly in hospitals (Ham and Dickinson, 2008; McNulty and Ferlie, 2002; Kitchener, 1999). Scott (1965) categorised such institutions as 'heteronomous professional organisations' and Mintzberg (1979) as 'professional bureaucracies' on the basis that they are institutions which are subject to external control, but the professionals within have a large degree of sway over what happens and how, with professional values established outside the organisation tending to dominate.

Mintzberg (1979) argued that professional bureaucracies have what he termed a small 'techno-structure', or a specialised management structure which designs processes. Rather, the work is co-ordinated by the professionals themselves, on a horizontal basis, such that there is a degree of inter-dependence amongst the different segments, or specialities in the case of medicine. This results in numerous micro-systems or informal networks of influence, within the overall organisation (Mintzberg, 1979). Despite this, medicine is also noted to be an upward looking, hierarchical profession; one in which consultants operate as role models for trainees (Hafferty, 2009; Sinclair, 1997) and where there are perceived difference in status amongst the specialities (Sinclair, 1997). For example, Sinclair (1997) observed that general surgery was considered to rank high on responsibility and medicine on knowledge, with psychiatry having the lowest status, resulting from its use of less scientific language and the adoption of a more multidisciplinary team approach. Differences in the attitudes of specialities towards the management of NHS organisations have also been noted (Willcocks, 2004).

The historical form of management in the NHS is in line with that of professional bureaucracies, and contrasts with that in a 'machine bureaucracy' (Mintzberg, 1979) where there is a vertical chain of command and work is co-ordinated and controlled by a management function through the use of practices such as clear objectives, targets, measures of performance and human resource management systems of appraisal and reward (Mintzberg, 1979). Local statutory bodies ran the NHS until 1974 and these had a large number of doctors as members (Ham, 1981). After that a system of 'consensus management' was in

operation (Harrison and Pollitt, 1994) in which a team of health professionals, dominated by doctors, made decisions as to how the hospital would run, in a collegial and consensual way. Services prior to the 1980s were planned, with plans and budgets formed on an annual and incremental basis, such that there was a custodial form of administration where change was limited (Ackroyd, Hughes and Soothill, 1989). Administrators facilitated the professionals' decisions, essentially enabling their will to be done. In fact, administrators are said to have acted more like 'diplomats' (Harrison et al, 1992) than managers, treating doctors as if they were the clients. Doctors viewed the management of NHS organisations as being of secondary importance to their clinical work (Reed, 1996) and have been found to prefer loose and opaque work processes, rather than transparent and standardised ways of doing things which can be easily overseen by others, and therefore potentially subject to external control (McDonald, Waring and Harrison, 2005; Degeling, Kennedy and Hill, 2001).

In sum, doctors have always been involved in decision making about the way in which NHS organisations operated. However, prior to the 1980s their involvement was based around directing others to do the things that they needed in order for them to carry out their clinical work. Doctors' allegiance has always been to their patients and colleagues, as it is the profession that sets the standards by which they must abide, and these standards have traditionally focused on clinical care (Freidson, 1970). As such, a 'cosmopolitan' as opposed to a 'local' orientation (Gouldner, 1957) has been attributed to doctors, on the basis that they tend to be influenced by, and show allegiance to, the profession rather than the particular local organisation where they work. Writers on professions have suggested that organising around professional values and priorities has both pros and cons, as the next section briefly outlines.

1.3 Scholarly views on organising according to professional values

The medical sociologist Freidson (1990, 2001) has argued that health systems such as those in the US and UK, in being professional bureaucracies, are organised according to a mix of professional and bureaucratic principles, beliefs and values, which he referred to as logics. Others, such as Scott (2008) and Lok (2010), have suggested that such institutional logics may co-exist, but that one usually dominates. In fact, professional and bureaucratic principles have

long been seen as in conflict (Hinings, 2005), with Freidson (1990) cautioning that engaging overly with bureaucratic means of organisation and control would be unlikely to succeed in professional organisations such as the NHS. This is because patients are reliant on doctors having expertise and exercising it and doctors are not motivated by bureaucratic rules and standards (Freidson, 1990, 2001). Freidson (2001) also suggested that organising according to a professional logic enables professionals to have the freedom needed to further knowledge, which is in the interests of their clients, and serves to counter potentially undesirable managerial decisions which threaten clients' interests. However, Freidson (1990) also recognised that use of some bureaucratic and market principles in which service provision is subject to competition are necessary, to curb professional excesses with regards to spending and taking collegiality too far, such that patient safety for instance is compromised.

Mintzberg (1979) argued that there are pros and cons to organising according to professional values. Like Freidson, he argued that professional bureaucracies tend to generate a higher level of satisfaction and commitment amongst the professional workforce than other types of organisational form. However, Mintzberg (1979) highlighted that there are downsides, in that professional bureaucracies tend to lack the capacity to innovate and change in a radical way, owing to the fact that they are dominated by workers who have all been trained in a relatively standardised way. Others (Larson, 1990; Abbott, 1988) have suggested that professionals tend to be slow to change, and that they defend their areas of jurisdiction once these have been established, only ceding control at the edges. Mintzberg (1979) suggested that having a high level of discretion also creates the potential for clients' best interests to be ignored. More recent events suggest this is the case, as an analysis of the reason for high mortality rates in paediatric heart surgery at Bristol Royal Infirmary (Weick and Sutcliffe, 2003) has suggested that even quite powerful voices were prevented from being heard. Both Mintzberg (1979) and Freidson (1990), however, cautioned that curbing potential excesses amongst professionals would not be achieved through bringing in external sources of control, such as more managers. Rather, Mintzberg suggested, it would be achieved by slowly working to change professions from within. However, such advice was not heeded as new sources of control, in the form of general managers, were introduced, as the next section will discuss.

1.4 Changing the conditions and ways in which doctors practice

Back in 1979, at the time a new conservative government assumed power, the UK was in a state of economic crisis. Professional organisations such as the NHS and social services were facing increasing demand. This was as a result of such things as an ageing population and new treatments being possible, which increased the cost of providing these services (Kirkpatrick, Ackroyd and Walker, 2005; Dent, 2003). This government arrived with new ideas about how the economy and welfare organisations, including the professionals within, should be managed. Professionals in the public sector were perceived as the underlying cause of many problems (Foster and Wilding, 200; Ferlie et al, 1996; Ackroyd, Hughes and Soothill, 1989). In the case of doctors, they were perceived as overly dominant, resistant to change and the root cause of failure to control costs, due to a lack of line management within the NHS (Dopson, 2009; Hunter, 2008; Fitzgerald and Ferlie, 2000). As a result, a management review of the NHS was conducted (Griffiths, 1983). This criticised the lack of personal responsibility within the system for setting direction and evaluating performance:

“[The NHS] lacks any real continuous evaluation of its performance...rarely are precise management objectives set; there is little measurement of health output: clinical evaluation of particular practices is by no means common and economic evaluation of these practices is extremely rare” (Griffiths, 1983, p.10)

Following this review a number of Griffiths’ recommendations were implemented. Essentially, the NHS was exposed to a new form of management (Dopson, 2009; Exworthy and Halford, 1999; Ferlie et al, 1996), associated with a set of ideas referred to as the ‘New Public Management’ (NPM) (Hood, 1991) which were sweeping across many developed countries. These ideas were based on a belief that private sector style management practices were superior to those in the public sector (Hunter, 2008). The core ideas included: a more ‘hands on’ professional form of management, designed to provide clear direction and a locus of power to deliver accountability; explicit standards of performance and measurement and greater emphasis on results and efficiency, based around more cost effective use of resources and more sophisticated budgeting processes (Hood, 1991).

All of the above were introduced ostensibly to improve efficiency and effectiveness, and to rule out variations in medical practice (Flynn, 1999). However, many writers argue that NPM

was a strategy through which government aimed to control doctors (and other professionals) by wresting some power back from them (Dopson, 2009; Evetts, 2006; Hunter, 2008; Dent, 2003) and altering their traditional ways of thinking and behaving (Harrison and Smith, 2003; Freidson, 2001; Flynn, 1999). This is on the basis that, firstly, doctors have been subjected to new management practices and new requirements. Secondly, a new cadre of managers with a mandate to impose these changes was introduced and remains, accompanied by structural arrangements which have required doctors to take on more complex and responsible managerial roles. These factors are now looked at in turn.

1.4.1 The introduction of new practices and ways of working

Initially management practices were introduced in the form of targets and performance indicators for such things as patient throughput, length of stay and bed occupancy per consultant. Targets gradually extended from hospitals to general practice, with general practices achieving a percentage of their remuneration when these were met (Harrison and Smith, 2003). Under the New Labour government a new raft of centrally defined targets, such as the maximum four hour wait in Accident and Emergency (A&E) were introduced, which led to hospitals having to create new ways of managing patient admissions (Dopson, 2009).

However, one of the most wide sweeping changes was initiated in the 1990s with the introduction of an internal market, which created a purchaser-provider split. NHS hospitals largely became providers of care and primary care institutions became purchasers of care, initially by General Practitioners (GPs) being given budgets as fundholders, which were later replaced by Primary Care Trusts (PCTs) (Ferlie et al, 1996). Under new arrangements being introduced by the current coalition government clinical commissioning groups (CCGs) will become purchasers of care (Department of Health, 2010). The idea behind the internal market was that by allowing new providers to tender for certain contracts purchasers would have more options regarding who they purchased care from for their patients, and this would force particularly hospital based professionals to consider and improve their performance (Hunter, 2008).

In the late 1990s this focus on improving performance was taken further with the introduction of a system of clinical governance. This made NHS managers and professionals responsible for continuously improving the quality of their services and for managing risk, both in clinical and financial terms (Currie, Waring and Finn, 2008; Dent, 2007; Scally and Donaldson 1998). It requires doctors to audit and monitor their clinical practice more regularly and rigorously than they did under previous voluntary and peer review systems of medical audit, which doctors controlled (Dent, 2007; Harrison and Pollitt, 1994). Harrison and Smith (2003) suggest that this is actually a way of the state controlling doctors, who are also now also subject to five yearly re-validation and expected by the General Medical Council to highlight poor performance of colleagues if they have concerns (GMC, 2006). Associated with these new governance arrangements, the profession has faced the gradual introduction of new procedures such as national service frameworks to guide treatment of certain conditions, plus clinical guidelines and protocols, designed to standardise treatment and rule out variations in clinical practice. These protocols and guidelines are, however, produced by the profession or certain members of it, in the form of medical experts who act under the encouragement of the National Institute for Health and Clinical Excellence (NICE), formed in 1999 to advise government on what treatments and drugs should be funded (Harrison and Checkland, 2009).

All of this has undoubtedly brought doctors into greater contact with formal management practices and general managers. Fundholding created the need for GPs to recruit practice managers to manage the increased managerial workload associated with this and other targets introduced by government (Ashburner, 1996). When Primary Care Trusts (PCTs) were established they had to bring GPs into management and roles associated with commissioning (Ferlie et al, 1996). In hospitals, the number of general or non-clinical managers also increased considerably during the 1990s (Kirkpatrick, Ackroyd and Walker, 2005) in response to all the new processes introduced. The next section looks at the introduction of this new management cadre.

1.4.2 The introduction of a new management cadre and other structural changes

A new separate management hierarchy was first introduced into the NHS in the 1980s in response to the Griffiths report (1983). General Managers were introduced at regional, district and unit level in a bid to introduce stronger line management. These managers have a

mandate to take decisions and are expected to act as change agents (McMurray, 2010; Dopson, 2009), rather than as diplomats, as they did previously (Harrison et al, 1992). They are expected to be concerned with the type of issues important to managers in private organisations: the external environment in which their organisation operates and issues such as 'excellence', 'quality' and 'dynamism' when it comes to delivery and performance (Parker, 2000, p.76). While Roy Griffiths worked on the premise that some doctors would take up these new management posts few actually did and interest in management appears limited to a small number of doctors (Kirkpatrick et al, 2009).

In terms of attitudes, these new type of NHS managers have been found to have a collective orientation to patients (Edwards, 2005; Degeling, Kennedy and Hill, 2001) and to value the following: formal rules rather than consensus decision making; accountability rather than clinical autonomy; the involvement of a wide group of stakeholders in setting standards; transparent mechanisms for controlling work processes and finally, service provision driven by financial realism and defined outcomes (Degeling, Kennedy and Hill 2001). Such attitudes are in contrast to those of doctors, as has already been discussed in chapter one, suggesting potential for discord between the two groups and also that involvement in management may not appeal to doctors. This will be discussed in more detail later in the chapter, in terms of what it might mean for the potential of leadership development.

Over time the number of NHS managers has grown considerably. According to the Kings Fund, "in 2009, the NHS employed the full-time equivalent of 1,177,056 staff, of whom 42,509 were managers or senior managers. While the total number of NHS staff increased by around 35 per cent between 1999 and 2009, the number of managers increased by 82 per cent over the same period, from 23,378 to 42,509" (Kings Fund, 2010).

NHS hospitals are now run as Trusts, along the lines of private organisations, with corporate style boards led by a Chief Executive Officer (CEO), with very few CEOs being medically qualified (Ham et al, 2010; Harrison and Smith, 2003). Greater autonomy became available for top performing NHS Trusts that met certain financial criteria in 2004 when Foundation Trust status was introduced. This was in line with New Labour's modernisation agenda which sought to devolve power and accountability, in theory at least, to the local level, through new network

governance structures which were responsive to and involved stakeholders from outside of government (Dopson, 2009; Newman, 2005; Dent, 2003). Over time, CEOs of NHS Trusts have acquired greater responsibility, now being responsible for not only financial performance but also clinical outcomes, against targets set by government. This means that they need to work closely with clinical professionals to ensure that these clinical targets are met and expected outcomes achieved. Similar restructuring has taken place in primary care. Primary Care Trusts were established under New Labour, with a board and primary executive trust committee (PEC) alongside. These deal with operational issues and include a mix of up to seven health professionals, although PCTs and their associated PECs are due to be abolished under changes being introduced by the current coalition government in favour of local commissioning groups (Department of Health, 2010).

Under the terms granting NHS Trust status for hospitals, senior doctors were required to become more involved in hospital management (Ashburner and Fitzgerald, 1995). Firstly, the role of medical director became a full time post and board level position (both within secondary and more recently primary care), although their level of influence has been found to vary, with some actively involved in decision making whilst others act in a more advisory capacity (Kirkpatrick et al, 2009). In addition, divisional type structures with accountability were also required. These were generally introduced, and continue to exist, in the form of clinical directorates, consisting of one or more specialities united under the management of a clinical director, almost always a senior doctor undertaking the role on a part-time basis along their clinical work (Ferlie et al, 1996; Harrison and Pollitt, 1994). The clinical director role is essentially a 'hybrid' (Fitzgerald et al, 2006; Llewellyn, 2001) role, which straddles both managerial and professional worlds, often held for a period of around three years.

While, as previously discussed, doctors always had some degree of managerial responsibility (Exworthy and Halford, 1999) the clinical director role is much wider, and more financially accountable, than previous head of department type roles (Dopson, 1996, 2009) and has drawn a greater number of senior consultants into management. Whilst the way in which the role is enacted varies considerably (Kirkpatrick et al, 2009), responsibilities include such things as a requirement to develop strategic plans and/or service development plans, financial planning and budgetary management, resourcing decisions, staffing decisions, marketing of

the service and responsibility for the practice and performance of professional peers (Giordano, 2010; Kirkpatrick, Ackroyd and Walker, 2005; Kitchener, 2000; Ferlie et al, 1996). Some GPs have had to take on similar part-time management roles, as chairs of Primary Executive Committees and clinical leads (Calnan and Gabe, 2009). These 'hybrid', or professional-manager roles (Exworthy and Causer, 1999), will be discussed in more detail later, as the way in which doctors have responded to them offers some insight into how the current strategy to engage doctors across all levels in management of the NHS, albeit under the guise of clinical leadership (Spurgeon, Clark and Ham, 2011), might evolve. The next section moves on to discuss the emerging discourse of clinical leadership in more detail.

1.5 An emerging discourse of clinical leadership

The idea of leadership by professionals has gained ascendancy not only in medicine but also other areas of the public sector, such as education and social work (Martin and Learmouth, 2012; O'Reilly and Reed, 2010; Currie et al, 2008; Ham and Dickinson, 2008; Lawler, 2007; Glatter, 2004). This section considers the range of opinions as to why the concept of leadership has emerged in policy discourse and is currently favoured over management, and what it might mean for professionals.

Lawler (2007) suggests that the move to a discourse of leadership can be seen as either a further development of the managerial agenda by policymakers, or as a more genuine attempt to involve professionals in how organisations are run. Thorpe and Gold (2010) assert that leadership is basically the preferred term for the management of professionals, and has "become dominant when discussing the way powerful, self-directing and knowledgeable workers might be 'managed'" (Thorpe and Gold, 2010, p.4), as it requires different skills to those traditionally associated with management which are pertinent in such contexts. These include an ability to interpret situations, influence and inspire others, negotiate and debate. However, Thorpe and Gold (2010) argue that this does not negate the need for good management and administration, a view with which the Kings Fund agrees in relation to the NHS (Kings Fund, 2011). In fact, Thorpe and Gold argue, along with a number of writers (Thorpe and Gold, 2010; Bennis, 2006; Rosenbach and Taylor, 2006; Valle, 2006; Mintzberg,

2004) that leadership and management overlap within many roles. A report by the Royal College of Physicians and Kings Fund (Levenson et al, 2008) suggests that the concepts of leadership and management are blurred and used interchangeably within the NHS. The ways in which leadership and management differ, and the concept of leadership itself has evolved in recent years, will be discussed in more detail in the following section, 1.6.

Martin and Learmouth (2012) posit that leadership may offer health professionals an “attractive self narrative” (p. 287) and thus be a desirable concept for policymakers to peddle in order to try and engage doctors in the management of the NHS. Other writers from a more critical perspective argue that the discourse of leadership is being used as another device aimed at controlling professionals and re-shaping them into organisationally oriented beings with managerial values (Bolton et al, 2011; Wallace, Tomlinson and O’Reilly, 2011; Thrupp, 2005). O’Reilly and Reed (2010) refer to the emergence of ‘leaderism’ in public services, which they describe as ‘an emerging set of beliefs that frames and justifies certain innovatory changes in organization and managerial practice.....and is a hybridization and adaptation of NPM and new public governance practices in public services’ (O’Reilly and Reed, 2010, p.960). The authors argue that the discourse of leadership, which they view as part of the shift to leaderism, positions professionals, along with managers and the public, as champions and agents of system wide change. They argue that this policy is not aimed at freeing professionals to make the changes they see fit. Rather, it is about enabling them to introduce change in line with government ideas, and around ‘a re-orientation of public services towards the consumer-citizen’ (O’Reilly and Reed, 2010, p.960).

This somewhat sceptical view implies that previous changes introduced by policymakers have not been as successful as hoped, in terms of controlling professionals and altering their traditional sense of professionalism. While some writers argue that such things as standardised protocols and procedures have reduced the individual autonomy of doctors (Dent, 2007; Reed, 2007; Degeling, et al, 2003; Harrison and Ahmad, 2000), others have found evidence of their engagement in activities designed to maintain their control, through ignoring or adapting guidelines and processes to suit their own needs (Martin, Currie and Finn, 2009; Waring and Currie, 2009; Locock, Regan and Goodwin, 2004; Dent, 2003; Salter, 2001; Ashburner and Fitzgerald, 1995). As a result, there is a considerable body of opinion unconvinced that the collective autonomy of the medical profession has been severely dented and that an overall

loss of power to managers has occurred (Dopson, 2009; Hunter, 2008; Ackroyd, Kirkpatrick and Walker, 2007; Kirkpatrick, Ackroyd and Walker, 2005; Dent, 1995; Freidson, 1994; Harrison et al, 1992). When it comes to whether professional orientations and values have been changed by the introduction of management practices and the drawing of doctors into roles such as that of clinical director, again there is a prevailing view that change has been limited (Kirkpatrick et al, 2009; Forbes, Hallier and Kelly, 2004; Hoque, Davis and Humphreys, 2004; McKee, Marnoch and Dinnie, 1999).

The other perspective on the discourse of leadership is that it is being promoted as a way of helping professionals maintain, and indeed regain, some autonomy and influence (Lawler, 2007), based on an assumption that medical involvement will improve healthcare delivery and outcomes. For instance, Hunter (2008) suggests that policymakers have moved from viewing doctors as the root of all problems to seeing them as the solution to many problems, such that they are effectively being urged to colonise management positions. He suggests that toward the end of the last Labour government policymakers recognised that ‘terror by target’ (Hunter, 2008, p.39) had not worked and that managers and management priorities had become overly dominant. Similarly, Brookes (2011) argues that there is some recognition that NPM practices have led to what gets measured being what gets done, with a detrimental effect on service development and public confidence. This is arguably a reason why policymakers are seeking doctors’ involvement, in order to find innovative ways of delivering an improved service and thereby boosting public confidence in it.

There are other possible explanations as to why medical leadership may be being pursued for genuine reasons related to service improvement by policymakers. Firstly, medical scandals over the last couple of decades, such as the Bristol heart scandal where surgeons were operating beyond their own capability (Dent, 2003), have raised the need for greater professional oversight of clinical performance. This is on the basis that a doctor is best placed to judge another’s clinical ability and performance (Hunter, 2008). Secondly, there is evidence from the US that having doctors in leadership roles has a positive impact on hospital ratings (Goodall, 2011) and from the UK that having more doctors on the board of hospital trusts relates positively to quality outcomes (Veronesi, Kirkpatrick and Vallascas, 2012). A survey by McKinsey and co. in conjunction with the London School of Economics of 1200 hospitals across seven countries (UK, US, Germany, France, Italy, Canada and Sweden) also found that hospitals

with the most effective management practices tended to be those with higher proportions of medical leaders (Dorgan et al, 2010). Medical leaders have also been found to effectively champion organisational change (Fitzgerald et al, 2006; Ham, 2003; McNulty and Ferlie, 2002), which has otherwise been very limited (Harrison and Smith, 2003), through influencing their colleagues via collegial networks and use of persuasion (Xirasagar, 2005; Thorne, 2002; McKee, Marnoch and Dinnie, 1999). Thirdly, a number of writers now suggest that medical leadership, and indeed broader clinical leadership, has become a necessity, due to the complexity of policy changes which have led to the need for increased cross-boundary networks and relationships and a focus on safety and quality (Currie et al, 2011; Ferlie et al, 2011; Dickinson and Glasby, 2010; Mountford, 2010; Hartley, 2008). Indeed, health and social care professionals are now being required to work across boundaries and as part of multidisciplinary teams which include managers, other professionals and service users (Dickinson and Glasby, 2010; Currie, Waring and Finn, 2008; Royal College of Physicians, 2005) in order to design and run services, and to make the quasi-market which relies on long term co-operative relationships actually work (Abbott, Proctor and Iacovou, 2009).

Whilst policymakers may, therefore, seek to control and re-shape professionals through a strategy and discourse of leadership, they may also genuinely seek doctors' involvement as a way of improving services. Similar strategies are certainly occurring in other countries such as the US, Australia and across much of Europe (Ham and Dickinson, 2008; Domagalski, 2007; Jacobs, 2005). In the UK context, considerable investment has been made in recent years to try and develop doctors (and other clinical professionals) as leaders, through organisations such as the National Leadership Centre and National Leadership Council, now united as the NHS Leadership Academy, to champion leadership and work with training institutions to create opportunities for leadership development. In contrast to when previous attempts were made to change doctors, which the British Medical Association (BMA) and medical academy fiercely resisted (Harrison and Smith, 2003), policymakers now appear to have the support of the academy in their bid to develop doctors as leaders. The academy has been working since 2005 with the NHS Institute for Innovation and Improvement on an 'enhancing engagement in medical leadership' project, aimed at creating organisational cultures where doctors want to engage with organisational issues and where general managers genuinely seek their involvement to improve services. This support may be important in terms of increasing the chances of success (Noordegraaf, 2011) and the next section looks in more detail at the way this is being pursued.

1.6 Developing doctors as leaders

The medical academy in conjunction with the NHS Institute for Innovation and Improvement has developed a Medical Leadership Competency Framework (MLCF), now in its third iteration, to inform the design of training curricula and development programmes for doctors. The idea is that it will guide their development through training and beyond. It outlines the competencies required for doctors to be able to become 'more actively involved in the planning, delivery and transformation of health services' (MLCF, 2010, p.6). Competency is required in five areas:

1. 'Personal qualities': This includes developing self-awareness through appraisal and feedback, acting with integrity, managing oneself and engaging in continuing personal development.
2. 'Working with others': This includes building relationships, developing networks, working within teams and encouraging others contribution.
3. 'Managing services': This includes aspects such as planning and managing people, resources and performance
4. 'Improving services': This includes working to ensure patient safety, being able to critically evaluate, encouraging improvement and innovation and facilitating transformation
5. 'Setting direction': This includes identifying the contexts for change, applying knowledge and evidence, making decisions and evaluating their impact

By the end of undergraduate training it is expected that doctors will be competent in the dimensions of 'personal qualities' and 'working with others' and have some competency in managing and improving services. By the end of postgraduate training doctors are expected to also be competent in 'managing and improving services' and to have some competency in 'setting direction'.

These five areas include aspects traditionally thought of as leadership and others traditionally thought of as management (Zaleznik, 2004; Kotter, 1990; Conger and Kanungo, 1988; Bass, 1985; Burns, 1978). Leadership, whilst having a longer history than management (Thorpe and Gold, 2010), came to prominence during the 1980s and 1990s, when individuals at the top of organisations were felt to require leadership skills, depicted by a number of scholars as being

able to create a vision and successfully steer organisations into the future by inspiring and empowering others to follow them (Tichy and Devanna, 1990; Conger and Kanungo, 1988; Bass, 1985; Bennis and Nanus, 1985). Management skills during this period came to be depicted as more transactional (Burns, 1978), focused on the present and maintaining performance through planning and use of processes such as budgets, to manage financial expenditure, and indicators to monitor performance (Zaleznik, 2004; Kotter, 1990).

However, the concept of leadership has evolved in recent years. It now includes not only individual characteristics associated with those in formal roles of authority, but is also perceived as a collective and relational process involving all members of a particular community (Yukl, 2009; Hartley and Hinksman, 2003). Noted writers such as Bennis (2006) have started to suggest that there are fewer opportunities where individual leadership by the person at the top of an organisation will suffice. This is on the basis that the most urgent tasks facing organisations today are too complex to be identified and solved by any one person and require collaboration. Academics writing about health systems suggest that leadership is now needed at a variety of levels: self-leadership, which includes the ability to influence colleagues; team leadership and finally organisational leadership (Kings Fund, 2011; Ham and Dickinson, 2008; Mohapel and Dickinson, 2007). Yukl (2009) has suggested that if organisations are to change and innovate then initiatives need to come from the bottom up, requiring a culture in which there are leaders at all levels and where experimentation, innovation, flexibility and continuous learning and improvement are valued. This idea underpins Lord Darzi's review of the NHS (Department of Health, 2008), in which he called for 'high quality care for all' and urged doctors and other clinicians to take a lead in transforming services in order to achieve this.

Gronn (2002) has argued that collaboration and a sharing of the leadership role is increasingly a feature of situations where highly specialised workers are dependent upon each other, as they are in healthcare, in order for the system to work. Gronn (2002) highlighted the concept of distributed leadership, as a fluid and emergent phenomenon that occurs within the activities of groups and may be facilitated through institutionalised practice. Others have spoken of concepts such as dispersed leadership (Bryman, 1996), and shared leadership (Pearce and Conger, 2002) amongst others in recent years. However, some writers (Woods and Gronn, 2009; Spillane, 2005; Gronn, 2002) have argued that distributed leadership can occur

without it necessarily being shared or democratic. Brookes (2011) attempts to offer clarity by suggesting that distributed leadership exists where leadership roles with some degree of allocated authority exist at various levels within a hierarchy, with shared leadership being that which emerges and exists horizontally across all levels and collective leadership being that which exists across organisational boundaries. In contrast, Thorpe, Gold and Lawler (2011) consider co-leadership and shared leadership as being aspects of distributed leadership, which they define as “the exercise of influence that produces interdependent and conjoint action” on an organizational and inter-organizational wide level (Thorpe, Gold and Lawler, 2011, p.241). However, they note that “a universally accepted definition of distributed leadership remains elusive” (p.240) and call for more research in a variety of contexts, beyond that of school leadership where the focus of UK research has largely been. Overall, what is common amongst all of these concepts is the idea that leadership is a process, and rather than being the preserve of just one individual at the top of an organisation can occur amongst a number of actors within, across and between organisations (Bolden, 2011).

When it comes to the Medical Leadership Competency Framework (MLCF) developed by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges, this has been formulated around an idea of ‘shared leadership,’ defined as:

“leadership [which] is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual. Therefore shared leadership actively supports effective teamwork” (Medical Leadership Competency Framework, Third edition, July, 2010, p.6).

Clinically, however, the concept of leadership has been perceived in different ways by the various health professional groups, with the medical profession using it in relation to roles such as those of medical and clinical director (Jakeman, 2008). The concept of clinical leadership will be considered here to include both management and leadership practices, and roles such as medical and clinical director, previously considered medical manager roles, will be referred to hereon as medical leadership roles. The next section looks in more detail at the medical academy’s objectives behind advocating leadership training and development for doctors.

1.6.1 The medical academy's objectives for leadership development

In advocating that doctors are trained in leadership and management it seems that the academy has dual objectives. The first objective is to develop leadership and management competency in all doctors, so that they can behave as leaders when necessary. This is on the basis that they have a skills deficit, owing to the fact that such competency has historically not been developed as part of their initial or specialist training. The second objective is to facilitate enactment of a new medical professionalism, defined by the Royal College of Physicians (RCP) in 2005 in response to the social and political changes emerging, in a report entitled 'Doctors in society: Medical professionalism in a changing world'.

Medical professionalism was defined as 'a set of values, behaviours and relationships that underpins the trust the public has in doctors' (Royal College of Physicians, 2005, p.14). These values were described as integrity, altruism, compassion, a commitment to excellence and continual improvement and to working with members of the wider healthcare team (p.15). The report stated that doctors had a responsibility to act according to the values set out, and that being a doctor involved working in partnership with patients and members of the wider healthcare team, with the doctor-manager relationship being key to the delivery of professional healthcare:

"Professionalism therefore implies multiple commitments - to the patient, to fellow professionals, and to the institution or system within which healthcare is provided, to the extent that the system supports patients collectively. A doctor's corporate responsibility, shared as it is with managers and others, is a frequently neglected aspect of modern practice" (Royal College of Physicians, 2005, p.xii)

The report recognised that this new professionalism would have implications in terms of leadership, teams, education, appraisals, careers and research. Leadership was particularly honed in on, and considered to be needed at four levels; the individual doctor, the front-line clinical team, the local service entity and the national policy stage (p.26). This view is in line with that of some health management academics (Kings Fund, 2011; Ham and Dickinson, 2008; Mohapel and Dickinson, 2007). It was suggested that every doctor has the potential to be a role model and that the behaviours underpinning medical professionalism 'indicate a leadership role, no matter how small, for every medical practitioner' (Royal college of Physicians, 2005, p.26). The report considered that multidisciplinary teams were the delivery

system for healthcare but that doctors would frequently be called on to lead the team and would therefore need the skills to do so:

“..the complementary skills of leadership and ‘followership’ need to be carefully documented and incorporated into a doctor’s training to support professionalism. These skills argue strongly for managerial competence among doctors. An individual doctor’s decisions have both clinical and managerial elements” (p.27)

In terms of the gap that exists between the traditional and the newly defined professionalisms, it was suggested that doctors tend to be task oriented in their work and communication with other professionals, have insufficient time for team building, have not spent enough time learning from other professionals such as nurses at ward handovers, and were often confused about their role. This is supported by evidence which has found that inter-professional boundaries remain between doctors and other health professionals (Powell and Davies, 2012; Ferlie et al, 2005; Fitzgerald and Teale, 2004), due to each group having its own well developed identities and practices. Hospital doctors have also been found to maintain the view that they are the key decision maker, even when new, supposedly more autonomous specialist nursing (Currie et al, 2010) and specialist GP roles (Martin, Currie and Finn, 2009) have been introduced.

The importance of education and integrated action was stressed in the report. Section 3.12 recommended that the academy, medical schools, the British Medical Association and other healthcare organisations all take responsibility for developing a cadre of clinical leaders. It stated that ‘these bodies need to define the skills of leadership that they seek, and implement education and training programmes to develop doctors with those skills’ (RCP, 2005, p.28). The proposal to train doctors in leadership and management has been supported by high profile, senior figures within the profession, such as Sir John Tooke in his inquiry into ‘Modernising Medical Careers, the revamp of postgraduate training (Tooke, 2008). This was built on by Lord Darzi (Department of Health, 2008) who, in his review of the NHS for the last Labour government, appealed for doctors (and other clinicians) to act not only as practitioners but also as partners, with patients and other professionals, and as leaders of service design and quality improvements. This concept of practitioner, partner, leader has now been incorporated into ‘Tomorrows Doctors’ (2009) the General Medical Council publication on outcomes and standards for undergraduate medical education in the UK.

The Royal College of Physicians report did, however, caution that the political and environmental culture was preventing many doctors from acting in the ways set out. It stated that managers had a responsibility to create the infrastructure to support doctors carry out their duties. Concerns were expressed that professionalism had been undermined in striving to achieve targets. The report noted that showing corporate responsibility would sometimes entail taking an adversarial role, and opposing managers' plans. Oliver (2009), a medical director with degrees in leadership and management, supports this in distinguishing between management and leadership:

“good leadership does not entail a headlong rush to implement whatever comes down the line, uncritically and regardless of the implications for patient care”
(Oliver, 2009)

This statement by Oliver (2009) implies that managers tend to implement government policies, irrespective of what they might mean for patient care, and that clinical leaders must prioritise patients. This view is supported by Cruess and Cruess (2009) who argue that amidst all the change that has occurred and the new expectations of doctors, they are still expected to put patients first. The next section considers the progress that has been made to date in training doctors in leadership.

1.6.2 The extent of development to date

According to the academy of Royal Medical Colleges website the 'Medical Leadership Competency Framework' (MLCF) is now incorporated into undergraduate and all postgraduate, specialist training curricula. However, recent evidence (Noordegraaf, 2011) shows that implementation is being left to local schools of medicine and deaneries and that at many establishments both undergraduate and postgraduate level training remains focused on medical practices. Where leadership is included the focus is on leading clinical teams for the benefit of patients. There are some exceptions to this, in that undergraduate level training at Imperial College in London for instance has for a number of years provided the opportunity for medical students to follow a management pathway after their first two preclinical years (www1.imperial.ac.uk/medicine/teaching/undergraduate/intercalbsc).

In terms of specific training and development initiatives, a number of training programmes have been run for doctors in leadership positions, such as those of medical and clinical director, since the 1990s. Some have been evaluated (Edmonstone, 2009; Hardacre and Keep, 2003; Dopson, 1996; Ferlie et al, 1996; Allen, 1995; Cowling and Newman, 1994; Fitzgerald, 1994) although from a variety of perspectives. Ferlie et al (1996) concluded from their early research with clinical directors that those who had not been coerced into the role had generally benefitted from training in terms of knowledge, understanding and ability to work with colleagues. A degree of personal change, in terms of confidence, self-awareness as well as attitudinal change towards organisations has been noted in some programmes (Hardacre and Keep, 2003; Cowling and Newman, 1994; Fitzgerald, 1994).

However, training and development for doctors already in formal leadership positions has been argued to be remedial (Simpson and Calman, 2000), or aimed simply at correcting skills deficiencies. It has been suggested that the postgraduate, specialist trainee stage (usually referred to as Registrar stage), is an appropriate time for leadership and management training, in order to prepare doctors for taking on future roles (Simpson and Calman, 2000). Dopson (1996) also found that clinical directors supported the idea of training at this stage. To date, most training opportunities for Registrars have been in the form of short, four or five day management courses (Griffiths et al, 2010; Clark and Armit, 2009) run in some cases by NHS Trusts and in others by external training companies and universities such as Keele University and Manchester Business School. However, a recent survey of junior doctors found that of qualified doctors, from foundation year onwards only 25 per cent had received any leadership training (PMETB, 2007). Ham and Dickinson (2008) found that internationally, leadership development interventions for this level of doctor tend to be localised and fragmented. In the UK more in-depth interventions include a management development programme for specialist trainees in psychiatry in West London, using experiential learning, group learning sets and mentorship via the medical director. Reportedly, attendees gained a better understanding of management processes and structures and a more positive outlook in terms of dealing with problems. They began to see that service delivery should involve both clinicians and managers and were surprised that leadership and management are evidence based (Fellow-Smith et al, 2004). A pilot 'leadership mentoring programme' also launched in London in 2008, for twenty Registrars interested in leadership and management, who worked on organisational projects alongside senior clinical and non-clinical leaders. Whilst reported as being successful, the focus was on the mentoring arrangements (Warren, Humphris and Bicknell, 2008).

These early interventions for the next generation of consultants and GPs suggest reasons to be optimistic about training as a strategy for re-shaping professionals' attitudes and orientations. However, evidence as to whether and how leadership interventions work to change attitudes, beliefs and practices is limited and as Noordegraaf (2011) highlights, the new definition of medical professionalism has yet to be achieved. A review of medical engagement with management (Ham and Dickinson, 2008) and a recent report into the state of management within the NHS (Kings Fund, 2011) both call for further development opportunities. As such, it is necessary to draw on existing theory and evidence as to what might occur. The next sections consider firstly the arguments for, and secondly the arguments against, training and development as a potential mechanism for change in doctors sense of professionalism.

1.7 The case for leadership development as a potential mechanism for change

Training and development in leadership and management might be viewed as a necessary and logical move, given that initial training has long neglected these areas, prioritising the acquisition of scientific knowledge (Edwards, Kornacki and Silversin, 2002; Smith, 2001; Sinclair, 1997), and the NHS and health provision has become increasingly complex (Mountford, 2010; Hartley, 2008). However, there are particular reasons why leadership development might now be a mechanism for change. Firstly, there is growing support within the profession for such development, both from senior figures at the helm and doctors at other levels. Secondly, involvement in management has the potential to be more attractive for doctors due to changes in the context in which they work. These aspects are now considered in turn.

1.7.1 Growing support within the profession for leadership development

As previously discussed, there has recently been support for leadership and management development from the medical academy and high profile doctors such as Professor John Tooke and Lord Darzi. In addition, there is some evidence which suggests that other members of the profession, at grass roots level, including a small number of Registrars (NHS Confederation, 2009; Khera et al, 2001) also support such development. For example, a small number of

Registrars in London have voiced the need for training to develop skills in team working, communicating with patients and other profession and skills in leadership and change management, which includes learning about the way the NHS works and re-shaping the way Registrars feel about change (Khera et al, 2001). A series of consultations about management in the NHS run by the Royal College of Physicians and the Kings Fund (Levenson et al, 2008) found a general view amongst doctors that they should not be solely responsible for resource decisions, and that they needed to be involved and work more closely with managers. Overall, the authors concluded that there were signs of a slight shift in attitudes in favour of doctors being involved in management (Levenson et al, 2008).

Others suggest that doctors accept the need for financial restrictions and some form of rationing (Cooke and Hutchinson, 2001; Dent, 1995) and to audit and collect data (Checkland et al, 2007). In fact, Pickard (2009) suggests that the medical profession has become re-professionalised in 'incorporating a new set of managerially defined competencies and a new type of clinical autonomy' (p.255). It has also been suggested that some specialities, such as pathology and radiology based ones, are more managerial and organisationally oriented than those such as acute medical and surgical specialities (Willcocks, 2004; Harrison, 1992). This is partly attributed to the fact that pathology based specialities are more exposed to competition from private providers than acute specialities such as general medicine (Willcocks, 2004). Sinclair (1997) also observed that psychiatrists were perceived as more geared towards collaborative working and using lay language with patients, which fits with ideas of partnership underpinning the new definition of medical professionalism (Royal College of physicians, 2005). The next section considers an argument that leadership roles might become attractive to doctors as external pressures on their ways of working continue.

1.7.2 Management has the potential to become more attractive

One possible reason that training and development in leadership may be successful is that involvement in wider organisational and managerial issues may be becoming a more attractive career prospect for some doctors than it once was. This idea is based on firstly, a theory of restratification amongst professions (Freidson, 1984, 1994) and secondly, the idea that there is increasingly shared control between professionals and managers within welfare organisations (Noordegraaf, 2007).

Firstly, Freidson argued that as professions continue to come under pressure from policymakers and the public to change, that they will not necessarily become deskilled or reduced to the same level as other workers, in the way some have suggested (McKinley and Arches, 1985; Haug, 1973). Rather, Freidson (1984, 1994) argued that they will become increasingly stratified, or restratified. Some tasks will be devolved to other professionals, and indeed nurses have taken on some of the tasks doctors once used to perform (Calnan and Gabe, 2009; Ashburner, 1996). Within the profession some members will assume what Freidson called 'administrative elite' positions, whereby they direct the work of others and some will assume 'research elite' positions, where they write the guidelines and protocols that the rest, the 'rank and file' follow.

One implication of Freidson's thesis is that acquiring an 'elite' management position may become attractive for doctors as a means of maintaining influence within the system (Kirkpatrick et al, 2009), making leadership development attractive. There is some support for this being the case. In general practice, there has been an introduction of new, specialist roles and 'administrative elite' roles within commissioning consortia and on PCT boards (Calnan and Gabe, 2009; McDonald et al, 2007, 2009). Martin, Currie and Finn (2009) found GPs keen to take on a new, advanced clinical role as a GP with Special Interests (GPSI). Within practices, McDonald et al, (2009) found evidence of a new informal hierarchy emerging amongst GPs; some willingly taking on a role they term a 'chaser' (p.1202), scrutinising and chasing others to meet performance targets. While the authors found that these chasers, and indeed GPs involved in commissioning, remained grounded in clinical work much of the time, they noted that some commissioning board members felt they had a wider understanding of the healthcare arena and were superior to other rank and file GPs on this basis. In the hospital setting, some clinical directors have also been found to be enthusiastic about the way in which the internal market enables them to be more entrepreneurial and develop their service (Forbes and Hallier, 2005; Forbes, Hallier and Kelly, 2004; Fitzgerald and Ferlie, 2000; Kitchener, 2000). Some doctors in management roles both in the US (Hoff, 1999) and UK (Llewellyn, 2001; McKee, Marnoch and Dinnie, 1999) have also been found to enjoy the power the role brings and the influence within the system they can develop. Recent work with medical and clinical directors has found that they feel well placed to make resource decisions and are keen to work on an equal level with general managers over issues such as clinical quality and safety (Giordano, 2010).

Secondly, Noordegraaf (2007) has proposed that for professionals in the public sector, traditional notions of professionalism, in which professionals exercise considerable control over what is done and how it is done, have given way to a more 'hybridized professionalism' (p. 773) in which they expect to take on managerial responsibilities and to share control with managers. Noordegraaf argues that this is making the professional identity harder to define and locate for professionals. One implication of this is that doctors may seek leadership development as a way to help them cope with these new elements, in terms of gaining an understanding of how to establish and exercise some control within the wider system, and also as a means of locating an identity in a context in which they face an increasingly mixed set of demands. Recently, a small group of Registrars has begun to champion clinical leadership, particularly medical leadership (Griffiths et al, 2010). However, they acknowledge that progress is likely to be slow and that the challenge is to how to bring leadership alive in the day to day actions of doctors and incorporate it within their sense of professionalism.

To summarise, these last sections have shown that leadership development for doctors has support at the top of the profession. There is also some, albeit limited, evidence that leadership roles can be attractive, such that development opportunities might be an attractive option. However, there are also some strong arguments which suggest that leadership and management training may not in fact be able to achieve a change in attitudes, beliefs and practices amongst doctors. The next section considers these.

1.8 The case against leadership development as a potential mechanism for change

The case against training and development being likely to act as a mechanism for changing doctors attitudes, beliefs and practices is based on three factors: that the medical culture is largely unsupportive of doctors taking on management roles; that there is a lack of incentive for doctors to take on such roles and finally, that traditional notions of professionalism are particularly well embedded during initial training. This section begins by looking at the culture and context in which leadership development must take place.

1.8.1 A hostile medical culture

One thing which may hamper change amongst junior doctors participating in leadership development is that the longstanding professional culture is one of apathy and hostility towards involvement in management and organisational issues. The BMA and the Medical Colleges opposed the introduction of general management and doctors' involvement in management (Ham and Dickinson, 2008; Harrison and Smith, 2003; Harrison et al, 1992). While Sir Roy Griffiths reportedly hoped that senior doctors would apply for any management posts created following his report (Hunter, 2008), according to Harrison et al (1992) only 9.5% of these initial posts were taken up by doctors. Reluctance to take on leadership roles has continued over successive years, both amongst GPs (Calnan and Gabe, 2009) and consultants (Forbes, Hallier and Kelly, 2004; Fitzgerald and Ferlie, 2000; McKee, Marnoch and Dinnie, 1999; Dopson, 1996). This is despite the fact that such roles would seem to offer opportunities for influencing decision making, and is in contrast to the situation in Denmark, where new Public Management emerged around the same time as in the UK. Attitudes towards managerial involvement amongst the profession in Denmark have been found to be more positive, and it is suggested that this is due to cultural factors including the Danish medical profession as a body being more supportive and arguing more strongly in favour of doctors taking on leading roles. More consultants there have also had formal management training (Kirkpatrick et al, 2009).

In the UK, the relationship between doctors and managers across the various levels of each hierarchy has also tended to be one of tension (Hunter, 2008; Rundall et al, 2004; Atun, 2003; Edwards, 2003; Fitzgerald and Ferlie, 2000). Tribal tendencies have been noted, with consultants in some cases simply refusing to do as managers ask (Bate, 2000). This has been attributed to differences in cultures and value systems amongst doctors, managers and other health professionals (Hafferty and Hafler 2009; Fitzgerald and Teal, 2005; McDonald, Waring and Harrison, 2005; Jorm and Kam, 2004; Willcocks, 2004; Bate, 2000; Degeling, Kennedy and Hill, 2001). Doctors have perceived managers to be focused on performance standards rather than clinical need (Calnan and Rowe, 2009; Degeling et al, 2006; Rundall et al, 2004) and to lack legitimacy to manage, or determine how practices such as risk management should be implemented, owing to their lack of clinical knowledge (Waring and Currie, 2009; Montgomery, 2000; Fitzgerald, 1994). All of this suggests that expecting them to suddenly work in partnership with managers may prove to be wishful thinking.

Nor is it only relationships between doctors and non-clinical managers that have been difficult. Clinical directors have also faced hostility from their clinical colleagues when attempting to introduce change amongst colleagues who are unreceptive to managerial issues and tend to see moving into a managerial role as betraying the profession and its values (Marnoch, McKee and Dinnie, 2000; Thorne, 1997a; Allen, 1995; Fitzgerald, 1994). All of this suggests that junior doctors may be discouraged from demonstrating leadership and new ways of thinking, even supposing they enter leadership development programmes with a strong desire to do so. Added to the issue of a potentially hostile culture is the fact that there are no incentives for doctors to take on leadership roles, as the next section outlines.

1.8.2 A lack of incentives to take on leadership roles

In the UK, added to the lack of training and preparation for doctors taking on leadership roles, which continues to be an issue (Giordano, 2010; NHS Confederation, 2009), other factors have been cited as potentially deterring doctors from taking on a leadership role and therefore seeking leadership development. These include such things as the lack of a structured management career path and a lack of appropriate rewards (Giordano, 2010; Mountford and Webb, 2009; Ham and Dickinson, 2008; Fitzgerald et al, 2006; Ham, 2003). While clinical excellence awards do now include recognition of a variety of aspects of medical leadership, (ACCEA, 2009) there are access issues to these for medical directors (NHS Confederation, 2009). Salaries of medical and clinical directors also fall within the consultant pay band (www.nhs.uk/library/.../payandgradingstructureseniorstaff) and do not recompense for the loss of potential income from private work, which is limited due to the time it takes to meet the commitments of the role (Giordano, 2010; NHS Confederation, 2009; Fitzgerald and Ferlie, 2000; Dawson, 1995). In addition to all of this, many medical leaders, such as clinical directors, have found that they face conflicting expectations as well as a lack of support and empowerment within the wider organisation (Forbes, Hallier and Kelly, 2004; Willcocks, 2004; Davies, Hodges and Rundall, 2003; Thorne, 2002; Fitzgerald and Ferlie, 2000). On this basis there is a risk that any junior doctors who do participate in intensive leadership development interventions may do so for their own reasons, for instance as a means way of exiting the system, rather than out of any desire to lead within the NHS. The next section looks at the idea that doctors' sense of professionalism is deeply embedded and will be difficult to change.

1.8.3 The deeply embedded nature of medical professionalism

It is argued that initial medical training goes beyond developing the required level of clinical knowledge and expertise in applying this knowledge. It also acts as a socialising mechanism, or way by which newcomers learn the behaviour, skills and attitudes that the profession feels are necessary to fulfil the role. Training is said to divest newcomers of their existing values and beliefs and instil new ones, which constitute a framework of medical professionalism (Hafferty, 2009; Apker and Eggly, 2004; Van Maanen and Schein, 1979; Goode, 1957).

It is proposed that this strong sense of professionalism is instilled by the *way* in which newcomers are trained (Van Maanen and Schein, 1979). Collective delivery of the formal educational component, separately from other professionals, is argued to leave newcomers in no doubt that they have a special role and are different from others. The informal, or on the job, aspects of training also expose trainees to already socialised peers who operate as role models (Hafferty, 2009; Van Maanen and Schein, 1979). A few medical schools have started to teach medical students alongside other health professionals in recent years, to try and encourage greater collaboration amongst professionals. However, such forms of education remain limited (Crues, Crues and Steinert, 2009). In the main, initial medical training has placed particular importance on developing scientific knowledge along with an appropriate stance, demeanour and values in which objectivity and emotional neutrality are prioritised over such things as team work and knowledge of how to run organisations (Hafferty, 2009; Silverman, Kirtz and Draper, 1998; Hafferty and Franks, 1994). This is instilled through such things as introducing newcomers early on to unusual situations, such as the dissection room, where they learn to convey the same approach and attitudes as displayed by established members of the profession (Sinclair, 1997). It is argued that newcomers are driven to try and cognitively make sense of these unusual situations, and that in finding plausible explanations for what they encounter new ways of thinking emerge, in line with those of established members of the profession (Louis, 1980b).

Socialisation theory suggests that the professional identity becomes deeply embedded because newcomers are highly motivated to fit in with established norms, having already invested a great deal to be accepted for initial training (Hafferty, 2009) and because initial training develops a strong sense of what it means to be a member of the professional

community (Van Maanen and Schein, 1979). The social identity approach, incorporating social identity theory and social categorization theory (Tjafel and Turner, 1985; Tjafel, 1978), suggests that individuals identify with, and categorise themselves as members of groups, in order to ease their way in the social world, by facilitating communication and co-operative working. From this perspective, medical students decide to join and categorise themselves as a member of the medical profession, and so adopt prototypical characteristics of the group. Developing this perspective further, Sluss and Ashforth (2007) suggested that individuals will relate to and identify with others, both in terms of the roles they hold and their individual qualities. However, utilising this perspective, Currie, Finn and Martin (2010) found that the professional, or group, identity of nurses had greater impact on the way relationships with doctors and others were enacted than did their personal identity, or the individual qualities the nurse brought to the role. They attributed this to the fact that professional contexts are one of the 'very strong situations' which Sluss and Ashforth (2007, p.12) proposed would allow individuals less latitude to enact a role and relate to others as they might like.

As a result, it is questionable as whether a more corporate orientation can be added to traditional notions of medical professionalism without one 'challenging the *raison d'être* of the other' (Ackroyd and Muzio, 2007, p. 744). Indeed, Ackroyd (1996) suggests that the professional identity has proved surprisingly resistant to attempts to erode it, despite some fairly major changes to professional organisations. While the clinical director role epitomises that of a 'hybrid,' in which professional and managerial practices are combined, a review by Fitzgerald et al (2006) concluded that clinical directors 'do not yet have a coherent work identity or credentialised knowledge base' (p. 170). Kippist and Fitzgerald (2009) have also found that clinical directors tend to view themselves first and foremost as clinicians, and have very different values and priorities to general managers (Kippist and Fitzgerald, 2010). The same appears to be the case of GP managers, if the remarks of the chair of Bassetlaw commissioning group are anything to go by. He described himself in a recent online journal as "between jobs - half GP, half manager" and as "looking forward to surgeries more than ever and the 'real challenges' they bring" (Kell, 2011). Even amongst younger doctors, reports suggest that many of the Registrars who attend the short management courses available see these simply as a tick box exercise prior to consultancy (Griffiths et al, 2010; Clark and Armit, 2008). All of this raises concerns as to whether even intensive training and development interventions will be able to change established values, beliefs and behaviours. The next section looks at what conclusions we can draw.

1.9 Conclusions and remaining questions

The chapter has outlined the changes that have occurred in the management of the NHS since the 1980s, which have been, in part, an attempt to get doctors to change the way they think and behave. While these have led to senior doctors gradually being drawn into managerial roles, with significant levels of responsibility for the service, the chapter has shown that policymakers continue to seek more widespread medical engagement with management and organisational issues. This is currently being pursued under the guise of clinical leadership, accompanied by considerable investment in development opportunities. As yet, little investment in intensive development interventions for up and coming doctors, who may be future leaders, has occurred. It is therefore difficult to know how successful this strategy might be in engaging them and altering their attitudes, beliefs and practices. Reviewing the evidence as to how doctors have engaged with management issues over the last thirty years, in conjunction with theories on professions, arguments for and against leadership development as a possible mechanism for change can be made. As such, questions remain as to whether this latest strategy of providing leadership and management training for doctors is a likely mechanism for engendering a re-orientation and new professionalism amongst them. The next chapter moves on to consider how this issue might be explored and what type of leadership development intervention the literature suggests may be the most likely to engender such a change.

Chapter 2: Leadership Development for Doctors

Introduction

As the discussion in chapter one has highlighted, policymakers and the medical academy currently perceive that doctors need to develop a new sense of professionalism and alter their orientation to their role as a doctor, in terms of enhancing their engagement with management issues and working in a more integrated way with managers and other professionals. Leadership development is being encouraged and pursued as a means of enabling the transition to this new sense of professionalism, but as yet it is unclear as to whether this strategy will be successful. As such, a way of exploring how the process of leadership development is experienced by doctors and impacts on their attitudes, beliefs and practices is needed. The objective of this chapter is to set out a way in which the process of leadership development might be explored and to consider the type of leadership development intervention that the literature suggests is best placed to enable such a transition.

The chapter is structured as follows: Section 2.1 outlines existing frameworks for evaluating the process and impact of leadership development and considers both their strengths and shortfalls. Given the recent proposal, that the process of becoming a leader be considered as one of role transition and identity change, role transition theory appears to offer a new and more appropriate way of exploring the issues of concern in this research and in section 2.2 the theory and model of work role transitions developed by Nicholson (1984) is detailed. Section 2.3 then moves on to consider the type of leadership development activities that might be used to enable role transition. Section 2.4 summarises the chapter and outlines the research questions emerging from the review of the literature in this chapter and chapter one.

2.1 Existing frameworks for examining leadership development

There are a number of existing frameworks which enable leadership development interventions to be evaluated, many of which are based on that of the four levels developed by Donald Kirkpatrick (1960). Kirkpatrick considered that evaluation should take place at the following levels: (1) learners 'reactions' to the intervention; (2) an assessment of 'learning' in terms of knowledge, skills and attitudes; (3) assessment of 'behaviour change' and (4) an assessment of the 'results,' in terms of organizational outcomes. Hamblin (1974) added a fifth level, that of the impact on organizational performance and Phillips (1996) included return on investment, developing a complex formula in an attempt to measure this. Warr, Bird and Rackham (1970) proposed that the context of an intervention be assessed and the impact on organisational results included.

While these frameworks have valuable elements they are also problematic, in that they are underpinned by certain assumptions (Hodkinson and Hodkinson, 2004; Stewart, 1999; Easterby-Smith, 1994). These include a belief that objectives and learning can be easily codified, and that learning, behaviour change and outcomes can and should be objectively measured. Whilst the ultimate impact on clinical and organisational outcomes of developing doctors as leaders is important, research has yet to determine whether and how participation in development might change them at an individual level. In addition, even Kirkpatrick and Kirkpatrick (2006) acknowledged that the fourth level of Donald Kirkpatrick's framework, that of assessing the impact on organizational performance, is difficult, in terms of determining what results can be attributed to participation in development activities.

Where the purpose of research is to understand how a leadership process focused on personal change and development is experienced and impacts on individuals, whilst taking account of the cultural complexity of the situation in which it occurs, such evaluative frameworks are less appropriate (Hodkinson and Hodkinson, 2004; Stewart, 1999; Bernthal, 1995; Easterby-Smith, 1994). This raises the question of whether there is a more appropriate way for these issues to be explored.

Drawing upon a stream of research that links role transitions with identity processes (Ibarra, 2003; Ashforth, 2001; Ebaugh, 1988) Ibarra, Snook and Guillém Ramo (2008) propose that the process of becoming a leader be considered as a process of role transition and identity change. Considering this in more detail, role transition is defined as a process of changing one's job role, or changing one's orientation to a currently held role (Louis, 1980a). Identity is defined as the various meanings attached to an individual by self and others (Michener, DeLamater, and Myers 2004, p 85). An individual's self-concept consists of multiple identities, with some being more central, or more important to them, than others (Ashforth, 2001; Hogg and Terry, 2000). Role identities are an individual's concept of themselves in a specific role (Michener, DeLamater, and Myers 2004), with a professional identity being a social identity, based on the meanings attached to the professional group that an individual is a member of, in conjunction with the personal traits they display and which others attribute to them (Ibarra, 2007; Schein, 1978). Individuals have a hierarchy of identities, with those most important to them sitting at the top of the hierarchy (Michener, DeLamater, and Myers 2004). For instance, someone may view themselves as a paediatrician or surgeon at a lower level, but as a doctor at a higher level, with which identity they draw on depending on where they are and who they are with (Turner, 1982). From this perspective, identity is a dynamic rather than fixed state, with multiple identities, or hybrid notions of professionalism, being possible.

Ibarra (2007) argues that identity transitions are driven by alterations in what an individual considers to be their set of 'possible selves'(p.7), or the images they have about who they might become, would like to become, should become, or fear becoming in the future. As such, she argues that having a conception of identity anchored in future possibilities, rather than current role identities, is important when it comes to studying voluntary role change. These possible selves act as a motive for change, and individuals interpret opportunities or constraints that arise against these desired or feared future selves. Ibarra (2007) suggests that individuals make transitions by "experimenting with provisional selves that serve as trials for possible, but not yet fully elaborated, professional identities" (p.7). According to Ibarra Snook and Guillém Ramo (2008) the leadership development process offers opportunities to experiment with, or try out, provisional selves. They suggest that during the process there will be a 'separation' from old ways of thinking and behaving, a 'transition' period involving trying out new ways of thinking and behaving and then a period of

'incorporation,' when some of the new ways of thinking and behaving are incorporated into the professional identity.

However, while Ibarra, Snook and Guillém Ramo (2008) offer useful ideas about how leadership development might enable role transition and identity transformation they state that "research and theorizing on leadership development have yet to specify the processes that account for identity transformations in role transitions" (p.1). Given that questions remain as to whether and how leadership development might engender role transition and a change in the professional identity of a group such as doctors, utilising a theoretical framework of role transition, overlaid with ideas as to how identity may change (Ibarra, Snook and Guillém Ramo; Ibarra, 2007) would appear to offer an appropriate way of exploring these questions. The next section looks at how leadership development might be explored through a framework of work role transitions.

2.2 Exploring leadership development through a framework of work role transitions

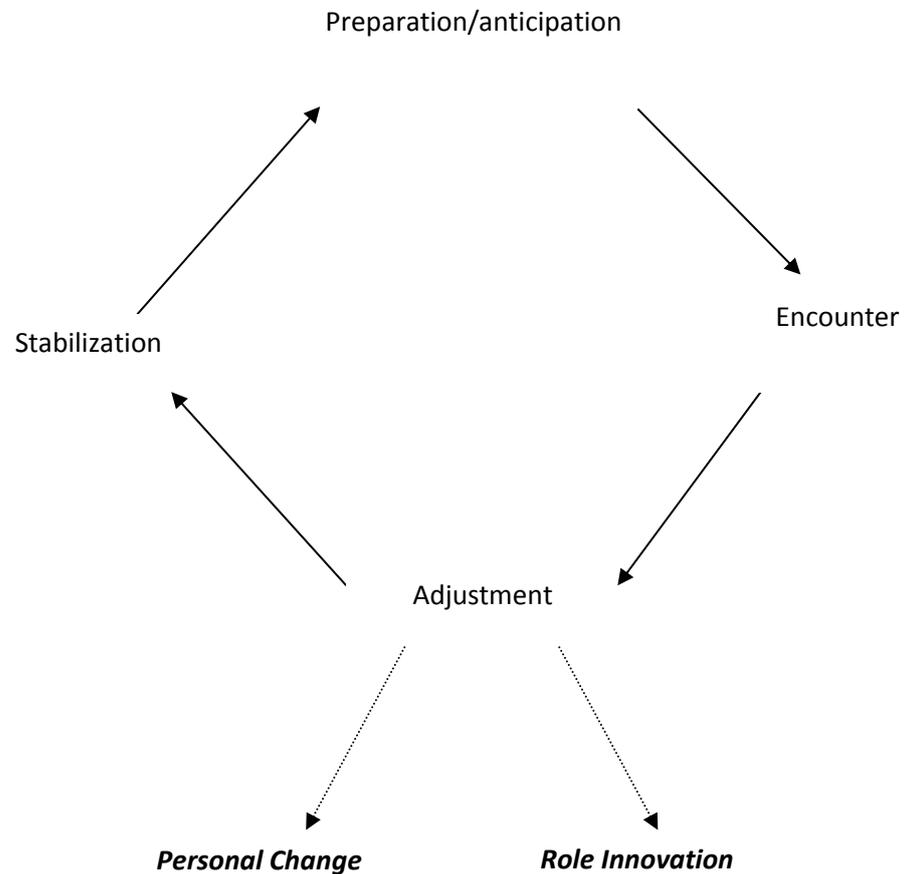
Research specific to work role and career transitions began in the 1980s, initiated by Louis (1980a, 1980b). She suggested that in changing work roles and moving into new careers, individuals undergo a process akin to the initial socialisation process newcomers to a role or organisation undergo. Louis (1980a) suggested that individuals experience a period of reality shock, or surprise, at the new things they are experiencing. This instigates a cognitive process whereby they try to make sense of what they are experiencing. Louis' work has been taken forward by others (Ashford and Taylor, 1990; Brett, 1984; Dawis and Lofquist, 1984), in terms of trying to understand how individuals alter and adjust to new work roles and all they encompass. In particular, Nicholson (1984) built on both Louis' work and socialisation theory (Van Maanen and Schein, 1979) to develop a theory and four stage model of work role transitions. Support for the model has been found amongst business graduates (Ashforth and Saks, 1995), nurses (West and Rushton, 1989) and both senior and junior job changing managers from a variety of sectors (Nicholson and West, 1988). The model is recognised as providing a useful perspective on the transition process and work role adjustment, having been incorporated into a wider model of career transitions (Stephens, 1994) and utilised in

linking role transitions with identity change (Ashforth, 2001). As such, the next section moves on to outline the Nicholson (1984) theory and model in more detail.

2.2.1 Nicholson's theory and model of role transition

Nicholson (1984) proposed a simple, four stage cyclical model of the transition process individuals undergo during a role change. This was designed as a descriptive and analytical tool to which rich details could be applied, with the four stages being: (1) preparation/anticipation; (2) encounter; (3) adjustment and (4) stabilization. The model was built on the assumption that the cycle is continual, that what happens at one stage will have an impact on the next but every stage will also have its own distinct processes. The adjustment phase, in terms of the way in which role changers adapt to new roles and all the requirements that go with them is viewed as being key (Stephens, 1994). Nicholson (1984) put forward the idea that individuals can adjust to role transitions either by engaging in personal change, or by engaging in role innovation, the latter being where they re-shape the role requirements to suit their selves. Figure 1 depicts the cycle of transition graphically, incorporating the stages and factors which will be covered in the following sections, beginning with the first stage of the cycle, 'preparation'.

Figure 1: The Cycle of Work Role Transitions (Reproduced from Nicholson and West (1988, p.97))



2.2.1.1 The preparation/anticipation stage

The first stage of the cycle is the preparation/anticipation stage. According to the theory and model (Nicholson, 1984; Nicholson and West, 1988) role transition can be sudden or well signalled, sought or imposed. This stage is felt to be important in the cycle as it is expected that individuals will have feelings about an impending change, such as a degree of anxiety about what is to come, with particularly high expectations at this stage in the process potentially leading to disappointment at the encounter, or second stage of the cycle. Previous experiences in education and employment, as well as prior socialisation processes, are

believed to impact on role changers' feelings, anticipations, and motives at the preparation stage, as well as reactions to what they encounter once in the new role.

In terms of potential identity transformation, the preparation stage of the cycle is when individuals may display signs of the future selves they feel they should become, hope to become or even fear becoming, and therefore the possible selves they might look to try out during the encounter stage (Ibarra, 1999; 2007). Signs of beginning to disengage from the traditional medical identity might also be seen at this stage, if a change is actually desired by those participating in a leadership development intervention.

2.2.1.2 The encounter stage

The second stage of the cycle is described as the encounter phase. This takes place in the first few weeks in a new role and is the period when individuals are expected to experience a reality shock, or some degree of surprise about the new role. This is thought to provoke them to engage in 'sensemaking', a process described by Louis (1980b) as one where individuals describe, interpret and make sense of what they are experiencing, ascribing meaning to things that surprise them. Weick (1995) has since described sensemaking as a process concerned with creating plausible meanings rather than accurate explanations of events. He suggested that it is about creating and authoring a perspective, as individuals will both shape, and be shaped by, others constructions of events.

The extent to which sensemaking occurs is proposed to depend on three factors. Firstly the 'contrast' or amount of difference between the requirements of the previous role and those of the new role, in terms of whether any prior experience and knowledge can be transferred. Secondly, the extent of 'change' experienced in terms of objective differences, such as a change in status, which is to say a move up or down the hierarchy. Thirdly, the level of 'surprise' experienced, in relation to whether expectations are met or not. For instance, the job changing managers studied by Nicholson and West (1988) were surprised by what their new roles entailed and also their own reactions, in terms of how integrated within their new environment and how competent they felt in the role.

In terms of the identity transformation process, individuals' work activities will change during the encounter stage and this will be the period where they are able to start trying out new attitudes and behaviours. The feedback they receive, in terms of their own reactions and those of others, will be a cause for reflection, followed by possible amendment to the attitudes and behaviours they display. This process may challenge individuals' sense of who they are, and also who they want to become (Ibarra, 2007; Ibarra, Snook and Guillém Ramo, 2008). All of this may lead to a 'liminal state' (Ibarra, 2003, 2007), that is to say a state in which individuals feel either slightly dis-engaged from their existing identity but not fully committed to a new one, or possible commitment to two different identities, which may seem incompatible (Ibarra, 2007; Ashforth, 2001).

2.2.1.3 The adjustment stage

The third, namely adjustment phase, involves individuals adjusting to: (a) the new role; (b) new people they are working and interacting with and (c) the culture of the new organisation or environment. Nicholson (1984) proposed that there are two possible forms of adjustment. One form is that of role innovation, which is where an individual moulds the new role to suit their own self. Nicholson perceived this as being a proactive form of adjustment. The other form of adjustment is that of personal change, which is when an individual makes changes to their own self in order to meet the role requirements. In identity terms, an individual may start to consider which aspects of the new behaviour and thinking that they are trying out are acceptable, both to them and others who are important to them, such that they begin to incorporate these aspects more permanently into their sense of identity (Ibarra, 2007).

Nicholson perceived personal change as being a reactive form of adjustment. Overall, four possible modes of adjustment were proposed:

1. 'Replication': This involves little change to oneself or the role. It is proposed as likely when an individual moves into a very similar role within the same work environment and can transfer their skills.

2. 'Absorption': This involves high personal change but little role innovation. Such a form of adjustment is perceived as most likely amongst young workers who are at the start of their working life, for example a young graduate entering their first role.
3. 'Determination': This involves low personal change but high role innovation. This is perceived as a likely form of adjustment amongst confident specialists who transfer their skills to a new environment which they are keen to alter, without having to make a change in their own identity.
4. 'Exploration': This involves high personal change and high role innovation. This is perceived as a possible form of adjustment for generalists who take on a higher status or functionally novel role and may make their mark through role innovations.

Amongst the job changing managers Nicholson and West (1988) studied 'exploration' was by far the most common mode of adjustment. Amongst doctors having to adapt to new role requirements replication perhaps appears the most unlikely form of adjustment. Established doctors, as opposed to medical students, however, might well adjust through 'determination' or 'exploration'. That is to say, they may seek to gain leadership and management skills without changing their identity or be open to changing their own ways of thinking and behaving whilst also keen to make their mark on organisational situations. The next section considers factors perceived as likely to affect the way in which adjustment occurs.

2.2.1.3.1 Factors influencing adjustment

Four factors are perceived as likely to impact on the type of adjustment that occurs in work role transitions: (a) prior experiences and socialisation; (b) individual factors, such as personality and how new experiences are made sense of; (c) the type of new role, its requirements and (d) the socialisation processes associated with the new role.

The type of prior socialisation doctors undergo has already been discussed in chapter one, in terms of the focus within training on developing scientific and clinical knowledge along with a more traditional sense of medical professionalism. In terms of individual factors, role transition theory (Nicholson, 1984; Nicholson and West, 1988) proposed that when it comes to making sense of a new role, individuals will draw on their own experiences, the interpretations of

others such as peers or mentors, and on shared interpretive schemes or ways of seeing things prevalent within the local culture. In the case of the medical profession we know that the culture has historically been quite hostile to doctors taking on leadership type roles. Personal disposition, which includes the motives of the role changer for taking on a new role, is also proposed as likely to impact on adjustment. For example, individuals with a high need for control over aspects of their work are proposed to be more likely to adjust by engaging in role innovation. In contrast, individuals with a high need for feedback are suggested as being potentially more receptive to what others say, and therefore more likely to change themselves to fit the role.

When it comes to new role requirements these are perceived as impacting on the type of adjustment that occurs. Job novelty (or the extent to which new skills and a new outlook are required) is perceived as likely to lead to adjustment in the form of personal change. Whereas, having a high level of discretion in the role is perceived as likely to lead to adjustment in the form of role innovation (Nicholson, 1984; Nicholson and West, 1988). Given what we know about doctors and their preference for autonomy and discretion, and the fact that they have been found to engage in activities to maintain control of process on their own terms (Waring and Currie, 2007), how they adjust to new expectations introduced as part of leadership development activities is of great interest. Finally, in terms of the socialisation processes within a new role, Nicholson and West (1988) suggested that if the aim is that individuals will conform to expectations, then they should be made anxious, whereas if the aim is that individuals innovate, then they should be given support to do so. Socialisation theory suggests that formal, collective processes will be more likely to lead to personal change and more individual, informal process to role innovation (Van Maanen and Schein, 1979). Details of how leadership development, as a re-socialisation process, might best be approached will be discussed later in the chapter. The next section now moves on to look at the final stage of the role transition cycle, the stabilization stage.

2.2.1.4 The Stabilization Stage

The fourth, or stabilization stage of the cycle, is viewed as a phase of consolidation, where new practices and behaviours are established and valued elements of the new role are maintained (Nicholson, 1984) and incorporated into individuals' identity (Ibarra, 2007). Nicholson (1984)

suggested that for some individuals the stabilization stage will mark the beginning of preparation for the next transition, in terms of individuals planning their next career move or starting to anticipate the next change. In testing the model with managers, Nicholson and West (1988) found that many did not reach stabilization, instead moving from the adjustment stage to the preparation stage, in terms of starting to consider their next transition once they had begun to adjust. The authors also cautioned that the significance of change may not be appreciated for some time, as minor developments may accumulate. The next section considers the critiquing of the Nicholson model that has occurred and related work on role transitions within the workplace.

2.2.1.5 Critiquing and developing the Nicholson (1984) theory and model

When Nicholson (1984) proposed and began to test his theory with job changing managers (Nicholson and West, 1988), research into work role transitions was in its infancy. He suggested that further work be done amongst other occupations, in other cultures and from other perspectives. Since then, empirical work has included: entry to new roles (Beyer and Hannah, 2002; Ashforth, Sluss and Saks, 2007; Ashforth and Saks, 1995); promotions (Ibarra, 1999); transfers (Black, 1988); moving from a general into a specialised nurse role (Currie et al, 2010; Glen and Waddington, 1998) and complete career changes (Ebaugh, 1988; Ibarra, 2003). Nicholson's theory and model has been incorporated in some of this empirical work (Ashforth and Saks, 1995; Glen and Waddington, 1998; Black, 1988).

Development of the Nicholson (1984) model itself has included testing of his proposed antecedents to personal change and role innovation, the two different types of adjustment. Work with managers (West et al, 1997) generally supported the propositions. Work with student nurses (West and Rushton, 1989) supported high personal change and low role innovation, in response to a highly novel role in a low discretion workplace, as expected. However, a high desire for control also led to high personal change, contrary to the theory's propositions. Work over a twelve month period with job changing managers from across a number of sectors (Nicholson and West, 1988) suggested that adjustment in the form of both role innovation and personal change is the most likely outcome of role change. In relation to this, Ashforth and Saks (1995) tested the model longitudinally amongst business graduates entering a range of occupations, and concluded that adjustment through both personal change

and role innovation is likely to depend on a complex mix of dispositional and situational factors. More recent work in the area of role transitions has focused on newcomer socialisation processes and on proactive types of adjustment, with Cooper-Thomas, Anderson and Cash (2012) recently extending the types of possible adjustment outlined by Nicholson (1984) to three categories, with the third type being 'mutual development.' They found experienced newcomers to professional service firms engaged in 'mutual development' strategies such as negotiating over the role, networking, exchanging resources and building relationships with their new boss and others in order to adjust to the new role.

Overall, in terms of exploring the process of role change, including the challenges role changers face and the rate at which change occurs, there is agreement on the utility of the Nicholson model (Ashford and Nurmohamed, 2010; Ashforth, 2001; Ashforth and Saks, 1995). In terms of developing the theory and model of role transition further, Ashford and Nurmohamed (2012) recently drew attention to the fact that such a model has been neglected in situations such as entry to new groups, or crossing levels within organisations, both of which doctors attempting to become leaders are likely to encounter. Ashforth and Saks (1995) also suggested that rather than trying to predict the type of adjustment that individuals will make, role transition theory could be enriched by researchers adopting a more phenomenological approach and exploring such things as the type of role changes individuals find desirable, how undesirable role changes are resisted and what happens during collective role transitions, particularly the way in which the context impacts on individual actions and social referents such as peers, clients and supervisors affect individuals' adjustment to a role.

A more phenomenological approach to the transition process and identity change of some health professionals has occurred, in the cases of nurses moving into a new, specialised nurse role (Currie, Finn and Martin, 2010) and doctors moving into a clinical director role (Hallier and Forbes, 2005), although this has done more to develop the social identity approach than the theory and model of work role transitions (Nicholson, 1984). Likewise, whilst leadership development has been proposed a process of role transition and potential identity transformation (Ibarra, Snook and Guillém Ramo, 2008), the way in which it might facilitate intra-role transition amongst a professional group, who are likely to have an established and deeply embedded sense of identity, has yet to be examined. This research will begin to address this, by exploring the process and impact of leadership development on doctors' orientation to

their role, specifically the way in which their attitudes, beliefs and practices might alter in relation to medical involvement in the management of health care organisations and their own interaction with managers and other professionals. The chapter will now consider how leadership development might attempt to facilitate role transition and adjustment through personal change in doctors.

2.3 How might leadership development facilitate role transition?

This part of the chapter looks at both the way in which doctors' leadership skills might be enhanced, and their attitudes, beliefs and practices altered through interventions designed to develop them as leaders. It begins by considering current thinking regarding training and development.

2.3.1 Achieving the objectives: Training or development?

Over the years, as understanding of how people learn has evolved, there has been a shift away from training type interventions, associated with a teacher-centred paradigm which is focused on imparting knowledge, towards an approach that is focused on the learning and development of individuals (Antonacopolou and Bento, 2004). Learning has been defined as 'a relatively permanent change in behaviour, with behaviour including both what is observable and processes such as thinking, attitudes and emotions' (Burns, 1995, p.99). Bloom et al (1956) developed a taxonomy of learning behaviours, in which cognitive learning relates to a change in mental skills and knowledge, affective learning relates to a change in feelings or emotions (usually referred to as attitudes) and finally psychomotor learning relates to a change in manual or physical skills. In the case of doctors a change in their cognitive and affective areas, or in other words their knowledge, skills and attitudes, is desired by policymakers and the medical academy.

Development has been defined as both a process and an outcome. From a process perspective it is defined as the activities through which people learn, designed around individual learning preferences and needs (Mumford and Gold, 2004). From an outcome perspective, development refers to a change in an individual's state of being (Easterby-Smith, 1994) and

includes individuals *learning how to learn* (Bolden, 2010; Burgoyne, 2010; Raelin, 2006; Mumford and Gold, 2004), or coming to understand how they might approach and deal with future situations, as well as ones they face in the present. This research is concerned with both these aspects of development, in terms of being concerned with the type of leadership development activities which lead to a change in doctors' state of being, or their overall orientation to the management of health services, and the way in which they do so.

The leadership development literature suggests that three factors are likely to have an impact on how successful the process of leadership development may be in engendering the type of personal change and enhanced skill set sought amongst doctors by policymakers and the medical academy. These include: the theories of learning and associated methods which underpin any intervention (Kolb, 1984; Schon; 1987; Bandura, 1977; Rogers, 1969); the extent to which skills appropriate for the NHS context are included (Burgoyne, 2010; Hartley, 2010; Scott and Webber, 2008; Mole, 2004) and thirdly, individual differences such as motivations for participating. These three factors are now considered in turn.

2.3.2. Theories of learning and associated methods which may be utilised

There are a number of possible theories of learning, associated with a variety of methods, which might underpin leadership development interventions and be utilised by practitioners to try and engender personal change and development. This section focuses on those most relevant to adult and professional learning: cognitive learning theory; facilitative learning theory and theories of experiential learning, including action learning and social learning theories.

Cognitive learning theory views learning as a process of relating new information to previously learned facts. Experience is seen as important in terms of the opportunity for problem-solving, the creation of meaning and the development of insights. Examples of this within medicine include learning surgical skills from doing repeated operations, or the way in which medical educators discuss the physiology of an organ before teaching juniors about the pathology of it, or what happens when something goes wrong with that organ. Within leadership development

for doctors this suggests that practitioners may facilitate learning by relating leadership and management situations, and how they might be handled, with clinical situations.

In facilitative learning theories, which were developed by Carl Rogers, the premise is that the practitioner acts as a facilitator and establishes an atmosphere free from external distractions, where learners feel comfortable to consider new ideas. Acting as facilitators, practitioners are willing to listen to learners and take on board their ideas. They also encourage learners to give input and assume responsibility for their own learning. A focus on solving significant problems or achieving significant results is encouraged, and self-evaluation is viewed as the best form of evaluation (Laird, 1985). Ibarra, Snook and Guillém Ramo (2008) suggest that to facilitate identity transformation, which is akin to the change in attitudes, beliefs and practices desired of doctors, leadership development should think about providing a safe psychological space and time for new ideas to be tried out. Many of these principles may be useful to incorporate in interventions for doctors, given the cultural antipathy towards management which is believed to exist within the profession.

Theories of experiential learning are based on the idea that learning results from experience and reflecting on that experience. They originated in the work of John Dewey (1938) who believed that adults' should be actively involved in the process of learning by working on real life tasks. One of the most widely recognised of such theories is that of David Kolb (1984) who developed the experiential learning theory (ELT) model, a four stage process depicting how people learn. This involves: doing something or having a 'concrete experience'; thinking about the experience or 'reflective observation'; theorising about what worked and what should be done next, or 'abstract conceptualization' and finally 'active experimentation' or testing out one's ideas. Kolb (1984) suggested that individuals have a preference for a particular stage of the cycle and characterised these as learning styles. However, for learning to be effective, Kolb argued that individuals must have the opportunity to go through all four stages of the learning cycle. Other models of learning styles include a variation on Kolb's model developed for use with managers by Honey and Mumford (1982) which is widely used. The authors outlined a similar four step learning process: having an experience; reviewing the experience; drawing conclusions from the experience and finally planning the next steps. They suggest that while individuals have a preference for one of these stages they can adapt, through choice or a

change in circumstances. This suggests that gaining insight into their preferences may be worthwhile for doctors.

Other learning styles models include that of Dunn and Dunn (1978), who suggested that individuals have a preference for either (a) visual (b) auditory or (c) kinaesthetic learning. In other words they have a preference for learning from: (a) pictures, diagrams, presentations and so on; (b) what they hear in lectures and discussions; (c) from doing, through such things as projects and experiments. As collective interventions are likely to involve individuals with a mix of learning styles, and doctors are used to learning both in the classroom and on the job, opportunities for a variety of ways of learning would seem likely to be needed.

The work of Schon (1987) has undoubtedly influenced professional development (Vince and Reynolds, 2006). Schon argued that professionals learn by doing and thinking about what they have done, supported by coaches who instruct them, critique them, show them how to do something (model) or experiment jointly with them. He was critical of professional training schools for focusing on scientific knowledge and failing to teach professionals how to deal with uncertain, complex or unique situations. Schon (1987) suggested that when professionals encounter such situations they engage in 'reflection-in action'. In other words, they think on their feet, question what is happening and bring their knowledge to bear on the situation. Schon argued that practitioners should aim to build on this approach and later work supports these ideas with regard to learning about leadership. For example, Antonacopolou and Bento (2004) argue that people learn and change by being able to experiment and practice leadership in terms of testing things out, and having the opportunity to reflect on what works and then try again, based on the lessons learned.

Action learning theory, associated with the work of Revans (1980), is very much in line with this. The focus of action learning is on re-education, which as has been discussed is in line with the objectives of leadership development for doctors. Proponents (Raelin, 2008, 2009; Yorks et al, 1999) suggest that whilst there is some value in introducing real life scenarios into the classroom via case studies and simulation, the best way for people to learn is through taking action and trying things out in real life situations. They suggest that the theory is implemented by learners working on problems, in the form of projects, which are aimed at both personal

and organisational development. Finding a solution to a problem and successfully enacting it is seen as less important than learning from the experience, and failing to find a solution is not deemed as failure per se (Dilworth and Willis, 2003). Suitable projects are suggested as being those that require co-operation to be gained, an element of risk to be taken and a moral position to be adopted. Such situations would seem to be readily available within the NHS, although a way of enabling this type of situation and experience for doctors who are currently focused on clinical work may be needed. It also has to be noted in the context of the NHS that the theory perceives any action taken to be a mechanism for learning, rather than an end in itself.

Dilworth and Willis (2003) have defined action learning as a 'process of reflecting on one's work and beliefs in a supportive and/or confrontational environment of one's peers for the purpose of gaining new insights and resolving real business and community problems in real time' (p.11). Therefore, if an action learning approach is utilised, learners tend to not only work on projects but also participate in ongoing peer learning groups of six to eight members, which provides the opportunity for them to get feedback on their actions as well as both support and challenge. Ibarra, Snook and Guillém Ramo (2008) suggest that feedback from social referents and role models is important in the transition to new ways of seeing things and behaving, such that it may be useful to include feedback from such groups. Fitzgerald and Sturt (1992) also suggested that doctors have a preference for action approaches using real service problems and in fact action learning has been proposed as a useful method for developing clinical leadership (Edmonstone, 2008).

Social learning theory (Bandura, 1977) proposed that learning occurs in a social context and that individuals learn from each other by observing, imitating and modelling tasks or behaviours. Schon's ideas of professionals learning from practitioners or coaches, who may critique, instruct or show them how to do things built on these ideas. Social learning theory has some similarity with situational learning theories which see learning as situated within real life work experience and as a process which is 'embedded within the activities, tasks and social relations that constitute communities of practice' (Fuller, Munroe and Rainbird, 2004, p. 303-4). For example, Lave and Wenger (1991) proposed that learning occurs informally via communities of practice, which are common in apprenticeship style learning situations, through observation and conversations with peers. These communities enable wisdom and

cultural practices to be passed on to new members. Doctors' clinical years of training, after their two initial years of theory, has been likened to an apprenticeship (Sinclair, 1997), such that creating communities of practice amongst those participating in leadership development may be valuable.

Others support the idea that learning and personal change occur in a group setting (Brodie and Irving, 2007; Sobiechowska and Maisch, 2007; Antonacopolou and Bento, 2004). For example, Antonacopolou and Bento (2004) suggest that 'learners make sense of their experiences, discover and nurture leadership in themselves and in each other, not in isolation but in a community', p.82). Learning in a collective context is also supported by socialisation theorists in relation to professionals, when changes in both the knowledge base and the way in which a role is practised are required (Van Maanen and Schein (1979). Allen and Hartmann (2008) also suggest that leadership development interventions focused on personal change will utilise methods that encourage participants to reflect on their behaviours and values, collectively as well as individually. They further suggest that opportunities to work in teams and to network with senior executives be included, to develop relational and influencing skills.

While all of the aforementioned theories and associated methods are associated with learning, and *may* enable personal change, all have potential problems. Learning style theories in particular have faced criticism. A review by Coffield et al (2004) found that few had been adequately validated by independent research. Kolb's model has been criticised by Smith (2001) for making exaggerated claims about the four learning styles, not addressing the process of reflection adequately or the way in which different cultural conditions and experiences may affect learning. Schon's work has also faced criticism for, amongst other things, failing to take account of the influence of power relations that may exist within the learning environment, and for focusing overly on individual aspects of learning and on retrospective reflection (Reynolds, 1999; Vince, 1998; Holman, Pavlica and Thorpe, 1997). Indeed, Thorpe and Gold (2010) suggest that retrospective reflection will only get leaders so far in complex and ever changing environments which require new ways of thinking about how to tackle issues.

Other methods also have potential problems. While communities of practice may be a familiar way of learning for doctors they may simply reinforce outdated or poor practice (Scott and Webber, 2008). It has also been acknowledged that the learning that occurs in this way is specific to the context in which it takes place, such that transfer between settings may be problematic (Lave, 1993). Any constructed communities of practice will therefore need to consider the mix of people involved.

In action learning and approaches which rely on learning from reflection and feedback there must be a sufficient level of both support and challenge from peers and facilitators if learning is to be effective. This means that participants must be willing to engage with a questioning approach, which seeks to uncover the assumptions underpinning their actions, in a peer group setting. There is a risk that doctors, who are not noted for liking their authority being questioned (Larson, 1990; Abbott, 1988) and who prefer not to interfere in the work of their peers (Armstrong and Ogden, 2006; Freidson, 1990), may not engage with these aspects. A recent systematic review of action learning (Cho and Egan, 2009) also found that whilst it has become a frequently used method within the UK public sector, and when the focus is on individual development, the reflective element is often missing. Where it is present, learning through reflection on experience is a slow process, as Schon (1987) noted, with the learner often experiencing shock and confusion and needing time to unlearn certain things that they have come to take for granted. This may be the case with doctors, who have already undergone a long training and socialisation process. Expectations of participants and those involved in supporting them will therefore need to be realistic. Doctors may have to deal with not knowing all the answers and being able to take immediate action, as they so often have to do in the clinical situation, and may need support with this. All of this suggests that the type of short programmes which are predominantly available for Registrar level doctors are unlikely to be of sufficient duration to allow for reflection and personal change to occur.

Finally, whilst the emphasis in recent years has moved to learning through work based experience and reflection, some writers (Cheetham and Chivers, 2005; Hodkinson and Hodkinson, 2004) have argued that professionals benefit from also having the opportunity to acquire theory, and that formal, classroom based training methods should not be abandoned completely. The classroom, or an external context, is argued to be a good way to introduce skills and to provide the opportunity for learners to practice them and get feedback before

putting them into practice in the workplace (Allen and Hartman, 2008). Others support the idea of providing the opportunity to acquire theory along with opportunities to practice skills in the workplace as best practice (Bolden, 2010; Eraut and Hirsch, 2008). The next section moves on to consider the context specific skills that the literature suggests are needed by doctors.

2.3.3 Developing context specific skills

It is now generally agreed that leadership development needs to be tailored for context (Burgoyne, 2010; Hartley, 2010; Scott and Webber, 2008; Burgoyne, Hirsch and Williams, 2004; Mole, 2004). This is on the basis that different types of leaders are needed in different situations, and that attitudes and practices within workplaces affect the extent to which individuals are able to put their learning into practice. Those with experience of the NHS have suggested that capacity, which Tyler (2004) defined as “the ‘wherewithal’ to use and improve capabilities to achieve an individual or organizational goal” (p. 154), needs to be built at both an individual and collective level (Iles and Preece, 2006; Hartley and Hinksman, 2003; Day, 2001) if health professionals are to be able to deal with future as well as present situations (Hamlin, 2010; Storey, 2004; Tate, 2004) as policymakers and the medical academy desire.

Individual capacity building is said to require a focus on building self awareness and confidence and developing skills associated with influencing and motivating others. It can also include acquiring knowledge of how the system works and how to gain an understanding of issues, in order to develop judgment and decision making skills (Hartley and Hinksman, 2003; Day, 2001). These ideas are supported by medical and clinical directors, who suggest that skills of ‘affective leadership’ (Newman, Guy and Mastracci, 2009) including being able to empower and motivate others and build relationships by communicating and collaborating across organisational boundaries are core to their role. Those medical leaders interviewed felt that such leaders need to be able to understand their own behaviour and how it will impact on others, tolerate disagreement and be able to understand other perspectives. Some medical directors argued that in order to build structures, support systems, evaluate situations and conduct quality assurance they need greater skills in such things as planning and budgeting, while although others felt that it is enough to work well with managers who have these skills (Giordano, 2010). Work with clinical directors has found they desire training in such things as

developing a business case, planning, risk management and financial matters (Giordano, 2010; Fitzgerald et al, 2006; Forbes, Hallier and Kelly, 2004; Fitzgerald et al, 2000).

Collective capacity building requires the establishment of networks of trusting relationships, so that exchange of information and resources takes place. This means that doctors are likely to need help in learning how to collaborate with different professional groups, so that shared meanings and values are built (Day, 2001).

In addition to all of this, Hartley (2010) suggests that as the public sector is a highly political one, it requires leaders to be able to do the following: analyse policy; read the environment and people, in terms of understanding where power lies and what the underlying agendas are, and interpret trends. This suggests that doctors are likely to need the type of information and guidance which enables them to become both politically aware and sensitive to a wide range of stakeholder interests, including policymakers, patients, the wider public, associated organisations and a range of professional groups. Before considering the way in which individual differences may impact on how well leadership development for doctors is able to achieve the desired objectives of policymakers and the academy, the next section considers the problems that may be encountered, in relation to incorporating the type of theories and methods previously outlined into development interventions.

2.3.3.1. Potential problems in the process

Whilst leadership development interventions may seek to incorporate theories and methods which can both engender a change in doctors' orientation towards the leadership and management of organisations, and develop a skill set which will potentially enable them to act as effective medical leaders, a number of writers (Raelin, 2006; Tyler 2004; Day, 2001; Storey and Tate, 2000) caution that achieving this is not likely to be easy. They argue that the learning and work environments will need to engage people and be supportive of them questioning and challenging if individual change is to result. Argyris (2002) proposes that for change to emerge, 'double loop learning' must occur. This is where individuals start to move beyond understanding what works, and to question why they are doing certain things as they are and to re-frame problems. This may prove difficult for doctors, given that they are likely to be

working with colleagues who tend to have a preference for maintaining the status quo (Abbott, 1988). Building such capacity and moving doctors to a stage where they are able to question the purpose of what they are doing and are able to re-frame things in new, more organisational ways, as is desired by the academy and policymakers, may be quite a challenge. The next section will briefly consider a number of individual factors, which may have an impact on the outcome of leadership development.

2.3.4 Individual factors

There are a number of individual factors which may have an impact on how participants in a leadership development intervention learn and adjust to a new situation and the new role requirements. Some of these individual factors such as personality, prior experience, motivations and expectations have already been discussed, earlier in the chapter (section 2.2.1.3.1) in terms of their potential impact on how individuals adjust to a new role such as becoming a leader. For instance, individuals with a high need for control over aspects of their work are proposed as potentially more likely to adjust by engaging in role innovation. In contrast, individuals with a high need for feedback are proposed as being more likely to change their selves to fit the role (Nicholson, 1984; Nicholson and West, 1988). With regards to the learning process individual learning styles have also been discussed (section 2.3.2), in terms of individuals having a preference for certain aspects of the learning process, which may mean they learn from certain aspects of an intervention, but not from others. The implication of this is that a mixture of methods to enable learning is likely to be needed.

Other factors that may influence learning and adjustment include whether doctors participate in leadership development on a voluntary basis, and hence are open to learning (Ferlie et al, 1996) as opposed to being coerced into participating, in which case they may be less open and motivated to learn. In addition, participants' self-efficacy, defined as the level of confidence an individual has in their ability to cope with a situation or complete a task (Lane, 1992) may also impact on how they learn and develop. Locke et al (1984) found that people judged their level of self-efficacy by estimating the demands of a situation or task and comparing this with a self-assessment of their ability to meet these demands. This was linked with their motivation to persevere. The next section considers the implication of the theories and evidence reviewed so far for the research.

2.3.4.1 The implications of theory and evidence for the research

As the last sections have shown, there are pros and cons associated with all the methods that may be used in a bid to achieve learning. In conjunction with this, the context in which leadership development takes place and individual differences amongst participants may affect the impact that leadership is able to have, and the extent to which it is able to engender a change in doctors' orientation and sense of professionalism. However, what is common to the various theories of learning and methods proposed is the idea that personal change and learning occurs through involvement in a community of learners and practitioners, and by being able to work through the learning cycle, in terms of trying things out in the workplace, reflecting on how well they worked and formulating new ideas about what to do next. This suggests that if leadership development is to have a good chance of achieving the desired change in doctors then a collective intervention which focuses on building a community amongst those involved, working on real tasks within the workplace, supported by opportunities for reflection guided by experts is desirable. Indeed, a number of writers (Bolden, 2010; Eraut and Hirsch, 2008; Hardacre and Keep, 2003), suggest that using such a mix of methods is best practice. The next section summarises the chapter and outlines the research questions which have emerged from the literature review.

2.4 Summary and emerging research questions

This chapter has looked at the way in which the strategy of developing leadership and management skills in doctors is designed to engender personal development or a change in attitudes, beliefs and practices. It has argued that this amounts to a requirement for doctors to undergo intra-role transition (Louis, 1980a). The theory of role transition (Nicholson, 1984) suggests that whether such a transition occurs is likely to be affected by prior socialisation, the motivations of doctors and the new form of socialisation (in this case the leadership development intervention) that occurs. It also suggests that it will depend on the extent to which the role requirements differ from those previously required.

The literature on leadership and management development suggests that interventions which seek personal change and development are best approached by focusing on building capacity for the longer term and utilising both formal and informal methods of learning, particularly

opportunities to practice leadership and management skills within the work context and to reflect on this, with guidance. However, the work and learning context will need to support learners challenging and questioning the status quo if they are to develop capacity to deal with complex situations that they may face in the future. While interventions may adopt all the points suggested by theories of learning, contextual and individual factors such as personality, motivations, expectations, learning styles and self-efficacy may also play a part in how successful they are able to be in engendering personal change.

Having reviewed the literature and considered the implications of this latest strategy to develop leadership skills and re-shape doctors ways of thinking and behaving, or their sense of professionalism, two over-riding research questions have emerged:

1. Will participation in a leadership development programme be able to facilitate role transition in doctors to a new sense of medical professionalism, or in other words will it lead to a change in established attitudes, relationships and ways of working?
2. How and under what conditions, might it do so? That is to say, if role transition is seen to occur, how might leadership development have facilitated it? If role transition is not seen to occur, what factors might have hindered transition?

The next chapter moves on to look at how these questions were approached, and at all aspects of the research strategy and process.

Chapter 3: Research Methodology

Introduction

This chapter outlines the methodology of the research including the ontological perspective which informs it and the research strategy used, including the choice of methods of data collection and analysis (King and Horrocks, 2010). The chapter is structured into four parts. Section 3.1 outlines the critical realistic perspective which informs this research, and considers how this led to the type of research questions posed here and to an intensive design. Section 3.2 considers the overall research strategy. This is one of a qualitative, single case study in which a leadership development intervention for doctors is explored through a lens of role transition (Nicholson, 1984). The factors taken into consideration in the design of the research are outlined, which include: the type of case, participants, data and instrumentation needed; the steps needed to ensure an ethical process; ways to minimise the possibility of selection bias; issues of reflexivity, or the potential impact of the researcher on the process, and finally the needs of stakeholders in the research. Section 3.3 then looks at the way the research was conducted, in terms of the process of data collection, through use of semi-structured longitudinal interviews, which incorporated the four stages of the cycle of role transition (Nicholson, 1984) and the collection of secondary sources. The process of analysis, which was carried out using template analysis (King, 2004) is then outlined. Finally, section 3.4 outlines the issues faced during the process.

3.1 Guiding perspective

The research is informed by a critical realist perspective, particularly that associated with Archer (1995) and Sayer (2000, 2003). This lies between a realist ontology, which assumes there is a world that exists independently of our knowing of it, and a relativist ontology which believes that the social world is the product of interaction between people. From a realist perspective the world can be objectively studied, whereas from a relativist perspective there are no universal laws or truths that can be uncovered, only different interpretations (Sayer, 2000).

In contrast, 'critical realist' ontology is a belief in a world that exists independently of our knowledge of it. Viewing the world from a critical realist perspective means being interested in why things might occur, as opposed to trying to predict what will occur, on the basis that the social world is open to external influence and constantly changing, as new phenomena emerge and individuals interact with them. In this research it means trying to explain what it is about a leadership development intervention and the doctors involved that led to the outcomes found being produced. This is because the nature of social phenomena can vary from one context to another, such that actions that people take cannot be understood independently of the context in which they occur. Knowledge of the world and the world itself are different, such that "the world can only be understood in terms of available conceptual resources, but the latter do not determine the structure of the social world itself" (Sayer, 2000, p.83). As all data collected is theory-laden, or collected and viewed in relation to existing perceptions, there are no absolute truths to be discovered, and multiple views of the world are assumed (Rynes and Gephardt, 2004).

The social world and existing systems are made up of structures which, while able to gradually change, are highly durable. These structures include both objects and sets of internal relationships (Sayer, 2000). Objects can be people as well as such things as resources, rules, norms and meanings. Internal relationships are the connections that exist between them. Whereas in an orthodox realist view, causality is seen in terms of regular associations between phenomena, from a critical realist perspective, existing structures have what are termed emergent properties (Sayer, 2000; Archer, 1995) or causal powers. That is to say they have potential to act in certain ways, but are dependent on other mechanisms in order to do so (Sayer, 2003; Archer, 1995). According to this, doctors may have the intellectual capability to lead, and a leadership development intervention may be the mechanism intended to release this capability, but whether doctors involved actually engage in leadership will be influenced by other conditions, such as whether the culture within the NHS allows them to do so. The extent to which the various parts of any system are integrated may also work to either constrain or enable change (Archer, 1995). For example, the healthcare system is currently made up of the Department of Health, Strategic Health Authorities, Primary Care Trusts, hospitals, patients and so on. However, researchers are advised to 'abstract' or decide what aspect they are focusing on (Sayer, 2000). In this research this is the attitudes, beliefs and practices of doctors involved in a leadership development intervention and how they change

throughout the process, in relation to the NHS organisations in which they work and the management of them.

While social structures condition and influence individuals' actions and their interpretations (Sayer, 2000, 2003; Archer, 1995) individuals are able to take action and to shape their own lives to some extent, through their interaction in society. However, in a stratified world, some individuals will have greater resources to make change than others. Depending on their cognitive, material and social resources people may reproduce or re-shape the structures and cultural practices that exist within society (Sayer, 2000; Archer, 1995). Archer (1995) suggested that institutions such as the NHS contain what she termed primary and corporate agents. Primary agents are able to reproduce the structure and culture in which they exist, whereas corporate agents are those with the resources and power to influence interactions and re-shape these aspects. As such, the medical profession can be considered a corporate agent (Kirkpatrick and Ackroyd, 2003) along with NHS managers, albeit government is the most powerful corporate agent of all within the public sector. The research therefore assumes that doctors are capable of undergoing and making some change and seeks to uncover the conditions under which role transition occurs and the way in which structures enable or constrain transition.

Adopting a critical realist perspective and seeking to explain why things may have occurred as they have requires an in-depth or 'intensive research design' as opposed to an 'extensive' one which looks for patterns and regularities amongst taxonomic groups, with the aim of producing a representation and generalisation (Sayer, 2000). As such, a qualitative design is often the one of choice (Sayer, 2000), on the basis that such a design is oriented to looking at processes, activities and relationships that are entered into. This was the approach adopted here and the next section moves on to consider the overall research strategy.

3.2 The Research Strategy

The research sought to gain an in depth understanding of how doctors undergoing leadership development experienced and progressed through the cycle of role transition. As such, a qualitative case study of a single intervention was adopted (Gummesson, 2000; Stake, 2005;

Yin, 2009). More specifically, Nicholson and West (1988) suggested that “the full import of role changes can probably only be articulated by case study methods, rather than by survey designs which aggregate and tend to obscure individuals’ idiosyncratic patterns of change (p.138).

The single case selected was unique, in being the first leadership development intervention designed specifically for Registrar level doctors. It, provided leadership experience, whereby doctors worked on the type of service development and quality improvement projects envisaged by Lord Darzi (Department of Health, 2008), removing them almost entirely from clinical work for a year. The only other known intervention to have taken doctors away from their clinical role for such a period was a pilot ‘Chief Medical Officers Scheme’ launched in 2008. In this, doctors were seconded for a minimum of a year to work under a lead doctor in organisations such as the Department of Health, National Patient Safety Agency or a Strategic Health Authority. This approach enabled in-depth study of the attitudes, beliefs and practices of those involved (Marshall, 1985). As well as being unique, and therefore of intrinsic interest (Stake, 2005), the case was also an ‘instrumental case’ (Stake, 2005) in that it provided insight into whether leadership development, role transition and identity change are linked, which is of wider interest. The intervention will be discussed further in the section on sampling (section 3.3) and in chapter five, which considers the background and context of the intervention selected, along with the objectives behind it and the overall design. The next section moves on to look at considerations in the research design.

3.2.1 Considerations in the study design

A number of things were taken into consideration in the design of the study. These included: the type of case, participants and data that would be needed; the type of instrumentation needed; the need for an ethical process; the possibility of selection bias; issues of reflexivity and finally the needs of stakeholders in the research. The next section looks at how the type of case, participants and data needed were decided.

3.2.1.1 The type of case, participants and data needed

In order to study an intervention which would advance knowledge (Gummesson, 2000), certain criteria were set, based on the literature review and the research questions. These were, firstly that it should be aimed at doctors not currently in a formal leadership role and at the Registrar stage, as there has been little exploration of the effects of leadership development in such as group, and the Registrar stage has been suggested as potentially a good time to provide doctors with this kind of development. Secondly, it should have a focus on personal development and change, in order to enhance understanding of whether the strategy has the potential to engender change in doctors' ways of thinking and behaving. Thirdly, it had to adopt appropriate methods for professionals, as recommended in the leadership and management development literature. This included the use of formal and informal methods, the opportunity for experiential learning in the workplace and the inclusion of support mechanisms such as mentorship and/or coaching. In terms of the sample of participants needed, different specialities have been seen to engage differently with management (Willcocks, 2004; Harrison and Pollitt, 1994) and so having representation from a variety of specialities was considered appropriate.

As such a purposive sampling (Stake, 2005; Patton, 1990) approach was selected. That is to say an intervention was sought which matched the criteria as closely as possible, including having a gender balance and a mix of specialities in the sample recruited, in order to get multiple perspectives. Some scholars, such as Gomm (2008), use the term theoretical sampling, in terms of selecting a case and participants relevant to the research questions who can help with theory generation. These principles were adopted, with the case selected representing an ideal and timely case to study, given the research questions posed. Ultimately fifteen doctors, seven men and eight women, were selected from a mix of specialities. A profile of the cohort is provided later, in section 3.3.2 on the selection of participants. In addition a group of doctors of the same level were recruited, as a comparison group. This was in order to enable more robust conclusions attitudes to be developed, as to the ways in which participation in the Fellowship impacted on attitudinal change (Miles and Huberman, 1994), to determine how representative or not the Fellows were of the wider population of Registrars (Gomm, Hammersley and Foster, 2000) and to corroborate certain findings (Fetterman, 2010; Sayer,

2000). The next section looks at the instrumentation used to ensure data was collected which enabled insight to be gained into the transition process.

3.2.1.2 The instrumentation to be used

Instrumentation refers to the devices or methods used for uncovering events and information. There are a number of possible methods by which qualitative data may be collected, including those that are more and those that are less pre-designed (Miles and Huberman, 1994). In this case a way of operationalising the four stage cycle of transition (Nicholson, 1984; Nicholson and West, 1988) was needed. As such, it was decided that one to one, face to face, semi-structured interviews would be conducted on a longitudinal basis, with the four stages of transition being incorporated into staged interviews. This was to enable change and development to be studied over time (Saunders, Lewis and Thornhill, 2007). The way in which this was done will be detailed later in the chapter (section 3.3.3), when the process of data collection is outlined.

Semi-structured interviews were selected as they allow for an in-depth exploration of views and experiences. They offer greater flexibility than structured interviews for both the interviewer and respondents (King and Horrocks, 2010; May, 2001) whilst also allowing for a comparison of emerging themes (May, 2001; Miles and Huberman, 1994). One to one interviews provide confidentiality for informants and enable their views to be heard uninterrupted (Gomm, 2008). Individual, face to face interviews were decided upon as they allow questions to be phrased in different ways, which ensures that participants understand the information being sought. This enables them to explain things in detail, such as the context in which things happened. Clarification and exploration of areas of interest can also be conducted more easily in person than by the telephone or internet. Body language is also more evident in face to face interviews, offering the researcher insights such as whether expressed comments and feelings seem to be in accord. This was helpful in one particular case, where an interviewee appeared far more negative than the text alone revealed. It is known that participants may say what they think is expected of them, rather than what they really think (King and Horrocks, 2010; Robson, 2002; May, 2001).

Assessments of change in the doctors' attitudes, beliefs and behaviours were made via self-reports of change. While self reports have potential issues with regard to potential social desirability bias (Saunders, Lewis and Thornhill, 2007), or respondents giving the answer they feel shows them in the best light, Nicholson and West (1988) argued that there is great value in taking account of 'people's own global judgments' (p.124) on the basis that if individuals feel they have changed then this may have more significance for them and others around them than 'shifts on measures of unknown relevance or importance to them or their situation' (p.124). They suggest that 'how a person evaluates the changes they have experienced and how they feel their identity has adapted and grown has important meaning.....[and] how a person construes themselves in the present encapsulates the values, ideals, motives and beliefs that set their bearings for future direction' (Nicholson and West, 1988, p.124). This fits well with a critical realist perspective which believes that individuals can shape their own roles and circumstances. Hardacre and Keep (2003) who have led many clinical leadership programmes for nurses also suggested that robust evaluations include participants own perspectives on how they have changed. In addition, and as a checking mechanism, researcher assessment occurred, in terms of comparing responses given in the first and second interviews.

With regard to understanding the context and gaining insight into how this might impact on the role transition process, interview with key informants were conducted. These included the Postgraduate Dean, who had been instrumental in the launch of the intervention, and educationalists involved in the design and delivery of the educational programme. These interviews focused on how the intervention had come into being and what the objectives behind it were. In addition secondary sources including written documents and information on the aims and ethos of the educational programme were sought. The next section looks at the need for an ethical process.

3.2.1.3 Ensuring an ethical process

Recruitment of a sample of NHS staff is conditioned by the NHS ethics approval process. This requires approval of any proposed research to be obtained from an NHS research ethics committee, along with approval from the research governance departments in each Trust where a member of staff who volunteers to participate is working. Potential research

participants must understand the purpose of the research and what will be required of them, be willing to participate and not feel pressurized by anyone into doing so. They must also understand that they are free to leave the research at any point without offering an explanation.

The NHS ethical guidelines produced by the Economic and Social Research Council sponsoring the researcher were consulted. The NHS online integrated research application system (IRAS) forms were then completed and submitted to the Leeds East Ethics Committee. I then attended the ethical committee meeting where my research was reviewed, in order to answer any queries the committee might have and outline the steps I would take to protect the identity of participants and all parties related to the intervention. Approval was granted (09/H1306/107) with minor amends to the research information sheet required and an agreement to keep the original data for seven years post completion of the research.

In line with NHS ethical requirements and in order to protect participants' identity all data collected was anonymised. Participants were allocated an identification code which was used on transcripts of interviews and any written materials. A table listing identification codes which linked with participants' names and details was kept on a separate, password protected spreadsheet on the University of Leeds system, accessible only by me. These identification codes were used on all transcripts, along with pseudonyms for all informants and quoted sources. The next section looks at how attempts were made to minimise the possibility of selection bias as a result of participation being on a voluntary, self-selected basis.

3.2.1.4 Minimising the possibility of selection bias

Owing to the voluntary nature of participation, in both the intervention and the research, the possibility of selection bias had to be considered (Saunders, Lewis and Thornhill, 2007). That is to say it had to be considered that the sample of Registrars participating in the intervention may be particularly management oriented and motivated, and unrepresentative of the wider medical population. This would make any theoretical generalisation (Yin, 1984) or generalisation to the wider population of Registrars problematic (Gomm, Hammersley and

Foster, 2000). The research therefore collected data via interviews from a comparison group (Glaser and Strauss, 1967) of specialist trainees who were not participating in leadership development. This was in order to enable more robust conclusions to be developed as to the ways in which participation in the Fellowship had an impact on attitudes (Miles and Huberman, 1994), to determine how representative the Fellows were of the wider population of Registrars (Gomm, Hammersley and Foster, 2000) and to corroborate certain findings (Fetterman, 2010; Sayer, 2000). This comparison group was questioned about their experiences of managers, attitudes towards working with managers and attitudes towards being involved in organisational issues. The next section looks at the issue of reflexivity.

3.2.1.5 The need for reflexivity

Reflexivity is the process of reflecting critically on one's self as a researcher in terms of the perspective, values and meanings one brings to research (Guba and Lincoln, 2005). This is on the basis that complete objectivity and value neutrality is not possible in social research (May, 2001; Sayer, 2000; Lincoln and Guba, 1985).

I acknowledge that having started my career as a nurse, and having informed the sample of doctors of this fact, this may have affected what they were prepared to tell me and how I interpreted the findings. However, I used a mix of deductive and inductive analysis and sought to be mindful of alternative interpretations and explanations. As Banister et al (1994) suggest, there can be a beneficial aspect to what the researcher brings. In this instance I did not need to spend large amounts of time checking medical terms and language as I was already familiar with these. Additionally, I believe that the respondents felt able to discuss their experiences openly on the basis that I would understand the NHS context.

In order to enhance trust in the research findings triangulation of data collection occurred, in that data was obtained from multiple sources including a comparison group, and both primary and secondary sources were used. Tentative conclusions being developed were tested out in subsequent interviews. A large number of quotes are also utilised in the presentation of the findings in chapters five to seven, in order to bring the informants views and perspectives to the fore (Fetterman, 2010; Saunders, Lewis and Thornhill, 2007; Hartley, 2004; Denzin and

Lincoln, 2000; Miles and Huberman, 1994; Strauss and Corbin, 1998). Different possible explanations for the findings are presented in the discussion in chapter eight. The next section looks at consideration of stakeholder interests.

3.2.1.6 Consideration of stakeholder interests

The research was funded by the Economic and Social Research Council and therefore had to be bounded, as the PhD was required to be completed within a given timeframe (Fetterman, 2010; Marshall and Rossman, 1999). As such, the research focused at the individual level; that is to say on the doctors participating in a leadership development intervention. Given more time, and more researchers, exploration of other perspectives and a more longitudinal approach could have been taken. The chapter now moves on to look at the way in which the research was conducted.

3.3 Conducting the research

This section looks at the way in which the research was conducted including sampling of a case and research participants, the process of data collection and then the process of data analysis. It begins by looking at the way in which sampling of a case and group of doctors occurred.

3.3.1 Selection of an intervention

The search for an appropriate intervention occurred during the latter part of 2008 and early part of 2009, via online investigation of medical education institutions and consultation with personal contacts. Leadership and management development interventions for doctors not in formal leadership roles were at this time of a short term, modular nature, such as the management courses run at Keele University and Manchester Business School. The North West Leadership Academy had done work with Chief Executive Officers (CEOs) and clinical leaders, but programmes for doctors not in formal leadership positions, and which incorporated project based work, were still in the development phase. This included the then existing British Academy of Medical Managers 'Learn to Lead' programme for junior doctors. A leadership development programme was being planned by Kent, Surrey and Sussex Deanery, which

initially appeared as if it would be a six month programme, although it proved to be a twelve month programme, commencing in September 2009.

Ultimately, a twelve month Leadership Fellowship for specialist trainees (Registrars) commissioned by a strategic health authority and partner deanery in the south of England was selected as the case to study. It was selected, following discussions with members of the team commissioned to co-design it and deliver the educational element (Easterby-Smith, 1994), because it represented an ideal case to study, given the research questions posed and criteria set. Access and agreement for the research was negotiated by the director of the team commissioned to deliver the educational element. The Fellowship will be discussed in more detail in chapter five. It was essentially an 'out of programme experience' which (almost entirely) removed Registrars from clinical work to work on 'live' quality improvement and service development projects whilst also participating in an educational programme. The next section looks at the selection of a sample of doctors.

3.3.2. Selection of a cohort of participants

Recruitment of a sample occurred by means of my attending an introductory day for the cohort of trainees recruited to the programme. Here I spoke to them about why I was interested in their experiences of moving into a leadership role and participating in the programme and what was likely to be required of them if they participated in the research. I appealed for anyone who may be willing to participate to contact me. Research information sheets were emailed following this briefing via the course administrator. Nine doctors emailed to confirm that they were happy to participate and then a further six responded confirming they were happy to take part after a subsequent email was sent out.

Ultimately, the sample constituted fifteen specialist trainees; eight women and seven men from a cross section of specialities. Two were from general practice, two from psychiatry, one from oncology, two from paediatrics, one from ophthalmic surgery, one from respiratory medicine/cardiac intensive care, one from anaesthetics, three from respiratory medicine, one from renal medicine and one from general medicine with endocrinology. Table A profiles the sample of doctors who participated in the research, outlining their specialist area of training,

gender and stage of training, in terms of how close to attaining their certificate of completion of specialist training (CCT) they were. The table shows that it was predominantly senior trainees who took part, although two were at a very early stage of their training. Only one, D14, (referred to as Louis) was in a surgical speciality (ophthalmology). This was representative of those taking part in the intervention in that of a total of forty one initially recruited (although two swiftly dropped out) there were nine psychiatrists, eight GPs, eleven from medical specialities, four anaesthetists, one oncologist, one from cardiac intensive care, two paediatricians, two ophthalmic surgeons, one colo-rectal surgeon and two from obstetrics/gynaecology.

Table A: Profile of doctors participating in the Fellowship

ID Code	Speciality	Gender	Stage of Training
D11 Lisa	Oncology	F	In first year of specialist training
D12 Lucy	Paediatrics	F	3 years until CCT (Part-time trainee)
D14 Louis	Ophthalmology	M	Completed CCT
D15 Amanda	Respiratory Medicine	F	Completed CCT
D16 Will	Anaesthetics	M	18 months until CCT
D17 Dev	Respiratory/ Cardiac ICU	M	Completed CCT
D18 Mark	General Practice	M	Completed CCT
D19 Nina	Psychiatry	F	24 months until CCT
D20 James	Psychiatry	M	12 months until CCT
D21 Ella	Paediatrics	F	About to enter 3 years sub-speciality training
D23 Majid	General Medicine/ Endocrinology	M	6 months until CCT
D24 Mike	Respiratory Medicine	M	18 months until CCT
D25 Caroline	General Practice	F	Completed CCT
D26 Bina	Renal Medicine	F	Completed first year as specialist trainee
D27 Zoe	Respiratory Medicine	F	18 months until CCT

As discussed previously, a sample of doctors not participating in a leadership development intervention was also recruited. This constituted eight doctors, from specialities deemed *more* and *less* oriented towards management; immunology and haematology, being pathology based specialities deemed more oriented to management, and surgical specialities, which are deemed more antagonist towards management (Willcocks, 2004; Harrison and Pollitt, 1994).

This was in order to try and gain a range of views. This sample was recruited from outside of the area where the Fellowship was taking place, to avoid potential influence from participants in the Fellowship and therefore bias, with the doctors being based at three hospitals in the north of England. Table B shows the profile of the doctors who formed this comparison group. The following section looks at the process of data collection.

Table B: Profile of doctors not participating in any intervention

ID Code	Speciality	Gender	Stage of Training
SR11 Costas	Cardio-thoracic surgery	M	24 months until CCT
SR12 Shakira	Immunology	F	Completed CCT
SR14 Liam	Liver surgery	M	36 months until CCT
SR15 Robert	General surgery	M	24 months until CCT
SR16 Jamie	General surgery	M	36 months until CCT
SR17 Indi	Haematology	M	Just completed CCT
SR18 Martyn	Allergy & Immunology	M	18 months until CCT
CL01 Massood	Liver surgery	M	Consultant & Clinical Lead

3.3.3 Collecting the data

This section looks first at collection of the primary data via interviews, including the way in which the cycle of role transition (Nicholson, 1984) was incorporated into the staged interview process. Following that, the secondary data sources collected are discussed.

3.3.3.1 Collection of primary data through interviews

Prior to conducting interviews with doctors in the Fellowship, potential interview questions were developed from the literature and these were piloted with my two PhD supervisors, the director of the Centre for Innovation in Health Management (CIHM) at the University of Leeds, who has considerable experience of leadership and development and working with doctors, and two Registrars. Piloting with the Registrars enabled an assessment of whether the mode of delivery and phrasing was appropriate and whether information generated was sufficient (Saunders, Lewis and Thornhill, 2007). Table C shows a breakdown of the interviews conducted.

Table C: Overview of interviews conducted

Interviews conducted Total no = 46	Breakdown of informants Total no =28				
	Doctors in programme	Educational leaders	Commissioner	Trust Sponsors	Doctors not in programme
	15	2	1	2	8
No of times interviewed					
Once Prior to F'ship		2	1	4	
Once					8
Once End of F'ship	3				
Twice On entry & conclusion	8				
Three times On entry, conclusion & 12 months post the F'ship	4				

As table C shows a total of forty six interviews were conducted with a total of twenty eight informants. Twelve of the participating doctors were interviewed at two points in time, on entry to the intervention and towards completion. Four of these twelve were also interviewed a third time, by telephone, at around twelve months post completion of the Fellowship. A further three doctors were interviewed once, towards completion of the programme. Interviews were also conducted with other key informants. These included one of the commissioners (the postgraduate dean), the director of the organisation commissioned to deliver the educational programme and one of the educational programme leaders. Data was also collected from interviews with eight doctors, constituting seven specialist trainees plus a clinical lead, who were not participating in development.

Interview guides were developed from the piloting stage which outlined the main questions and themes to be explored. These allowed for some flexibility in the interviews, but included possible probes that might be used to gain further information, such as how did that occur and what did you then do. The guide was amended slightly as the research progressed, in order to follow up on themes that were emerging (King and Horrocks, 2010). The interview schedules used at stages one and two (on entry to and towards completion of the programme) and with the doctors in the comparison group are included in appendix A.

The first interviews with doctors in the Fellowship took place shortly after entry to the Fellowship, between May and July 2009. These interviews ranged from between one hour and one hour forty minutes. The interview questions were ordered differently for each respondent, to allow them to elaborate on certain points and to maintain a fluid and more natural flow to the interview (King and Horrocks, 2010). At the start of each interview the purpose of the research was re-iterated as an ice-breaker. The topics to be covered were discussed and the opportunity to ask questions was provided.

These first interviews focused on the 'preparation stage' of the role transition process (Nicholson, 1984). The participants were asked about how they had been recruited and selected, their motivations for participating in the Fellowship and their prior experiences of leading service development type projects, or other organisational involvement. They were also asked about their goals for the year and any concerns that they had. This was because

prior socialisation and motivations for a new role, as well as inflated expectations or high levels of anxiety, are all associated with the way in which individuals adjust. In addition, the group was also asked about their attitudes towards managers and clinical leaders at this stage, in order that changes in their attitude over the course of the year could be assessed. Owing to the need to gain ethical and individual Trust research approvals, along with the fact that entry to the Fellowship was staggered, attitudes could not be explored prior to the start of the Fellowship. However, the Fellows did relate when they felt their attitudes were in the process of changing in comparison to their views on entry. Given that many of the group had already started work on their projects questions related to the 'encounter stage' of role transition (Nicholson, 1984) were also included here. Those who had started work were asked how they were finding the new role, whether anything had surprised them and about any early learning at that point.

The second interviews were conducted towards completion of the Fellowship, between April and June 2010. They ranged from thirty minutes (in a single case) to an hour and three quarters, with the average duration being one hour and a quarter. The structure was a little looser than the first as this interview sought to explore the 'encounter' stage in more detail and the type of 'adjustment' that was occurring (Nicholson, 1984). Some of the things which had emerged in the first interviews were pursued (King and Horrocks, 2010).

As adjustment may occur through either role innovation, personal change (Nicholson, 1984) or both, the group was questioned about how they had approached their projects. This was in order to determine whether they had shaped their projects in any way or simply followed the guidance of the programme leaders. In order to assess whether any personal change through shifts in attitude had occurred the participants were asked as to how they now felt about the following: being involved in organisational issues; working with non-clinical managers and working with other stakeholders. In addition, they were asked whether they felt that they had changed in any ways. Whilst the intervention was time limited, such that all participants were effectively moving straight on to the next transition, they were asked about any elements of the role they would be maintaining and what they planned to take forward, in line with Nicholson's (1984) ideas of 'stabilization'.

'Stabilization' was pursued in more detail with the four doctors who were followed up twelve months later. These follow-up interviews took place by telephone between April and June 2011 and lasted between thirty and forty minutes. It was considered that a rapport had already been established with the group at this stage and this was the easiest way to access the doctors concerned, who were now back in busy clinical roles (Saunders, Lewis and Thornhill, 2007). These interviews focused on three key areas: the extent to which the Fellow was still using the new skills and understanding they had developed, and if they were not, why not; their attitudes towards managing and leading within the NHS and finally, whether anything had changed as a result of the experience, such as taking on a new role or new career plans.

Three additional participants were interviewed on a single occasion, between April and June 2010. These interviews provided some rich data additional data in relation to the entire transition process, proving useful for checking some of the propositions being developed, particularly in relation to themes emerging from the other first stage interviews (Saunders, Lewis and Thornhill, 2007; Strauss and Corbin, 1998; Miles and Huberman, 1994).

In order to gain additional insight into the Fellowship and potential factors impacting upon the process of role transition, interviews with other key informants related to the Fellowship were conducted. Prior to the start of the Fellowship interviews were conducted with the educational programme director and one of the programme leaders. These revolved around the following: the focus of the programme; whether they had provided any guidance regarding selection of the cohort; what was known about the participants and what they as educationalist hoped to achieve. The postgraduate dean was also questioned about how the Fellowship came into being, how it was funded, the objectives the commissioners had and what would count as success for them. In addition two sponsors of doctors taking part in the intervention were informally interviewed at a briefing event in February 2009. They were asked about their recruiting methods and rationale for selection of a Fellow. Interviews with the comparison group of doctors took place between August 2009 and June 2010 and lasted an average of forty minutes. These interviews focused on the doctors' experience of management and leadership and their attitudes towards non-clinical managers, management practices and involvement in organisational issues.

All but one of the face to face interviews with the Fellows was recorded on a digital recorder, after written consent had been obtained. The interviews were then transcribed verbatim in order to provide an accurate record. This allowed for transparency over what was said and how the researcher may have affected the situation (Gomm, 2008) and enabled 'confirmability' of the findings and conclusions (Lincoln and Guba, 1985). Where interviews were not recorded, notes were taken and typed up on the same day.

A single interview of approximately an hour in length took between seven to eight hours to transcribe. In addition to which another day and half on average was spent listening to an interview and reading the transcript through twice, to check for accuracy in the transcription. Transcription is noted to be highly time consuming (King and Horrocks, 2010; Gomm, 2008) but the process was valuable as it enabled considerable familiarity with the data. Notes were made of the context in which these interviews occurred and any impressions of body language at odds with what was being said recorded (King and Horrocks, 2010). For example, one doctor's tone of voice suggested they felt quite negative about their experience and this was noted. These notes were made immediately after the interviews had been completed and added to the transcripts. Copies of the transcripts were sent to each participant and no issues were raised, although one participant made minor grammatical amends in the form of changing yeah to yes.

All interviews were uploaded into computer assisted qualitative data analysis software (CAQDAS) in the form of NVivo 8 as this enables transparency of data analysis and creates an audit trail (Ezzy, 2002; Lincoln and Guba, 1985). NVivo 8 was selected because it provides the code and retrieve functions required, allows diagrammatic display of relationships, operates in a similar way to familiar packages such as Microsoft Word, enabling proficiency within a reasonable timeframe, and training was available via the University of Leeds, as the package is supported by their IT department. The next section looks at the collection of secondary sources.

3.3.3.2 Collection of secondary data sources

Secondary data was collected on the background to the intervention and the local context and the content of the educational programme. Additional sources in the form of recorded podcasts by key informants. Table D provides an outline of all the secondary sources utilised.

Table D: Secondary data sources collected and analysed during the research

Secondary Sources	Details
Strategic plans of the SHA regarding developing clinical leadership	Available via Deanery website
Preparatory/advisory documents prepared for commissioners by McKinsey	Available on internet
PowerPoint presentations outlining rationale and development of programme	Given by Postgraduate Dean at a launch event early in programme
Written summaries of projects	Produced by 14 of 15 doctors participating in the research
Podcasts	Available via Deanery website <ul style="list-style-type: none"> • Four doctors participating in the research • CEO of SHA (commissioner) • Postgraduate Dean (commissioner) • Educational leader • Lord Darzi
Educational modules documents	<ul style="list-style-type: none"> • NHS Structure • Working systems • Designing and leading change • Medicine and Management • Co-production of services • Clinical governance
Short video	Available on website Simulation exercise run by educational leaders on roles and systems

As table D shows, documents relating to the rationale for commissioning the leadership and management development programme were sourced from the SHA and deanery websites. Other additional information also became available during the course of the research. This included Microsoft PowerPoint presentations given by the postgraduate dean and podcasts recorded by commissioners, module leaders and four of the Fellows. The podcasts were recorded and then transcribed. Additionally, educational documents related to the modules were sourced from the CIHM, and short videos of simulation exercises were accessed via their website. All of the text based documents and 'PowerPoint' presentations were uploaded into NVivo 8 ready for analysis. The short videos of simulation exercises were watched, with notes being taken. These were then uploaded into NVivo 8. The next section looks at the methods and process of data analysis.

3.3.4 Analysing the data

In terms of data analysis it was decided that a mix of deductive and inductive analysis would be used, given that a theoretical framework of role transition (Nicholson, 1984) was being used to guide data collection such that some 'a priori' themes existed. A particular way of thematically analysing the data through template analysis (King, 2004) was used, which facilitates a mix of deduction and induction. A template of themes within the data was constructed from the twelve, detailed interviews which took place with participants at the start of the Fellowship. In line with Nigel King's suggestion, a limited number of 'a priori themes,' or themes that were expected to occur in the data, were developed. These were based on the four stages within the model of role transition (Nicholson and West, 1988; Nicholson, 1984) and specific interview questions used in the first stage interview guide, for instance regarding the Fellows motivations for participating. The final template can be found in appendix B.

Within NVivo8 a new project 'Leadership Fellowship' was created, so that all of the transcribed interview data and secondary sources could be uploaded. The 'a priori' themes which had been determined were then created within 'tree nodes' within the project. After each first stage interview had been conducted it was transcribed verbatim and then as well as being uploaded into NVivo 8 it was also printed out. The printed transcripts were read through twice, in order to gain familiarity with the data and to get a sense of the overall context and the themes which may be emerging before coding began.

Segments of the data, in the form of sentences were analysed (Ezzy 2002). These segments were coded to the 'a priori' themes where they were relevant. When data was relevant to the research questions but no 'a priori' theme existed, a new one was created, initially within 'free nodes.' Strauss and Corbin (1998) suggest that themes assigned can come from one of three sources: terms that emerge from the data, actual terms used by participants (known as 'in vivo' codes) and thirdly from terms used in existing theory and literature. In this case, codes were assigned which related to the existing theory and literature. This process was repeated until all the initial twelve interviews had been analysed. In some cases data was coded to more than one node. Creating new nodes initially in 'free nodes' allowed a list of themes to be created which could be refined as analysis progressed and then moved into a hierarchical order within 'tree nodes'. As analysis progressed a more hierarchical coding structure emerged with categories being redefined, deleted and merged into broader categories as patterns and relationships were determined, with codes reflecting interpretation of the data (King, 2004; Strauss and Corbin, 1998). Coding took place to five levels, in order to show sufficient depth, but allow the key themes to emerge, which is in line with Nigel King's suggestions (see http://www2.hud.ac.uk/hhs/research/template_analysis/).

As interviews were conducted longitudinally in the majority of cases, analysis was conducted on an ongoing basis, in line with suggestions of a number of writers (King and Horrocks, 2010; Charmaz, 2006; Hartley, 2004; Strauss and Corbin, 1998; Miles and Huberman, 1994). This allowed findings to be followed up with other informants, and tentative conclusions and explanations to be tested out. The themes that were emerging at the first stage interviews helped refine the second stage interviews. Altogether a ten step process occurred, detailed below.

Step 1: The 'a priori themes' were created in 'tree nodes' - see appendix B Item 1

Step 2: The entire data set of the twelve first interviews was coded, with relevant data being assigned to the 'a priori' codes within the initial template, with new themes that were emerging being created in free nodes - see Appendix B, item 2

Step 3: Once all twelve interviews had been coded the themes were re-visited. Some themes in 'free nodes' were merged and refined, resulting in some being deleted.

Step 4: The interview transcripts were read through again, to get a holistic feel.

Step 5: The themes within free nodes were then re-visited and further refinements occurred

Step 6: The themes which had been developed in 'free nodes' were then assigned to the relevant broader categories developed within 'tree nodes', allowing hierarchical coding to occur, and some of these broader themes were also refined - see Appendix B, item 3

Step 7: The second stage interviews and interviews with the comparison group of doctors were uploaded and step 2 was repeated, with new themes emerging being created in 'free nodes' initially

Step 8: Once all the second stage interviews had been coded steps 5 to 6 codes were repeated, with themes again refined and merged.

Step 9: The overall hierarchy was reviewed, with further refinements occurring until the template was satisfactory - Appendix B, item 4 shows the final template with a five level hierarchy.

Step 10: Tables were produced within some themes to depict the detail and enable the drawing out of patterns and a matrix was developed to show the shift in attitudes of the Fellows towards non-clinical managers (Miles and Huberman, 1994). This was to enable propositions about the findings to be made and conclusions to be drawn (Miles and Huberman, 1994; Saunders, Lewis and Thornhill, 2007; Strauss and Corbin, 1998).

3.4 Issues faced in the research process

The main issue faced was in relation to access. Initially access to the Fellowship was gained via the Director of the CIHM commissioned to deliver the educational element and co-design the Fellowship. I then met with the postgraduate dean who was initially keen for both the Fellows and sponsors' perspective to be explored. However, access to the sponsors and Trusts was subsequently withdrawn and limited to interviewing those Fellows who agreed to participate. The commissioners did go on to conduct their own evaluation, which may explain this change of mind. Whilst the research sought to focus on the participating doctors' perspective this ruled out the possibility of any observation of educational sessions or further interviews with other stakeholders.

The expertise of the module leaders and director of the CIHM was very helpful in terms of helping to select and initially access the intervention, as well as to pilot the interview questions. However, given that they were delivering the programme and potentially had a vested interest in the outcome of the research, I did distance myself and have less contact with them as the research developed. A first report of findings was produced in September 2010 and some anonymised quotes to support a tender for a following cohort were used. The next section briefly summarises the chapter before the Fellowship is outlined in more detail in chapter four.

3.5 Summary

Informed by a critical realist perspective the research adopted a single, qualitative case study approach in order to study in depth the process of a new leadership development intervention designed specifically for specialist trainees (Registrars) through a lens of role transition (Nicholson, 1984). NHS ethical procedures were followed and approvals gained, with consideration given to issues such as the need for reflexivity. A total of fifteen doctors from a mix of specialities and at various stages of specialist training were sampled in order to gain multiple perspectives, with twelve interviewed at two points in time. Data was also collected by interview from a comparison group of specialist trainees who were not participating in training and development, plus other key informants including commissioners, educational programme leaders and (informally) some sponsors. This was to triangulate data collection and corroborate findings emerging from the participants in the Fellowship. Secondary data in the form of strategy and educational documents were also analysed.

A mix of deductive and inductive analysis took place through the use of template analysis (King, 2004), a particular way of thematically analysing the data. A CAQDAS package, NVivo 8, was used to assist this analysis and provide a transparent audit trail. Propositions regarding how the intervention impacted on participating doctors' sense of professionalism, that is to say their values, beliefs and practices were tested out by means of a thorough assessment of the data, a search for alternative explanations and instances that challenged these ideas. The next chapter moves on to look at the Fellowship in more detail.

Chapter 4: The Darzi Fellowship

Introduction

This chapter provides an overview of why and how the Darzi Fellowship came into being, what it aimed to achieve and how the task of enhancing the participating doctors leadership skills and orientations to their role was approached. It considers the way in which experiential learning was enacted and the structure and content of the educational programme which ran alongside. The chapter is structured in five parts. Section 4.1 begins by looking at the overall design of the Fellowship. Section 4.2 considers the background to it and the context in which it emerged. Section 4.3 considers the objectives of the commissioners and educational programme leaders. Section 4.4 outlines the learning inputs in terms of the projects designed by the sponsors of the participating doctors. Section 4.5 then outlines the structure and content of the educational programme, including the principles of whole system working which underpinned it.

4.1 The Fellowship

The leadership development intervention selected for study was the first Leadership Fellowship of its kind specifically developed for specialist trainees (Registrars) known as a Darzi Fellowship. It was commissioned by a Strategic Health Authority (SHA) responsible for the health care provided within a large metropolitan area in the south of England, which will be referred to hereafter as 'NHS Southlands', and its partner deanery.

The Fellowship was designed as a twelve month 'out of programme' experience for Registrars who were appointed to work in a newly created role, known as a Darzi Fellow, within a primary care, hospital or mental health care NHS Trust. Within their appointing Trust they were to work on 'live' change management and quality improvement projects designed by their sponsoring medical director or Primary Executive Committee (PEC) Chair. The Fellows were to be guided on these projects by a mentor, usually the same sponsoring medical director or PEC Chair, and supported by a structured programme of education, peer learning and individual

coaching running throughout the year. The commissioners had appointed the Centre for Innovation in Health Management (CIHM) at the University of Leeds to deliver the educational programme and co-design the overall Fellowship. A design team was formed which included a project manager from the SHA, the postgraduate dean, the director of the CIHM and two associates, 'Susan' and 'David'. The latter are both management consultants and former Kings Fund Fellows who were selected by the CIHM to lead the educational programme. In addition, employing Trusts were to provide opportunities for development including attendance at board meetings, project management experience and exposure to trust financial management. The next section looks at the background to and context in which the Fellowship emerged.

4.2 The Background and Context of the Fellowship

In 2007 'NHS Southlands' began work on 'A Framework for Action' which set out a vision for world class health care for every local citizen, in line with the first report from Lord Darzi's review of the NHS, 'High Quality Care for all' (Department of Health, 2008) which placed quality at the heart of all action. The framework identified a need to develop a cadre of clinical leaders and to invest in developing leadership skills amongst the workforce if the SHA's goals were to be achieved. A 'Leading for Health Foundation' was introduced to work closely with the NHS Leadership Council to develop CEOs and other top leaders, and with higher educational institutions, medical schools and the local deanery to embed leadership skills during doctors training. Funding for clinical mentoring places and for up to twenty Darzi Fellows per year was to be available. This was in order to provide opportunities for junior doctors to lead on key 'Healthcare for Southlands' initiatives.

Initiatives for junior doctors began in 2008 with a pilot mentoring programme for specialist trainees (Registrars) known as 'Prepare to Lead'. Twenty Registrars who had shown evidence of team working and an interest in leadership were recruited to a twelve month programme. During this period they shadowed a mentor, either a CEO or senior manager. They also attended educational sessions including a two day course 'power, politics and persuasion' and workshops and seminars on topics such as workforce development, ensuring patient safety, policy creation in government, leadership and strategy and leading in the NHS.

Following this, it was decided to develop the Darzi Fellowship as an 'out of programme' experience for Registrars. That is to say it was developed as an aside from the specialist training programme.

The Postgraduate Dean, who was a driving force behind the Fellowship, stated that alumni had been telling the deanery for some time that 'no-one told us it would be like this', in terms of the level of organisational responsibility they encountered on becoming a consultant. However, the timing and title of this particular venture evolved for particular reasons:

"We had a million pounds available to us that had not been used by someone else and we decided to use it this way. We related it to Lord Darzi's new ways of working and started calling them Darzi Fellowships, which was our own internal shorthand. Lord Darzi somehow got to hear about it and was very keen and this became the formal title, which increased the profile of them."(Postgraduate Dean)

The overall structure of the Fellowship appears to have been based on the thinking of the commissioners, as the following quote from the Postgraduate Dean highlights:

"Many of our Registrars go on management courses which are separate from their Trusts and they do their work as Registrars and then they go off for a 2 or 3 week course to do their management course. It always struck me that this was, if you like, missing a trick, because they needed to learn about organisational practice, how to work in systems within the Trust within which they're working and so in fact the organisational training, the management training, the leadership training that they are having on their course actually makes sense" (Postgraduate Dean)

A presentation given by the Postgraduate Dean at a launch event in April 2009 revealed that the deanery felt that system changes were needed so that all clinical professionals could acquire organisational and leadership skills during their clinical training. It was stated that this organisational learning should be centred on improving clinical care, and that organisational skills needed to be valued and assessed, so that trainees came to expect to take on appropriate organisational responsibilities. The commissioners felt that opportunities for learning were readily available within Trusts, but they needed the capacity, resources, and possibly also the permission to make these opportunities available. The response of the sponsors to the idea of a Fellowship was very positive according to the Postgraduate Dean:

“When I emailed the medical directors and PEC leads to see their interest in the idea all but two came back straight away, wanting to be part of it and wanting more Fellows....One of the other two came back after a couple of days and said they had spoken to people and wanted to be part of it. Only one resisted” (Postgraduate Dean)

Working in conjunction with NHS Southlands, forty one Darzi Fellowship posts were made available in all Trusts; acute, general practice and mental health Trusts. The next section looks at the objectives the commissioners and design team hoped to achieve.

4.3 Objectives of the Fellowship

According to a statement on the deanery website they had “partnered with the Centre for Innovation in Health Management (CIHM) to provide trainee doctors with the unique opportunity to develop organisational and leadership skills necessary for their future roles as consultants and clinical leaders”. It was not clear from this whether there was an expectation that these doctors would become clinical leaders in the formal sense, as clinical or medical directors for instance. However, at a briefing event for the sponsors in February 2009 the Dean Director stated that their objective was to “get all our Registrars organisationally savvy”. She stated that she would be delighted if they had Registrars approaching them in the future asking to be involved in projects in order to improve their skills.

The idea of being organisationally savvy was backed by Susan, one of the programme leaders:

“...I would like to make the Darzi Fellows more ‘organisationally savvy’, able to read political environments and to be canny designers of how to involve people in change. They need to understand what counts as an effective way of doing things. For example, committees are not the most exciting way of spending time; they can be useful for some things but are not necessarily the best way of getting some things done. A lot of people spend years within organisations, but few people really understand them, they get confused as to what are poorly designed and what are normal organisational constraints that you have to work around” (Susan, Programme Leader)

In interview Susan stated that her objective was to build the capacity of the Fellows so that they could set the right conditions for change in the future, which is in line with recommendations for developing leadership in the NHS (Day, 2001, Iles and Preece, 2006).

Susan stated that the programme would not be simply giving the Fellows a toolkit to use, nor preparing them for any particular role. However, at the briefing event for the sponsors she referred several times to the Fellows as 'change agents'. This was questioned by one of the sponsors, who queried "but that's not what we are trying to do with them is it, turn them into change agents?" Susan responded by saying that perhaps she should stop calling them by this name, although it was unclear whether this was because it was not the explicit objective of the programme, or simply because the term was not recognised by the sponsors. Susan did, however, clarify what was expected of the Fellows with regard to responsibility for the projects they were to tackle:

"They hold themselves responsible for getting involved and being willing to try things but they are not responsible for the whole change. They will be part of the project, not totally leading it" (Susan, Programme Leader)

Other documents produced by the CIHM outlined the educational objectives. These were to develop the Fellows' understanding of work as a process and provide experience of 'designing' healthcare practices. The programme also sought to provide opportunities for the Fellows to collect, aggregate and analyse data on work processes, to develop outcome measures and to collaborate with patients and NHS managers. This was based on skills outlined in the "New Clinical Skills of Quality Management" by Don Berwick of the Institute of Healthcare Improvement in the USA. In addition the educational programme leaders sought to enable the Fellows to do the following:

- uncover their assumptions about change and the roles of managers and clinicians
- explore the perspectives of others (professionals and patients)
- understand how NHS organisations work
- develop their ability to read political environments
- engage in change efforts
- gain from the real life experience of working as part of a team and part of the overall system
- reflect on their practice
- find ways of working successfully with others and build a network of colleagues facing similar challenges

Interviews and course documents show that in order to help the Fellows achieve this, the programme leaders planned to work with the Fellows on four areas: their ways of learning (in terms of how to learn with others and how to reflect on their own practice); their ways of seeing things (or their sensemaking of situations); their ways of knowing (in terms of understanding the types of evidence that is appropriate when making change) and finally their ways of designing interventions. The next section looks at the learning inputs, beginning with the projects designed for the Fellows.

4.4 Methods of Learning: The work based projects

The Fellowship post was designed around the Fellows learning through working on three types of work based projects, designed for them by their sponsoring Medical Director or PEC Chair. The three types of projects included:

4.4.1 A Service Development Project

This was a service-reconfiguration or change management project, designed to help the Fellow develop an understanding of implementing change and benefit the Trust by progressing its strategic aims. Examples include the setting up a high dependency unit, gaining support for a polysystem and improved GP access, establishing a Paediatric Clinical Decision Unit in Accident and Emergency (A&E) and establishing an urgent care centre involving both A&E and the local PCT to improve patient access to unscheduled care.

4.4.2 A quality or safety improvement project

This was a project based around improving the quality and safety of delivered patient care. The expectation was that permanent changes would be achieved within the year of the Fellowship. Examples include: improving patient handovers by implementing the introduction of a communication tool; introducing a 'Think Glucose' campaign in the community to improve recognition of, and care for, patients with diabetes and the introduction of care bundles to reduce infections within a high dependency unit.

The change management and quality/safety improvement projects were submitted to a project manager at 'NHS Southlands' for approval and then shared with the educational programme leaders. In some cases one project incorporated the objectives of both change management and quality/safety improvement. Eight of the Fellows had projects which straddled boundaries. In five cases (Bina, Caroline, Zoe, Majid and James) this was between primary and secondary care. In two cases (Mike and Dev), the project involved two sites and in one case (Lucy) the project involved developing a network and guidelines amongst five hospitals. An overview of the Fellows projects is provided in table E.

Table E: Overview of the Fellows projects

Fellow	Service development and quality improvement project
James	<ul style="list-style-type: none"> • To put systems in place to collect information for CQUIN targets and Quality Accounts, as well as to help signpost problems • To review electronic methods for gathering information on patient satisfaction and introduce a method of capturing patient satisfaction • To implement patient reported outcome measures (PROMS), piloting 3 measures and developing a training package for clinicians to use Health of the Nation Outcomes Scales across the trust
Ella	<ul style="list-style-type: none"> • To establish a Paediatric Clinical Decision Unit (PCDU) in the Emergency Department, as part of ongoing development of urgent care ambulatory services for children. • To develop protocols for use of the unit
Majid	<ul style="list-style-type: none"> • To introduce the 'Healthcare for Southlands' diabetes guide, a wide spanning guide looking to improve the ability of patients with diabetes to self manage • To deliver a new integrated model of community care • To establish the 'Think Glucose' clinical pathway
Mike	<ul style="list-style-type: none"> • To gain clinical engagement for a bespoke clinical documentation system • To develop clinical assessment unit patient directed pathways in oncology
Caroline	<ul style="list-style-type: none"> • To establish an urgent care centre to improve patient access to urgent care and reduce the PCTs expenditure on urgent/unscheduled care
Bina	<ul style="list-style-type: none"> • To assist in the development of an urgent care centre, to manage emergency access patients across the community, with extended GP opening hours • To develop a Patient Response Outcomes proforma
Zoe	<ul style="list-style-type: none"> • To develop a primary care based spirometry service in the 'Northborough' Practice Based Commissioning cluster - To Introduce education for primary care staff from this cluster in spirometry and COPD management - To Increase spirometry screening for patients >35 years at risk of COPD
Lisa	<ul style="list-style-type: none"> • To improve the quality of the patient experience for inpatients diagnosed with cancer • To develop an innovative patient pathway, incorporating input by Oncologists prior to histological diagnosis of cancer
Lucy	<ul style="list-style-type: none"> • To establish a clinical network in paediatric gastroenterology for north central sector (comprising one specialist paediatric and 5 other hospitals) • To develop joint network guidelines and educational sessions • To promote greater information sharing through establishing remote access to specialist hospital IT system

Fellow	Service development and quality improvement project
Louis	<ul style="list-style-type: none"> • To help establish a community based ophthalmic service in the first purpose built polyclinic in NHS Southlands, which will provide access to urgent, semi-urgent and chronic ophthalmic disease management.
Amanda	<ul style="list-style-type: none"> • To develop a Chronic Obstructive Pulmonary Disease (COPD) service as part of an overall improvement in respiratory services for the locality
Will	<ul style="list-style-type: none"> • To help in the creation of a new 18 bedded high dependency unit through amalgamation of existing separate units • Involvement in planning, policy making, architectural decision making and governance procedures • To establish a family satisfaction data collection tool and use process mapping to arrive at local solutions for enhancing the family experience of ICU. • To establish central venous catheter and ventilation association pneumonia care bundles on the unit
Dev	<ul style="list-style-type: none"> • To help create a 26 bedded cardiac high dependency unit (CHDU) • To help develop the plans, clinical governance and policy processes for CHDU • To Implement compliance and infection monitoring in two sites with regard to a central line care bundle and ventilator care bundle and achieved targets and a variety of other quality • To implement use of a communication tool to standardise handover of patients • To carry out a safety audit of chest drains inserted on CICU in line with a national safety alert.
Mark	<ul style="list-style-type: none"> • To highlight the case for change towards a polysystem delivery model in 'Leafyborough' PCT and extend patient access to primary care with a 7 day service.
Nina	<ul style="list-style-type: none"> • To review the Trust's provision of services to one borough • To develop the Trust's quality account • To develop and agree quality indicators and metrics for 2009-2010 • To incorporate service users into the planning for future Quality Accounts and get agreement for quality priorities for 2010-2011

In addition to the service development and quality improvement projects, all of the Fellows had a project aimed at enhancing their Trust's capacity to train and develop other doctors, as the next section outlines.

4.4.3 A project to enhance the capacity of Trusts to train and develop others

The Fellows were all required to explore and develop their Trust's capacity to train other junior doctors in an essential organisational skill such as leadership or team working. No formal criteria were set at the start of the year in terms of how far each Trust's capacity should be developed, but as the year evolved additional money was made available by the commissioners which the Fellow could bid for to launch training and development initiatives. This was referred to as the 'Dragon's Den' initiative, based on the BBC television programme in which entrepreneurs bid for money to launch their business ideas. The next section considers how the educational leaders viewed all of these projects.

4.4.4 The educational leaders views of the projects

Analysis of documents produced by the CIHM noted that the educational programme leaders felt there was "considerable emphasis on [the 'live' projects] as a major use of the Fellows' time and effort" (p.1). These documents also stated that, owing to the fact that these projects had been already identified by the SHA with the sponsors, they were "a potential source of frustration for the Fellows and us." The titles of some projects were felt to potentially be a "red herring" and to involve things which were in "sharp contrast to most management tasks" (p.2). This written concern was reinforced by Susan, one of the programme leaders, when interviewed:

"Most of the problems are 'wicked' problems that could have been introduced at any time over the last couple of decades but haven't been. They are going to be ongoing problems and not ones that can necessarily be solved within the year. There will be a legacy which is something the Fellows must be prepared for"
(Susan, Programme Leader)

'Wicked' problems are particularly identified with public sector organisations, which have to deal with complex social problems which involve a number of agencies (Hartley, 2010; Head and Alford, 2008). They were identified in the 1970s and described by Rittel and Webber

(1973) as problems which are unique and complex, and often a symptom of another problem. They have no definitive formulation or solution, such that solutions are not right or wrong, simply good or bad, with there being no ultimate test of them. Wicked problems are argued to be the most difficult for a leader or manager to tackle (Heifetz, 1994). Conklin (2007) has attested that:

'You don't so much "solve" a wicked problem as help stakeholders negotiate shared understanding and shared meaning about the problem and its possible solutions. The objective of the work is coherent action, not final solution' (p. 5)

The implication of this, from the educational leaders' perspective, was that the Fellows would need to be given very careful direction about how to approach the projects. Hartley (2010) notes that leadership and management development programmes have only recently taken on board ways to tackle wicked problems, which may have explained some of the programme leaders concern. Head and Alford (2008) offer advice as to how such problems might be tackled. They suggest that these problems require more than collaboration amongst different stakeholders, which is the favoured approach of policymakers. Rather, they require systems thinking. This entails consideration of all the inputs, processes and outputs along with an adaptive form of leadership. Adaptive leadership is described as the leader resisting from providing the way forward. Instead, they lead organisational members to collectively identify the problem and develop ways to deal with it, such that those members take a shared leadership role in setting the direction (Heifetz, 1994).

The next section looks at the structure and content of the educational programme, both the taught elements and the opportunities for skills development through peer learning and individual coaching.

4.5 Methods of learning: The educational programme

A total of twenty four days of education was commissioned by NHS Southlands and their partner deanery from the CIHM. This included six taught modules and a learning review day, totalling eighteen days. A further six days were split across attendance at communities of practice and action learning sets. On a personal level, support and skills development was

offered in the form of up to six coaching sessions, three of which could also be attended by the sponsor/mentor. Six optional 'design surgeries' were also available where the Fellows could seek specific project related advice either on a one to one basis or by telephone. The overall cohort was split into two groups, A and B, such that each module was delivered twice. The next section looks at the taught modules that were delivered in more detail.

4.5.1 The taught modules

This section briefly outlines the introductory module and modules 1 to 3 which were all run by the programme leaders, and then the three modules which constituted a postgraduate certificate in management, run by academics.

4.5.1.1 The introductory module (1 day)

This module introduced the idea of individual, team, organisational and system levels. The four areas the programme leaders aimed to focus on were outlined: learning shaping behaviours; sensemaking; ways of knowing and designing interventions. The Fellows were introduced to an Associate who could help them in developing outcome measures for their projects.

4.5.1.2 Module 1: The NHS as a system (3 days)

Day 1: The role of policy in public services

This considered the way in which money flows in the NHS, different organisational structures and archetypes and differences between public companies and public service organisations. Governance issues were also introduced.

Day 2: A full day workshop based on the work of systems expert Barry Oshry

The workshop utilised a simulation exercise, based on Oshry's 'Power Lab Exercise' in which leaders act out roles within a three class community. The Fellows adopted the role of a 'top', 'middle' and 'bottom' within an organisation, and role played scenarios associated with these positions in an organisational structure. The idea was to develop an understanding of different

roles within systems, the way in which partnerships and collaborations occur and how to lead effective organisations.

Day 3: Current organisation of the NHS

The existence of networks and collaborative working was considered, along with change processes and the role of an internal change agent. Role plays using a co-consulting approach occurred, in order to try out an approach that might be used in semi structured interviews which were to be conducted with a range of key stakeholders prior to the second module.

4.5.1.3 Module 2: Working within organisational structures (3 days)

Day 1: Team structures, roles within teams and effective behaviours

The Myers Briggs Personality Type Indicator (MBTI) was introduced in order for the Fellows to gain an understanding of their personality type and personal preferences for learning and problem solving. This was in order for a consideration of appropriate communication styles for their projects to be made. The role and design of effective committees was also considered.

Day 2: Strategic planning.

A range of possible future workforce scenarios were introduced in order to explore ways in which strategy is formed. The session then considered stability and change in systems and introduced the theoretical concepts, principles and examples of methodologies associated with a 'whole systems approach'.

Day 3: Systems dynamics in action.

The day was organised around a simulation exercise known as 'The Beer Game' in which the Fellows worked in teams of four, each taking a particular role: manufacturer; distributor; sales agent or buyer. It was designed to demonstrate how outcomes are determined by structures and to enable the Fellows to start to recognise patterns which emerge in systems and can give rise to unexpected and undesired results. An afternoon 'cafe style' session was held to gather collective insights, with contributions from sponsors and managers, as to 'what makes change stick' and how the change process might be measured and evaluated.

4.5.1.4 Module 3: Innovation in public services and leading change (2 days)

Day 1: Reflections on working as a 'middle manager'

This included consideration of innovation in public services, in terms of what is distinctive about it and 'what makes new ideas stick'.

Day 2: Further reflections and exploration of case studies related to change management.

These case studies were related relation to the Fellows' roles and projects.

Following the modules led by the programme leaders, there were a further three academic module: medicine and management; clinical governance and co-production of services'. These are outlined in the next section.

4.5.1.5 The Postgraduate Certificate in Management

The 'Medicine and Management' module introduced the background to the introduction of medical manager roles, and considered the differences between professionals and managers in terms of training and socialisation, from a sociological perspective. 'Clinical Governance' introduced the principles of clinical governance, considered how governance processes could be introduced and managed and ways in which doctors might take a lead in ensuring the right processes were in place. 'Co-production' introduced the principles behind co-production of services and considered ways in which doctors might work with patients and other service users to enable them to co-design and own service developments.

Each of these modules was of 3 days duration and accredited for a postgraduate certificate in Medical Management. This required a pass grade to be achieved on an essay associated with each model, plus a fourth reflective piece on what the Fellow had learnt over the year about change. The next section looks at the other developmental opportunities provided as part of the educational programme.

4.5.2 Other learning and development opportunities

In addition to the six taught modules there were also six ‘communities of practice’ offered, with attendance at two being required. These were sessions to which Fellows could self-select to work in groups on developing particular skills. Sessions included: negotiating conflict; asking good questions; ways of designing collaborative change initiatives; ways of engaging stakeholders; styles of leadership and presenting to different styles of individual.

Four action learning sets were also scheduled for each Fellow to attend. In these, groups of six to eight Fellows from a cross section of specialities met to discuss their projects and open themselves to questions, ideas and other perspectives. Six individual coaching sessions with an assigned coach were also offered. These were designed to challenge and support the Fellows learning experience and provide an opportunity for them to work on individual or system related issues. Mentors could attend three of these sessions. Analysis of CIHM documents shows that coaching was also designed as a way of managing the potential risk of the Fellows slipping back into clinical work, should life managing the projects became tough. The next section considers the whole systems approach which underpinned the educational programme.

4.6 Principles underpinning the educational programme

Documentary analysis also shows that the educational programme adopted and advocated a whole systems approach to leading the projects, as the following extract shows:

“We will be designing this programme to meet the client’s specifications in ways that are congruent with our understanding, so we will be bringing ideas about working whole systems, co-production in service delivery etc.” (CIHM briefing document for coaches)

Whole system working is a particular way of thinking about change in complex organisations such as the NHS, which have to tackle issues beyond the ability of that organisation alone to solve. The whole systems approach underpinning the programme defined the system as a network of organisations and people who share a particular purpose. It drew on work by

Morgan (1986), which distinguished between organisations as designed and living systems. Designed systems are described as those which can be broken down into manageable parts. In a designed system behaviour occurs in a linear fashion. Analysis is followed by planning, action and then review, with policy and strategy being separated from implementation. This approach is suggested to be most appropriate when the desired future is known, as is the way to achieve it.

In contrast, thinking of organisations as living systems means thinking of individuals, teams, departments and organisations as linked and interdependent and as able to act in ways other than those designed or directed for instance by a senior executive. This approach is said to be more appropriate in situations where it is not possible to know what actions will be needed in the future, partly because any solutions trigger behaviour change in others. Structures based on more equal, peer relationships are advocated as the most effective way of enabling organisations and individuals to do their best work. This idea underpinned the programme leaders' way of working, with documents stating that:

“We find this metaphor [of living system] more sympathetic to the individual creativity of conscious human beings and the familiar patterns of behaviour structured by social context. Many different sorts of people co-create their shared future, in more equal relationships” (CIHM document, Working Whole Systems: An introduction)

Certain principles underpinned working in this way, which were described as being like a tune that is kept in mind when designing and implementing change. These principles are outlined in table F.

Table F: The five key principles of whole system working and their implications

The Principles	The implication of the principles for the Fellows
Meaning	<p>Sufficient time should be spent talking about the purpose and meaning of change before moving into action mode.</p> <p>*Particularly important when there are different perspectives on an issue</p>
Many perspectives	<p>Leaders must find ways to have conversations with a diverse range of people, and to get together groups with a wide range of opinions. This is to ensure that the whole system is represented and that they gain a more complete understanding of issues.</p>
A web of communications and connections	<p>New connections must be nurtured, with information being shared through reports, presentations and so on. However, conversation with those affected by change is vital, so as to establish shared understandings.</p>
Participation	<p>Leaders must use processes that allow people to engage as individual experts and contribute their personal experience and stories.</p>
Trusting local resourcefulness	<p>Leaders must find ways to enable people to recognise their own assets and capabilities. They must foster relationships based on trust, so that people feel able to come up with their own solutions</p>

The next paragraphs look at how these five principles were implemented by the educational leaders. In terms of creating meaning, or talking about the purpose of change, one of the programme leaders described how she and her colleague would work with and guide the Fellows:

“This is about working with them to develop the capability to identify problems, making sure they don’t rush into finding and giving solutions...they are going to be ongoing problems and not ones that can necessarily be solved within the year; there will be a legacy, which is something that the Fellows must be prepared for” (Susan, Programme Leader)

Susan was keen to ensure that the Fellows recognised that they may not be able to complete all their projects within a year. This approach was clearly communicated as Nina highlights:

“..as I talk to the other Fellows and talk to David and Susan, you know as they’ve said, we’re not expected to come in with all the solutions, and there will be a legacy and that’s no bad thing, and you know changes sometimes in the NHS take decades” (Nina, Hospital Fellow)

Initially the Fellows were asked to interview key people within their organisation, with a view to understanding their role and needs. This was to help them to get a sense of different roles and prepare them for building a network of new connections. The Fellows were then encouraged to begin the process of understanding the existing situation in their own organisation. They were encouraged to analyse any available data related to the project, gather as much information as they could and to take a ‘temperature reading’, that is to say to gauge the extent of support for and/or opinions about the project ideas. It was suggested that the temperature reading include as diverse a range of perspectives as possible. Gauging the level of support for a change idea and understanding the issues was the start of developing a network of contacts. As Mike described, this involved “lots and lots of conversations” and doing what Majid and Mark both termed “the leg work,” in terms of getting to meet as many people related to the project as possible. Majid highlights the way in which these principles were taken on board:

“we’re too ready to have the answer, without doing the grunt work, the leg work, which is sometimes more difficult, and less appealing, because it’s finding out where things are problematic, so you can actually direct your answers more appropriately” (Majid, Hospital Fellow)

The type of approach described previously is in line with suggestions as to how ‘wicked problems’ should be tackled by leaders (Head and Alford, 2008; Heifetz, 1994). It was only once the Fellows had done all of this that they were encouraged to start to work on implementing change. It was at this point that principles of participation and trusting local

resourcefulness came to the fore. These principles link closely with ideas of co-production of a service, which constituted one of the taught modules and has been defined as:

'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours' (Boyle and Harris, 2009, p.11)

Co-production ideas link with government policy ideas about encouraging service users to take an active role in service delivery (http://www.institute.nhs.uk/share_and_network/pen/co-production.html), suggesting that the educational programme was in line with policy thinking. The next section summarises the chapter.

4.7 Summary

This chapter has outlined the fact that the experiential learning side of the Fellowship was based around three types of project, designed by the sponsoring medical directors. Many of these were considered to be 'wicked' or highly complex problems by the educational programme leaders, who expressed concern at the nature of the projects. The implication was that the Fellows would need careful guidance as to how to handle such projects and their expectations would have to be managed. Unusually, this Fellowship tackled these problems (Hartley, 2008) with a whole systems approach, as recommended by Head and Alford (2008), underpinning the educational inputs. This all suggests that the way in which programme leaders guided the Fellows to approach their projects, and whether they followed the advice given, may have been crucial to how the Fellows experienced their new role during the encounter stage of the transition cycle, with implications for how they adjusted to it. Chapter 5 now moves on to look at the findings in relation to the first, namely the 'preparation' stage of the role transition cycle.

Chapter 5: The 'Preparation' Stage for Role Transition

Introduction

This chapter is the first of the three chapters (5 to 7) presenting the findings of the research, in relation to the four stages of the role transition cycle: (1) preparation; (2) encounter; (3) adjustment and (4) stabilization. It focuses on the first stage of the cycle for the Fellows, that of preparation for the Fellowship role they were assuming and the educational programme they were committed to. According to the theory of role transition (Nicholson, 1984; Nicholson and West, 1988) the preparation stage is particularly important, as high expectations at this stage may lead to disappointments at the second, namely encounter, stage. Readiness for change at the preparation stage is seen as key to how individuals later adjust to role change, with the following factors perceived as likely to have an impact: the amount of warning role changers have of role change; the clarity and level of their own expectations; their feelings and motivations about the change and how well equipped for the change they feel in terms of skills and knowledge. Excessive anxiety at this stage is proposed to decrease the likelihood of adjustment occurring through role innovation and impair stabilization. In addition, the recruitment process is argued to have a bearing on how well individuals fit the new role, and how accurate a view of it they are able to form of it before they commence in it.

The research therefore sought to understand the following: how the participants came to hear about the Fellowship and be recruited; how they were selected; factors that influenced them to participate; their motivations for participating; their goals for the year; any concerns they had and their prior experiences of leading service development type projects. Sections 5.1 to 5.7 present the findings in relation to each of the above aspects. Incoming attitudes of the Fellows towards clinical leaders and non-clinical managers were also sought and are presented in section 5.8, with section 5.9 presenting the attitudes of a comparison group of Registrars not participating in leadership development. Section 5.10 summarises the chapter.

5.1 The Recruitment process

For recruitment purposes, template job descriptions and person specifications were developed by the deanery, but it was left to the appointing Trusts to decide who to appoint and how. Interview data revealed that the appointed Fellows heard about the Fellowship from a variety of sources and Table G provides an overview of these.

Table G: Ways in which the Fellows heard about the Fellowship

Ways in which Fellows heard about the Fellowship	Fellows	Comments
Received an email notification from training scheme administrator/supervisor	n=4 Will, Nina, Louis, Mark	Mark also notified by a non-clinical colleague
Directly approached by sponsor/supervisor	n=3 Caroline, James Amanda	
Heard the sponsor promoting the post	n=2 Bina and Lucy	
Notified by respected clinical colleagues	n=5 Lisa, Mike, Dev, Majid and Ella	Lisa also aware of Fellowship through work with Royal College of Physicians
Saw role advertised	n=1 Zoe	
	Total = 15	

As table G shows, the Fellows heard about the Fellowship from a variety of sources, with two (Mark and Lisa) hearing about it from more than one source. Four Fellows (Louis, Will, Mark and Nina) received an email about the opportunity. Mark, a GP fellow, received an email from a practice manager where he had been doing some locum work, after letting it be known he

was interested in doing some sort of Fellowship, whilst the others received emails from their training scheme administrators. One other Fellow, Zoe, saw an advertisement for the role.

Three Fellows (Amanda, James and Caroline) were directly approached by a project sponsor or supervisor. Whilst the director of the CIHM leading the educational programme suggested that Lord Darzi had put pressure on the SHA and deanery to get the Fellowship launched, resulting in a number of sponsors “nobbling” Registrars to get them on board, there was no suggestion of any coercion having occurred. For instance, Amanda had just completed her specialist training and gained her certificate of completion of training (CCT) when she was approached to work on a project at the hospital where she was already based. She felt that the Trust wanted someone with speciality knowledge but remarked that the post was not particularly sold to her:

“..actually it wasn’t portrayed as a great prospect at all really. It was sort of, well the deanery are very conscious of the fact that consultants are being asked to do an awful lot of things that take them away from clinical and management processes, and so this is a sort of compensation for all the things that they’re being expected to do, so it wasn’t really a sort of progressive description”
(Amanda, Hospital Fellow)

Amanda received some information about the educational programme from her training scheme administrator and decided to take the post, despite the fact that her medical director knew very little about the actual project. In fact, she began work on her projects before the educational programme started. James was also approached by a Medical Director with whom he had already been working clinically, although he was informed that he would have to go through a competitive process. He considered the job descriptions for two posts, applied for both and ultimately accepted the one in the Trust where he was already based. Caroline, a practising GP, was approached by her previous clinical supervisor, who was acting as supervisor for the Fellowship project. Whilst working in a refugee camp when approached, on her return home she read through the job description and decided to formally apply for the post.

Five Fellows heard about the role from clinical colleagues they respected (Lisa, Dev, Mike, Ella and Majid). Lisa heard about the role from her medical director during a discussion they were

having about Lisa's career plans and possible interest in being a future medical director. Lisa was aware of the Fellowship, as a result of work she was involved in with the Royal College of Physicians, but had felt that the posts were directed at more senior Registrars until her medical director suggested she consider them. In contrast, Dev was coming to the end of his CCT and looking to gain some experience in quality and safety issues. He had previously approached the Head of Clinical Governance where he was working and she had informed him that there would shortly be a role coming up which he should apply for. When he contacted her again she emailed him the job advertisement. In Mike's case his college tutor suggested that he apply as he was struggling with a research idea, although he had also heard about the planned Kent, Surrey and Sussex initiative which had prompted him to investigate the situation at NHS Southlands and to look at the job descriptions on the NHS website. He subsequently applied for one outside his own speciality in a specialist hospital. Ella had sent her CV and application for sub-speciality training to a friend, who happened to have taken part in 'Prepare to Lead', to look over. He knew a consultant who was looking to recruit a Fellow and recognised that his project was in line with Ella's interests, and so encouraged her to apply. Finally, Majid heard about the role from three friends associated with the Trust where he took up his post and had worked previously. He had informal discussions with the sponsors about the projects and felt they were "specifically related to my interest and also in the Trust's interest."

Two Fellows (Lucy and Bina) heard about the Fellowship from a sponsor promoting it. In Lucy's case this was from the supervisor in the department where she was already working. In Bina's case it was from the medical director at a hospital where she attended a study day:

"the medical director came down and explained to us about this project and how it was such a good opportunity to try and to see the NHS from a different point of view altogether, and it was more about learning about management. I immediately became interested and contacted my medical director who said to wait until the application forms come through, so that's how it all happened"
(Bina, Hospital Fellow)

Bina was inspired to apply, despite the fact that the hospital was a considerable commute. She had received no other information about the Fellowship and was under the impression that one had to apply within one's own speciality.

In sum, there were a variety of ways in which the Fellows came to hear about the role. In some cases there was an element of luck involved, in that they heard about the role just in time to apply, or happened to know someone who knew about it. Some Fellows had more information than others about the post they were actually applying for and the educational programme at this stage. The next section looks at the selection process.

5.2. The Selection process

The person specification developed by the deanery suggested that the Fellows should have some understanding of the challenges of healthcare delivery within ‘Southlands’ and the wider NHS, and some previous involvement in change. As one Fellow pointed out:

“I don’t think all Trusts did competitive interviews necessarily, but for the interview process you would have had to provide some proof that you had done something about change already” (James, Hospital Fellow).

In fact, all but one (Amanda) of the fifteen Fellows interviewed did go through a formal selection process involving a panel of interviewers. However, not all had the experience of involvement in change suggested in the person specification, as will be discussed in more detail later. For example Bina, albeit a very junior Registrar compared with most of the Fellows, revealed that she did not even know there was such a thing as ‘NHS Southlands.’ This suggests that the sponsors either did not follow the guidance, or did not get applicants with such experience and understanding. Informal discussions with four sponsors revealed that they had a variety of reasons for appointing the Fellow they did. Two felt they had projects which required speciality knowledge, whereas another, a PEC Chair, argued that the Fellowship was about generic skills development and was an opportunity to appoint, for example, a GP in a hospital environment. Ultimately, however, she appointed a GP known to her. One medical director was primarily concerned about getting someone that she felt that she could establish a rapport and productive working relationship with, on the basis that she had already decided what she wanted to do and had a project manager in place.

Selection of the Fellows took place between October 2008 (in one case) and March 2009. For instance, Amanda was selected when the Trusts were first contacted about the Fellowship in October 2008 and started work on her projects in February 2009, prior to commencement of

the educational programme in April, 2009. However, other Fellows started work on their projects later, in some cases not until June. This was partly owing to the fact that some Trusts were slower to appoint a Fellow and partly due to the fact that specialities rotated their training posts at different times in the year, such that some trainees would otherwise have been out-of-sync with their training programme and without a post at the end of the Fellowship year. The next section looks at factors which influenced the Fellows to participate.

The fact that the majority of the Fellows (all but Amanda) went through a formal selection process implies that they had an opportunity to discuss the projects with some key stakeholders and mentors and to ask questions about the role and what was expected of them prior to commencing in it. As such, it is perhaps reasonable to assume that there were partly, if not fully, prepared for what they would later encounter. However, in being the first year of the Fellowship it would seem likely that there would be some surprises in store when the Fellows commenced in the new role and started work on their projects. The chapter now moves on to consider the Fellows motivations for participating in the Fellowship.

5.3 Motivations for participating

The motivations of the medical academy, and to some extent policymakers, for developing leadership and management skills in doctors are known. However, it is known that the motivations of those participating in leadership development can be different (Storey, 2004). These findings revealed that three (Ella, Caroline and Mark) were motivated by the opportunity for self-development, but the majority (twelve) were primarily motivated by the opportunity to gain management experience and improve their career prospects. The findings related to self-development are presented first.

5.3.1 Self development

Three Fellows (Ella, Caroline and Mark) were predominantly motivated by the opportunity for potential self development. Caroline related that she was flattered that she had been approached to apply by her supervisor and that she was seen as someone who would be potentially good at the role. She felt that it was a new opportunity and that she would rather

regret taking it than regret not doing so. For Ella, the Fellowship was a chance to take time out of her clinical training, reflect on what she had done and what the future might hold and to do something that was non-clinical:

“...taking the opportunity to do something different, be involved in a project that wasn't clinical for a year. You're just taking a side step, having a deep breath and just giving yourself time to think about where things are going, 'cos if you just carry on with clinical stuff it's hard, 'cos you're just so busy with that, to just stop and think and I think it is just a really good year that that, that will set me up I reckon for when I move on and up” (Ella, Hospital Fellow)

For Ella there was an element of preparing herself for the future, although in a slightly different way to those who saw management experience as specifically necessary. Likewise, Mark had just completed his CCT and liked the idea of participating in *some* kind of Fellowship. He was motivated by the idea that this would be a continuation of training, rather than being thrust straight into the GP role. He also saw this as something which would potentially lead to other opportunities:

“what kind of attracted me was the idea that you're paid, it's continuing your training, so you don't suddenly end training and just drop off into an abyss.....I guess I'm quite into life-long learning as well. And there is also something about, that I know that these opportunities can lead to things, whereas, being a GP, can also lead to things, but this feels a bit more exciting, and also we are going to be a GP for years and years and years, so one year of not doing, being a GP, sounds to me that we can afford that” (Mark, GP Fellow)

In addition, whilst not citing a specific belief that management experience was needed as a GP, Mark recognised that he had a skills gap in this area. He related that he did not understand the language and so might come across as fearful of it. The next section moves on to look at those who were motivated by the opportunity for career development.

5.3.2 Career development

Ten Fellows (Lisa, Lucy, Amanda, Will, Dev, Nina, Majid, Mike, Zoe, James) were interested in having management experience on their CV, for two reasons. Firstly, they wanted to increase their employability, by making their selves a more attractive proposition when it came to

applying for consultant posts, and saw having greater management experience than is the norm amongst doctors as a way of doing so, as this quote from Lisa highlights:

“I want to have it on my CV, I want to have done the diploma so that when I go for a consultant post it’s under management experience, because I want to, it’s an incredibly competitive market at the moment and I want to get a job” (Lisa, Hospital Fellow)

Likewise, Amanda felt that having such experience made her a more attractive prospect and this was what particularly attracted her to take part:

“I think it makes me a much more attractive prospect in terms of future employment as a consultant, and I think that was the thing that attracted me most strongly” (Amanda, Hospital Fellow)

Secondly, these ten wanted to prepare their selves for the management tasks they expected to face as consultants. Four (Nina, Mike, Will and Dev) perceived that management was a demanding element of any consultant role, and not simply the preserve of clinical or medical directors, as the following quote from Nina demonstrates:

“I’ve now come to see that as a consultant the clinical stuff is not what gives you headaches. Its management that gives you headaches and that you need to be skilled at. I think having one year away from other responsibilities to just focus on learning about this whole new world that I’m entering, is going to be invaluable, absolutely invaluable, because nobody else is really going to have that opportunity, not yet anyway” (Nina, Hospital Fellow)

Eight of these ten (Amanda, Will, Dev, Nina, Majid, Mike, Zoe, James) were senior registrars and `discussions with peers, who had recently taken on consultant roles, appear to have shaped the view that they would shortly need to deal with managers and management issues, as this quote from Will highlights:

“...I’ve just had a conversation this morning with a chap ...who said as soon I was a consultant, within a few years someone was asking me to write a business case for such and such a thing, or to plan this or put a proposal in for this, and you know suddenly you’re thrown into this meetings where, as he put it, you are absolutely ambushed, and you only realise that you’ve been out-maneuvered when you come out of the meeting. So getting some experience and some knowledge behind us before we get exposed to that is critical as far as I can see” (Will, Hospital Fellow)

These eight were clearly thinking about their transition to the consultant role and where they had skills gaps. For example, Dev had been involved in a number of projects with professional associations but felt that he was lacking the political skills he would need as a consultant:

“I’ve always side-stepped the politics; you can call it being chicken if you want, or you can call it a way of making progress, I just don’t find conflict helps in anything. Some people I’m sure are pretty good at doing it, and this for me was a perfect vehicle in that way, of acquiring, of having to deal with it. I think subconsciously I’ve thought to myself, well, I’m going to enter this brave new world, and, maybe I’m not skilled in these areas” (Dev, Hospital Fellow)

Dev felt that acquiring skills in how to promote himself would be of use in his future career, and that the experience was an opportunity to shine and think about the future:

“this is actually the opportunity to shine in some way and if you’re keen on working in the Trust that you’re working in, or if you’re not, it doesn’t really matter, the fact that you are successful or you have made a contribution...very positively and very effectively, then actually it’s got to be visible I think” (Dev, Hospital Fellow)

However, only two of the ten who wanted management experience on their CV (Lisa and Lucy) expressed interest in being a future medical director. Lucy commented, “I’d like to, potentially, become Medical Director or something like that.” Two others (Mike and Louis) were interested in exploring whether some sort of clinical management role in the future might be for them. Mike also had some doubts, as his father had been one of the first clinical directors and had not had an enjoyable time, but had expressed that he wished that he had received more training before he took on the role. This influenced Mike to participate in the programme. Louis felt that management was one way in which to make a difference to patients’ lives outside of clinical work, with the other being through groundbreaking research, which he felt was more difficult to achieve:

“It’s something that I’ve always found interesting anyway, so, but to be given the opportunity and training, in a recognised role for a year, to develop it with other peers.... I’m quite interested to explore what the year offers me, and what I can learn from it and see. I think it gives me other options for what I could do in the future as well” (Louis, Hospital Fellow)

One Fellow, James, did not want to be a clinical leader in any formal sense, but felt that some management experience would be useful in relation to a potential career interest he had, of

being a liaison psychiatrist. He was aware that some of his colleagues in this role had needed to present a case to a Trust and then set up a service from scratch.

Whilst only four of the fifteen expressed any thoughts about being a future medical leader in the formal sense, four (Amanda, Nina, Ella, Will) perceived that others viewed them as such, as Will highlights:

“I know that’s what people have mooted already, ooh NHS leaders of the future, and in a sense that’s sort of rammed down our throats a little bit, but I’ve got no expectations whatsoever. I think that this next year is going to be invaluable for working as a bog standard consultant in any NHS institution” (Will, Hospital Fellow)

Nina also highlighted that the group were not participating because they were motivated to be future medical directors, but because they were interested in being more effective consultants:

“So we weren’t people saying we’re future medical directors, which I think initially was the idea, that people doing the Fellowship were the aspiring medical directors...we were trainees who will one day become consultant , but we want to be better consultants.” (Nina, Hospital Fellow)

In fact, all but one of the Fellows (Mark) made some reference to the fact that they were a like-minded group who had selected to participate in the Fellowship, and the motivations described by Nina appeared to be widespread.

However, the Director of the CIHM, who were leading the educational programme and co-designing the Fellowship, perceived the Fellows to be “...the leading lights who will pioneer Lord Darzi’s work,” although comments by the postgraduate Dean suggested the whole venture was perhaps less certain, and she saw the group as risk takers:

“They all took a great risk in applying for a Fellowship. We wrote broadly what they were about but they were the first cohort, to some extent it was unknown and it was uncertain. They all clearly saw that it might be an advantage to them and to some extent they are the obvious risk takers” (Postgraduate Dean)

Given the Fellows views about the desirability of management experience for career progression, which contrast with suggestions that doctors do not consider it necessary for progression (Causer and Exworthy, 1999; Mountford and Webb, 2009) doctors in the comparison group were questioned about their views on this issue. The next section presents the findings on this.

5.3.2.1 The views of other doctors on the need for management experience

Table H gives an overview of how other doctors viewed management experience in relation to their career development.

Table H: Views of comparison group on desirability of management experience

Registrar	Views on management experience in relation to careers
Martyn, Allergy Registrar 18 month until end of training	Felt that management and leadership experience was needed and expected at consultant level.
Indi, Haematology Registrar Just completed training	Management questions included in the Royal College of Pathology (RCPATH) exams. This is relevant owing to the interface with laboratory staff at consultant level in this speciality
Shakira, Immunologist Just completed training	Recognised RCPATH see management experience as important. Juniors now being given opportunities to develop business cases etc.
Liam, General/Liver Surgery Registrar 3 years until end of training	<i>Personally</i> interested in having management training
Jamie, General Surgery Registrar 3 years until end of training	Recognised some management experience desirable when it comes to applying for consultant posts.
Robert, General Surgery Registrar 2 years until end of training	Recognised some management experience was seen as desirable at consultant level.
Costas, Cardio-thoracic Registrar 2 years until end of training	Felt that senior managers should be medically qualified and that some way of achieving this was needed, potentially training
Massood, Consultant Liver Surgeon & Clinical Lead	Management experience is sought at consultant interviews and explored in more detail than clinical expertise

Table H shows that the doctors in the comparison group largely recognised the value of having management skills and experience when it came to consultant level, as this quote by Robert highlights:

“I’m told part of the interview process for consultants is based on their interest in management generally and how they would shape or reconfigure services within that Trust and things, so I do realise it’s an important issue at the next stage when you start to apply for consultant training” (Robert, Surgical registrar)

This had prompted Martyn, a Registrar in Allergy/Immunology who had eighteen months to go until completion of his training to apply to take part in a five month leadership programme being run by Birmingham University, as he felt that he “need[ed] to show management as part of my experience.” Another surgical Registrar (Liam) expressed a desire to do a management degree and was keen to be able to work with managers to change things and get the best for his service:

“I like to think that I have an interest in management and I think that unless you understand management you can’t change anything... I’d like to do a management degree really, because I think it would be useful, not because I want to be a manager, I don’t. I’ve got no desire to be a chief exec, but I know that if I can speak the management language, then I can get what I need for my service”
(Liam, Surgical Registrar)

Liam had a similar level of experience as three of the Fellows who had worked as doctors reps and been involved in negotiating work rota changes. Like most of the Fellows he had no desire to be a future clinical leader, demonstrating instead the instrumental type of approach to management seen amongst some clinical directors (Allen, 1995; Kitchener, 2000; Thorne, 2002), who on gaining an understanding of management language are able to use it to gain what they want for their service

The desirability of having management experience when it came to consultant stage was backed by a consultant liver surgeon/clinical lead. He related that interviews for consultant posts assume that applicants have the requisite clinical expertise and tend to focus on how they would run a service.

“Like I say 2008 was the year I was being asked these questions and they’re all - although I didn’t do any specific consultant interview courses I’d been given information from people who’d been on these courses and - certainly that was a major part of the discussion, ‘cos they’re not going to sit down and ask you how to do a specific operation, all they’ll say to you is, how would you manage a team, resolution of conflict and stuff that like that, those are big things, so it’s all to do with that” (Masood, Clinical Lead)

Massood had applied for two consultant roles within recent years and felt there was slightly more concern with management issues at his current Foundation Trust than there had been at his former NHS Trust. He felt that management is the area where many Registrars struggle, in

terms of “understanding how the NHS works, how money flows, you know PCTs and FTs and the roles of different things” and having experience to cite on applications for consultant posts.

In summary, data from the Fellows and other Registrar level doctors, suggests that management experience now has currency for doctors at this level when it comes to applying for consultant posts and is increasingly viewed as a necessary part of career development. This is a significant finding as it challenges previous work which suggests that doctors do not feel the need to have such experience (Mountford and Webb, 2009; Causer and Exworthy, 1999) and suggests that attitudes towards management, in terms of its importance for them and the wider system, may be changing. In terms of preparation for transition, the findings in relation to their motivations suggests that the Fellows were open to learning and participating in management in order to gain some experience of it. The fact that a small number were motivated by the opportunity for personal development suggests that these Fellows were perhaps particularly open to making some form of personal change. However, a number of factors were found to have influenced participation, which the next section moves on to outline.

5.4 Factors influencing participation

Alongside the fact that a number of Fellows were informed about, and possibly persuaded to participate in the Fellowship by respected clinical colleagues, other factors were found to have influenced their decision to participate in the Fellowship. These included: their current job status; the existence and content of the educational programme; the nature of the projects on offer and the organisation sponsoring the post.

Job status was cited as an influencing factor for three Fellows (Amanda, Dev and Mark), who were all at the end of their specialist training when the opportunity arose. As Amanda highlights:

“For me it was the right opportunity at the right time in terms of my career, because I didn’t have a consultant post and I was approaching the end of my training, and so it was an opportunity to develop” (Amanda, Hospital Fellow)

Likewise, Dev did not have a consultant post, and so “it all fell into place that way.” Mark, who had just qualified as a GP, was interested in doing some sort of Fellowship in order to gradually make the move into being a full time GP. Whilst one other Fellow, Louis, was also at the end of his specialist training he did not cite this as an influencing factor.

The fact that there would be a structured educational programme running throughout the year was important to three (Mark, Mike and Lisa), with both Mike and Mark being attracted by the idea that the postgraduate certificate might be able to be linked to an MBA. Mike had looked at doing an MBA previously, but had been put off by the cost. Lisa had just finished a PhD and did not want to work purely with one supervisor. She investigated the educational programme and was attracted by what she read:

“The fact that there was a very specific module of training, and I looked through what they were planning and discussing, and it looked very thorough and that appealed to me as much as anything else” (Lisa, Hospital Fellow)

For Lisa and three others (Ella, Majid and James), the nature of the main service development project was particularly important. Lisa had looked at two projects within the area she was working but was only motivated to apply by one:

“The project at ‘Hayfield Hospital’ I just wasn’t interested in at all, but then the project here got circulated..... this is an oncology project, setting up a new team, looking at new patient pathways, new ways of, new processes which will reduce length of stay and there was a new consultant starting, and it was working with proactive people. Plus, from an oncology point of view, it’s a very recent idea that’s been pushed forward, so it’s kind of right place right time for the oncology idea, so that project appealed and I think will be a good thing for me to be able to talk about in the future” (Lisa, Hospital Fellow)

Ella was excited by the fact that her project was within Paediatric Emergency Medicine, which she wanted to specialise in, and the community aspect of Majid’s project which involved working with GPs, nurses and patients was of great interest to him. James had applied for two posts but was particularly keen on the one he took which involved liaising with GPs. He describes how this interest had arisen:

“my last job before that one I was going to some GP link meetings, so myself and one of the CPNs would go to a GP practice every six weeks, meet up with GPs, discuss difficult cases, discuss their referrals, and I’d been to a conference in Manchester the year before where a consultant, a professor, was talking about what’s the best way to communicate with GPs and I just thought that’s quite interesting themes” (James, Hospital Fellow)

For these four Fellows it was the relevance of the project to their speciality and career interests that was important to them. While only four actually cited the nature of the project as being influential on their participation all but one of the fifteen Fellows worked on projects within their own speciality.

The organisation hosting the project and employing the Fellow was of some importance to two Fellows. Mike, who was the only Fellow to work outside of his own speciality area, was attracted by the idea of working in a specialist hospital and reporting to the medical director. In Will’s case, he wanted to work in a place that he enjoyed:

“it had to be in a place that I would enjoy working, and having just really completed six months at ‘Wellington’ it was clear to me that, for me anyway, it is a very enjoyable place to work, there’s a real team spirit about the place..... So, the place and the people were very important to me (Will, Hospital Fellow)

Of the other Fellows, all but three (Bina, Mike and Zoe) took a post in either the Trust they were working in when the Fellowship post arose, or a Trust where they had worked previously.

While clinical colleagues made a number of Fellows aware of the Fellowship, as outlined previously, Nina was influenced to participate by a consultant she had sought as a clinical mentor, who happened to have held a number of clinical leadership posts and had steered her towards getting more management experience:

“I was very focused on clinical needs and saying, you know I want to be a consultant so I need to do X, Y, Z, and he was saying well, actually you need to think more about management at your level, you’re going to be a consultant in 2 years andthrough his guidance and his experiences he actually sort of steered me down that path and opened my eyes to this whole new world” (Nina, Hospital Fellow)

The importance of, and need for more, positive role models in terms of influencing doctors' careers and driving a new professionalism has been noted (Allen, 1994; Coulehan, 2005), with Nina the only Fellow who related that she had been steered towards obtaining management experience during her day to day working life. The next section looks at the Fellows goals for, and expectations of, the year.

5.5 The Fellows goals and expectations

The role transition model (Nicholson, 1984) suggests that expectations on entry to a new role will affect how individuals later adjust. The expectations of the Fellows were explored by asking what they hoped to get out of the year (their goals) and what they were looking forward to. The goals of the twelve Fellows who were interviewed on entry to the Fellowship were sought and are outlined in table J.

Table J: The Fellows' goals for the Fellowship

Goals and expectations	Number (n) of Fellows
To increase knowledge & understanding of how the NHS works	n=8 Lucy, Will, Dev, Mark, Mike, Majid, Amanda, James
Demonstrate own ability to lead a project	n=5 Ella, Mark Dev, Nina and Lucy
Contribute to a Trust and make a positive difference	n=4 Ella, Will, James and Majid
Gain a new perspective on career	n=3 Amanda, Dev and Majid
Understand how to lead and relate to others	n=7 Amanda, Dev, James, Will, Nina, Ella, Louis
Understand how to get change ideas supported & implemented	n=3 Majid, James, Lisa
Gain organisational skills such as chairing meeting, writing reports, working as part of a local management team	n=5 Louis, Will, Dev, Nina, Majid

As table J shows, the Fellows had a number of goals they hoped to achieve during the year. Eight wanted to increase their understanding of how the NHS works. This included: understanding how organisations are structured and organised (Will, Dev, Amanda, Mike and Majid); how money flows around the NHS (Dev and Mark); how decisions get made and who does what from a management perspective (Mike, Lucy and Majid). Two Fellows (Majid and James) wanted to know how to put a business case forward, as Majid highlights:

“...I have the knowledge to say well, this is why we need to do this, because here’s the evidence, here’s the audits, here’s the business plan. I want to have that management grounding, to know how to prove my case and actually have not only have proven it, get people in post to do it” (Majid, Hospital Fellow)

Majid, along with James and Lisa, also wanted to understand how to make sustainable change. All three had some prior experience of trying to introduce change which affected their clinical

colleagues. For example, Lisa felt that she had good ideas but that these sometimes her initiatives ended up falling apart when she left:

“why things that I have tried to do in the past haven’t worked. This whole concept of what makes change stick, and you know, how to embed a process, so that it’s not hugely, entirely dependent on your own energies so that when you leave it just crumbles” (Lisa, Hospital Fellow)

Lisa expressed that other junior doctors were quite happy to have teaching sessions set up for them but did not want to take responsibility for sorting this out for themselves, such that when she left that initiative collapsed.

Five Fellows wanted to get more practical organisational skills, including such things as how to chair a meeting and how to write reports (Nina and Louis), better time and self-management skills (Majid) and an understanding of how to develop hard measures of clinical outcomes (Dev). Will wanted to hone his team working skills within a Trust and learn how to lead at a local level, having led teams at other levels:

“..while I’ve done that on a national, and on some occasions international scale, I’ve never done it working within a single Trust, within a much smaller organisation, and so that’s one aspect of this, in the sense that this would fill a gap for me...I want to play a useful part wherever I end up working, I want to be an efficacious member of a team” (Will)

Understanding how to relate to and lead others was a goal for seven Fellows (Amanda, Dev, James, Will, Nina, Ella, Louis). Dev wanted to learn how to deal with the politics and the conflict he expected to encounter as a consultant. He related that he had always managed to avoid this when working with others in groups, but felt that he would be unable to avoid this as a consultant. Two Fellows (Amanda and Louis) wanted to understand how they might develop their selves as a leader. Amanda felt that it was going to be a part of her career as a consultant and that she needed to find a way to deal with it, whereas Louis had an interest in understanding what involvement in management might be like and whether it might be of future career interest. Three Fellows (Ella, James and Nina) were keen to know how to make an impact. In James case he wanted to understand how this could be achieved as one individual within an organisation. In both Ella and Nina’s case they were keen to learn how to voice their opinions confidently with senior clinicians and managers above them in the hierarchy.

Five Fellows (Dev, Ella, Nina, Lucy and Mark) specifically hoped to demonstrate their ability or as Lucy remarked, to “mark myself out from other trainees” through involvement in the projects. Ella saw the year as an opportunity to demonstrate what she could do, but was also keen to lay the groundwork for an improved children’s emergency service:

“I think the kind of main idea of reducing short stay and reducing in-patient when it’s not necessary, and mainly just improving the care that children get in Paeds A&E, that what I’m hoping we’ll see. I mean probably won’t see it that much in the year but if it lays the groundwork for it that will be good” (Ella, Hospital Fellow)

Similarly, Mark expressed that he wanted to be able to demonstrate his involvement in his projects and then build on what he had done and learnt in the future:

“I guess my target is to be able to put my finger on a project that I have shaped or influenced or have done or achieved. I’m very, you know, there’s lots of things you can learn, lots of things you can pick up and study but it’s actually about, but I’m wanting at the end of the year to be able to say that I shaped that or I achieved that or whatever, so however small, so that the following year do something a bit bigger or a bit wider” (Mark, GP Fellow)

Three other Fellows (Majid, Will and James) specifically related that they wanted to have developed something that was of use for their Trust, colleagues and patients by the end of their year.

A new perspective on their career was desired by three Fellows (Amanda, Dev and Majid), all of whom were at the end of their specialist training. In Amanda’s case this related to being confident that she had leadership and management skills and also the opportunity to put these into action as a consultant:

“I think a change of perspective in terms of how I view my future career.....I think the confidence that I’ve got the skills, the confidence that I’ve developed those skills, which I will be utilising in whatever my next role is. I hope that I’ll have my next role, in order to put all this into practice, and I think that’s my short term aims and what I hope to get at this point” (Amanda, Hospital Fellow)

Dev hoped that the year would enable him to “look at the whole picture of where life is going and where this fits in and then the next step.” Likewise, Majid hoped for some insight into his strengths and weaknesses and to find some future direction in terms of his career:

“I’ve got some insight into my strengths and weaknesses and my organisational skills for running a take, running a ward is there, but my self-regulation in steering myself in a right pathway. Where do I want to end up, where do I see myself, how do I see what I’ve been doing over the last five, well eleven years?I hope that by engaging with this programme that I’ll be able to at least know my strengths and my weakness rather than think I can maybe do it all without actually any realisation that that’s not really possible” (Majid, Hospital Fellow)

Overall, the Fellows were looking to broaden their understanding of the NHS, obtain greater clarity with regard to their own careers and for the chance to demonstrate their ability whilst contributing something to a Trust that could be taken forward. In terms of preparing for transition these findings appear to link with the Fellows motivations, as discussed earlier in section 5.3. Whilst the findings suggest some openness to personal change, they also suggest that some role innovation might be expected, given that Nicholson and West (1988) suggested that newcomers makes their mark, which some Fellows ought to do, through this form of adjustment. The next section moves on to look at the Fellows concerns about participation.

5.6 The Fellows’ concerns about participation

According to the model of role transition, the degree of anxiety felt at the start of a new role may impact on how individuals adjust to a new role (Nicholson, 1984; Nicholson and West, 1988). The Fellows were therefore asked about any concerns they had about taking part in the Fellowship, with two main concerns emerging. Firstly, whether they would be able to lead and make successful change and secondly, how participation in the Fellowship might impact on their career and collegial relations. These are considered in turn.

5.6.1 Ability to lead and make successful change

Seven Fellows (Nina, Will, Lucy, Mark, Lisa, Louis and Majid) expressed some concerns about whether they would be able to make change. Interestingly, ability to fulfil the role was the most pressing concern for job changing managers studied by Nicholson and West (1988). Majid, for instance, related that his medical director had told him to be prepared for the fact that the projects might fail. He realised that being ready to do so was something that he was going to have to try to accept:

“being ready to fail I think is something that I’m gonna try to accept and learn, ‘cos medics are pretty pants at knowing how to fail” (Majid, Hospital Fellow)

Nina was concerned that, with the role being for a defined period, she may not be able to complete her projects and would then contribute to the stereotype of managers not listening to clinicians or taking any action:

“I guess this could go under the fear section, is that I’m going to build relationships with people and then leave, and probably feed into that whole, managers don’t listen to us, you know nothing changes because they leave, so again that’s another, even though I’m not a manager, I’m coming very much from that world.....and if nothing’s actually changed then it just feeds into that whole stereotype, what’s the point, they don’t listen to us anyway, we tell them, they don’t do anything” (Nina, Hospital Fellow).

Will felt whether he was able to make change would probably depend on whether everyone in the Trust had embraced the idea. He had heard of other Fellows, who had started their projects earlier than him, having problems such as there being only one person in the Trust who really supported the idea and that person having then left. Mark was also concerned that the change he was trying to introduce, in the form of establishing a new polyclinic, may be perceived as having made little difference at grass roots level:

“..there is a part of me that thinks you can make lots of changes up at higher level but actually down at ground level you just don’t feel it makes any difference.... which may not be very helpful” (Mark, GP Fellow)

Louis felt that leading change may be difficult due to the Fellows position in the hierarchy and the prevailing culture:

“I think to make a really significant change is not easy to be honest, because it depends on where you are at, in your, in how junior or senior you are.until you are in some sort of leadership position I think it’s difficult to make - it depends on the organisation, but a lot are very structured, hierarchical and so on,Some of the things you can’t just try yourself in the position you are, you need to be in a greater leadership role to be able to do that” (Louis, Hospital Fellow)

Three others (Dev, Lisa and James) felt that success would depend on whether the people they needed to engage in order to deliver change would positively engage with them and their ideas. Lisa felt that one of her projects, which involved setting up a new initiative which would enable the junior doctors to be more involved with managers, might fail if they did not engage with it. However, she had decided that “...even if that doesn’t work I will count it as a win if some steps have been made”. James recognised that some of the things he was likely to have to introduce may be unpopular with his colleagues:

“I think just knowing what the projects are that I’m going to be working on - any sort of change thing is pretty unpopular, people just don’t like change - and if I’m going to be going in and saying to people that I’ve previously been working with, oh by the way you need to start doing this, or we’re going to do that, it might not go down very well” (James, Hospital Fellow)

One Fellow, Dev, explicitly expressed that good relationships would be the key to success:

“Relationships, that’s what it is. You can put as many structures in as like, I’ve worked in four different deaneries, and I tell you the single most recurring theme for success or failure is relationships. That’s what it is. You can have as many structures as you want, but if people won’t interact positively it aint gonna happen” (Dev, Hospital Fellow)

These seven all showed some insight into the difficulties that they would face when it came to leading the projects, as will be demonstrated in chapter six on the encounter stage, although some were more aware than others of the difficulties they were likely to face. This suggests that, in terms of preparation for what was to come, these Fellows at least did not entertain unrealistic expectations. The only other concerns expressed were related to potentially being given insufficient work to do and being bored (Mike) and of failing to strike a balance between analysing what was happening and taking action (Majid). As such, the group overall did not appear excessively anxious about the new role, and therefore predisposed to adjust through

personal change. The next section looks at concerns regarding potential impact on career and collegial relations.

5.6.2 Potential impact on career and collegial relations

Previous work with clinical directors has found that they strive to operate in a way which maintains good working relationships with their clinical colleagues whilst undertaking the role (Thorne, 1997a, 2002). Three Fellows (Louis, James and Mike) expressed some concern about the potential impact of participating on their future career. Louis had some slight concerns about how the Fellowship role would be perceived within the wider medical culture, on the basis that taking on a management role was not always seen as a positive step:

“I think there are still people who are very sceptical about doctors becoming managers, or being involved in management....it's you just want to be involved in the sort of political side of things, so it's not always looked upon in a good light. It's not always viewed upon as career progression.....it may be perceived by some people as veering away from being a clinician and wanting to do something else, and taking your eye off what's important, so you know....sometimes you do have to think about some of these things” (Louis, Hospital Fellow)

Mike was also concerned that he might be seen as having “gone to the dark side” by his medical colleagues when he started to actually implement change, whilst James was concerned not just about implementing change but also about how he would fit back into clinical work at the end of the year:

“I suppose the big fear is what happens at the end of this year. You go back into a clinical job and either you wind people up that you're working with, or you've just been out of clinical work for quite a long time, so that's the other fear I think I've got really” (James, Hospital Fellow)

James foresaw that the projects that he was involved in would involve him having to get colleagues he had very recently been working with to change their practice and that they might not appreciate his role in this.

Given the fact that doctors are known to perceive colleagues who move into management type roles in a rather negative way (Thorne, 2000; Fitzgerald, 1994 Riordan and Simpson, 1994;

Montgomery, 1990) and as moving to the 'dark side' (Spurgeon, Clark and Ham, 2011) it is perhaps surprising that only three specifically related concerns about the potential impact of being a Fellow on collegial relations and their career prospects. It will therefore be interesting to see whether any of the Fellows experienced negative reactions from colleagues and were surprised by them when it came to the encounter stage, which will be looked at in the next chapter. The next section details the Fellows prior experience of leading service development type projects.

5.7 Prior experience of leading service development projects

According to the theory of role transition (Nicholson, 1984; Nicholson and West, 1988) prior socialisation, in terms of such things as prior experiences, is likely to impact on how individuals adjust to role change. Despite the fact that the job specification suggested that Fellows should show some evidence of prior management or leadership experience, they had more experience of change in terms of ways of working than they did of leading service development and change. This was largely in terms of the introduction of new working hours and rota changes, along with the implementation of new procedures and ways of meeting policies and targets such as the four hour wait in A&E, as Majid highlights:

“The European Working Time has had a massive impact and change on the way we work, the hours we work, and how those hours are distributed as well. So European Working Time, 4 hour wait...” (Majid, Hospital Fellow)

Only three Fellows (Mike, Zoe and Majid) had any experience of implementing service development type change of the sort they were expected to lead as Fellows. Mike had been part of a working group “re-jigging some of the hospital protocols, the patient pathways”. This had involved working with the clinical director, nurse managers and other consultants. He found it an “eye-opener” in terms of what was involved and how long the process took:

“I think I probably thought it would be quick, because as a medic, a Registrar, you wander around the ward, you see how people move, say hi, get them to do this, get them to do that. It's not quite as easy as that as it turns out [laughter]. There are little things like, well who's going to take the patients from here to there, which A&E grade is going to be able to do the referral, or who would the Radiologists accept, this that and the other, blood tests have got to be done. It was quite interesting.” (Mike, Hospital Fellow)

Mike had clearly gained some insight into the change process from this experience. Similarly, Zoe had “done a lean project, trying to involve some patient flows” which involved working as part of a team and putting forward proposals for consideration to the business managers. She felt that the managers were very negative about the ideas the group put forward, which had frustrated her, but then quite a few of the ideas were ultimately adopted. As a result, Zoe questioned whether this was typical or just down to that particular organisation and group.

Majid had been involved in setting up a hospital at night team and medical admissions unit (MAU), including auditing how MAU was run, suggesting that the MAU was a way of circumventing the maximum four hour wait target in A&E, although “a slightly better setting than a bed in a corridor” for patients. However, he felt that he had been “part of those ongoing changes rather than initiator at the beginning” and more of a “doer” and a “workhorse” than a leader. In fact, he described himself as “having positively avoided management.”

Beyond these three Fellows who had some, albeit limited, experience of involvement in service development type work, six others had some other form of leadership experience and six had no prior experience. Table K gives an overview of the other prior activities that Fellows had been involved in.

Table K: Prior leadership/management experience of the Fellows

Level of experience	Number	Fellows
Acted as doctors representative	3	James; Zoe; Mike
Chair/ member of professional committees or Department of Health (DH) working groups	3	Will (Chair of GAT) Lisa (DH groups plus a Founder of 'Remedy') Dev (British Thoracic Society, DH)
Taken a lead on small changes in practice within a GP surgery	1	Caroline
Shadowed and deputised for consultant	1	Nina
No prior leadership/management experience	6	Lucy; Louis; Amanda; Ella; Mark; Bina

In the case of the Fellows who had some other type of leadership experience, two (Lisa and Dev) had been members of working groups at the Department of Health. In addition, Dev had worked on educational projects with his professional association and Lisa had been a founding member of Remedy. This was the junior doctors' action group set up in protest at the changes to the process of application for specialist training places. She had met with member of the Royal colleges and the head of the BMA in this role. Will had led teams and chaired committees, being the outgoing chair of the 'Group of Anaesthetists in Training' (GAT). He related that this had involved a number of leadership related tasks:

“...working within an organisation and being restricted by finances, abilities, conflict, having to negotiate things, having people that I'd essentially got to persuade to carry things out for the good of the committee and the organisation, is something that I had been doing for some time, I mean over 5 years now” (Will, Hospital Fellow)

James had also been involved in negotiating the European Working Time Directive (EWTD) and accompanying rota changes. He had represented the junior doctors who were fighting against some of the changes whilst working alongside a consultant who was also medical director and

pushing for change. Overall, he felt that the experience had given him insight into how the system operated and a wider perspective and understanding than many of his colleagues. Two of the Fellows who had prior service development type experience (Zoe and Mike) had also acted as doctors' representatives and been involved in similar negotiations.

Of the six who had no real leadership or management experience (Lucy, Louis, Amanda, Ella, Mark and Bina) there were some signs of an interest in service development. Ella related that she had begun attending the Association of Paediatric Emergency Medicine (APEM) conferences which were quite new, with the thing that she had most enjoyed being the discussions on how to improve services:

“I used to enjoy the conferences from the scientific point of view but the thing I really enjoyed most was talking about how to improve services, what recommendations to make, that sort of side of it, and this really tied into that “
(Ella, Hospital Fellow)

Mark, as part of his GP training, had also done a six month stint in a public health role, which involved “working differently”, and in a similar way to what was ultimately required within the Fellowship role; attending lots of meetings, being part of networks and so on. Two Fellows (Lucy and Louis) reported that they had observed organisational changes in hospitals where they had worked. Lucy had seen a ward re-arranged to make it more efficient for nurses in getting drugs ready. This had dramatically reduced the amount of time it took, which Lucy felt was “quite clever.” Louis had seen new I.T. and booking systems introduced, and while in one case this had been successful he remarked that, “often I’ve seen it just fall flat on its face.”

Overall, experience of leadership and managing change was limited, with none of the Fellows having specific project management skills on entry. This suggests that they were likely to encounter a number of surprises and challenges on commencing their project work. Given that the projects would require interaction with non-clinical NHS managers and medical leaders, such as medical and clinical directors, the Fellows prior experience of interacting with them was explored and is outlined in the next section.

5.8 Prior experience and attitudes towards clinical leaders and non-clinical managers

Overall, the Fellows experience of interacting with clinical leaders, such as medical and clinical directors, was limited. As Zoe highlighted, “to even email someone on a higher rank...it’s not something that you do.” Only three Fellows (James, Mike and Nina) had some experience of this, as a result of working with consultants who had a clinical leadership role (James and Nina) or because they had worked with clinical directors on a working group (Mike). Mike had some additional insight because his father had been one of the first appointed. Lisa had also worked previously with the clinical director who was one of her project supervisors as a Fellow and knew him well. Despite little experience of interacting with clinical leaders three other Fellows (Amanda, Lucy and Louis) expressed the view that many clinical directors fell into the role and did not necessarily have the right outlook on it or the competency to fulfil it well.

In terms of non-clinical managers, only four Fellows had dealt with them to any degree. Three (James, Mike and Zoe), had experience due to their role as doctors’ representatives, largely in terms of negotiating changes to hours and working rotas. Nina had been involved, along with her consultant, in initiating concerns about the leadership of a ward manager to the management team. She found that they valued her input and took action, removing that particular ward manager to the benefit of the other staff and patients. One other Fellow, Lucy, had briefly met some managers as a result of attending a few departmental meetings. Mike highlights that such limited interaction was likely to be the norm amongst Registrars:

“I mean there are many, many SpRS out there I should imagine who would have had extremely little to do with managers apart from their own Human Resources Managers and they phone them up and say, who’s doing the on call tonight or do you need any locum work.....I think it’s very possible as a Registrar/SHO all the way through to just not be involved at all” (Mike, Hospital Fellow).

This raises questions as to what their attitudes towards non-clinical managers, who they must work with as part of the Fellowship, might be at this point in time. Table L provides an overview of these attitudes.

Table L: Attitudes towards non-clinical managers on entry

Attitude expressed & No of Fellows expressing it	Supporting quotes
Managers not always consult with doctors or take their views on board n=3 (Mike, Zoe, Bina)	"I always found that the management, it was very top down led, where we just got told what to do" (Bina)
Slightly sceptical about the need for the number of managers there seems to be n=3 (Majid, Mike, Bina)	"perhaps the unnecessary level and degrees and depth of management...yeah I was sceptical of that quite frankly" (Majid) "it's interesting to see how large that group is and how at the bottom we are as well" (Mike)
Managers have different concerns –less interested in patient care than doctors n=4 (Amanda, Majid, Louis, Lisa)	" I thought managers would be different" (Amanda) "I think they do have a different perspective in that they are driven by what senior management needs or what the targets are" (Louis)
Not sure that managers understand how clinical care operates in the way that doctors do n=3 (Lisa, Lucy, Ella)	"it does take, in something like medicine, it takes someone who understands the system" (Lisa) "..obviously you need business acumen as well, but you've got to understand the job to implement change" (Ella)
Neutral - not see a 'them and 'us' n= 4 (Mark, Nina, Dev, Caroline)	"I've never really seen and us and them, it's just different people, different jobs really. I think hospital doctors see it far more than we do" (Mark)
Now recognise that managers have a big role to play in the system n= 2 (James, Ella)	"I guess when I started work clinically ...I just saw management as obstructive....but as I've got further into my training I've realised that management does play a really essential role" (James)
Some empathy for the position managers find themselves in n=2 (Lisa, Will)	"It's also that they [doctors] don't want to engage. It's not all the managers' fault. Doctors have put up a very specific barrier to it" (Lisa)

Table L shows that there were a range of attitudes towards non-clinical managers on entry. Three Fellows felt that decisions were top down and that managers do not always consult doctors. Three were slightly sceptical about the need for the number of managers perceived to exist. Four perceived that doctors and managers have different aims, with managers being less interested in patient care. Three were unsure that managers really understand how clinical care operates and what is involved. The literature suggests that these views are similar to those found within the wider medical population (Calnan and Rowe, 2009; Waring and Currie, 2009; Degeling et al, 2006; Rundall et al, 2004). However, four Fellows were more neutral about the role of managers and two had some empathy for the position that managers are in, recognising that doctors can block things and often refuse to engage with managers. Six (Amanda, Lisa, Dev, Will, Lucy and Ella) also felt that doctors and managers need to work together for effective clinical care to take place, although this appeared to be on similar lines to the pragmatic way in which collaboration between doctors and managers in Canada was observed by Reay and Hinings (2009).

Given that the Fellows were self-selected to the Fellowship and the research, the attitudes of other Registrars who were not participating in leadership development were also explored, to help determine how representative or not the Fellows were of the wider population of Registrars (Gomm, Hammersley and Foster, 2000) and also to enable more robust conclusions as to the ways in which participation in the Fellowship impacted on attitudes (Miles and Huberman, 1994). The next section considers the attitudes of this comparison group.

5.9 Attitudes of the comparison group towards non-clinical managers

Amongst the comparison group the same lack of interaction with clinical leaders was noted, although one senior Registrar (Indi) suggested, as had three of the Fellows, that he had enough experience to be able to recognise good clinical directors from poor ones. In terms of experiences and attitudes towards non-clinical managers, table M provides an overview of these.

Table M: Attitudes towards non-clinical managers amongst the comparison group

Attitudes Expressed	Registrars	Exemplar quotes
Managers have different concerns - predominantly £ and target oriented	n=2 Shakira, Liam	<p>“Not much is in the clinicians’ hands anymore. It is very target based” (Shakira)</p> <p>“The only way anything changes is if you are talking about cost analysis. That’s the only thing that anyone really seems to be interested in” (Liam)</p>
Managers do have an important role in the system	n=3 Liam, Indi, Costas	<p>“I think the NHS needs more managers, but it actually needs <i>managers</i>, not just people who have been there long enough so that they just get given a management role”(Liam)</p> <p>“it’s helpful to have someone sort of, who probably can be more objective about the way things are done or resources are allocated” (Indi)</p>
Managers have skills and understanding doctors do not have	n=4 Indi, Costas, Jamie, Liam* (*some managers)	<p>“I can’t see personally many doctors wanting to become chief execs and willing to take on chief exec positions within the Trust board, because that’s not for us. That’s for people who’ve trained in business. ...we were trained to do this job” (Jamie)</p> <p>“Whilst doctors criticise managers for their lack of understanding, managers probably think doctors don’t understand all the issues either” (Costas)</p>
More clinical input is needed into decision making	n=2 Indi, Costas	<p>“there is too little involvement of doctors when change is made. Something needs to be done to bring doctors and managers together more” (Costas)</p>

As table M shows, two Registrars felt that managers were predominantly concerned with financial issues and targets. One senior immunology Registrar recognised that her fellow clinicians were worried about the financial situation, believing that CEOs may not see pathology as a big speciality which brings in money:

“...everyone is very worried about the financial situation because for many CEOs pathology is not a very big speciality, and immunology is the smallest of all of that, even though 70% of the diagnosis comes from pathology overall and it brings money into the hospital” (Shakira, Immunology Registrar)

Liam, a surgical Registrar, who was very interested in working with managers to make change, also suggested that the financial implications were actually what concerned everyone the most:

“Patient care, people say oh yeah it’s all about patient care. The reality is that complications are very expensive, so reducing complications is cost effective, and I’m, you know, very cynical” (Liam, Surgical Registrar)

Another surgical Registrar, Costas, suggested that targets were at a consultant level and so tended to affect them more. He thought that Registrars were protected from such things, a view which was in line with that of Fellows such as Majid and Mike. Three Registrars felt that managers had an important role to play in the running of the NHS, which was similar to two Fellows (Mike and James) and four felt that they have skills that doctors do not have. Liam suggested that the NHS has become increasingly complex and needs people with the right management skills to run it, as opposed to professionals who have come up through the ranks without management skills. Jamie supported his view that managers are a mixed bunch, and vary from Trust to Trust. He felt that the good ones were those who spoke to you and you knew who they were but tended not to notice, as the department just seemed to run well. Costas felt that most junior doctors would feel that managers should be medically qualified in order that more logical decisions were taken:

“I think if you were to survey junior doctors - SHOs and Registrars- I’m certain that 90% plus would say that managers of hospitals should be medically trained, in order to make more logical decisions. It’s obvious that some of their decisions come from a lack of clinical experience” (Costas, Surgical Registrar)

This view was similar to that of three Fellows (Lisa, Lucy and Ella) on entry to the Fellowship. However, Costas also recognised that managers may feel that doctors lack business and that essentially more needed to be done to bring the two sides together. Likewise, Indi felt that doctors have a better understanding of what patients need, and so need to take a leadership role, but that non-clinical managers are needed because management of the system is needed:

“I think it’s a very good thing for clinicians to take leadership and have leadership skills because I think they will always have a better understanding of the patients’ needs than managers but I think we need managers because that’s what they do really” (Indi, Haematology Registrar)

Jamie, also a surgical Registrar, felt that doctors need to be “management savvy,” but that most were unlikely to want to take on CEO roles and that it was not right that they did so, as this was “for people who are trained in business”. While another surgical Registrar, Robert, felt that his experience of managers was too limited to have a well-developed personal opinion, he remarked that he had formed a perception of consultants and managers as two deeply entrenched groups, based on his viewing of the 2006 BBC television programme ‘Can Gerry Robinson Fix the NHS’?

Overall, the views of Registrars in the comparison group towards non-clinical managers and doctors’ involvement in management were mixed and along similar lines to those of the Fellows on entry to the Fellowship. All of this raises questions as to how the Fellows might encounter and make sense of interactions with such managers. The next chapter will consider this, following a short summary and reflection on the findings presented in this chapter.

5.10 Summary and reflections

Looking at the Fellows preparation for the Fellowship, and the new role they were taking on as part of it, has highlighted that they were a self-selected group, mainly motivated by the opportunity to gain management experience. They perceived this would enhance their prospects of taking the next step on the medical career path, in terms of acquiring a consultant post. A small number were primarily motivated by the opportunity for personal development, although this was also linked with making the transition to a consultant role. All of this implies that the group was open to learning and working in a new way. This might, according to the

theory of work role transitions (Nicholson, 1984) mean that they were open to feedback and adjusting through personal change, particularly those who were motivated primarily by the opportunity for personal development. However, the fact that a number wanted, in working on the projects, to demonstrate their ability and make their mark, suggests that they might adjust through role innovation, or shaping the role to suit their own goals. The fact that a variety of factors influenced participation, such as the Fellows current job status, projects related to their career interests and the suggestion of respected clinical colleagues that participation would be a good career move might also suggest that a number would adjust through role innovation.

The fact that management experience was seen as desirable and valuable in career terms by both the Fellows and other Registrars in the comparison group suggests that the Fellows were not a group who were particularly different in terms of their attitudes on entry from the wider population of Registrars. These findings also support the view of Harrison (1992), who argued that management skills would become increasingly necessary for doctors' career progression, and challenge the view that doctors do not feel they are necessary in order to progress (Mountford and Webb, 2009; Causer and Exworthy, 1999). This suggests that attitudes within the profession might to some extent be changing, especially given that around a third of the Fellows expressed that the better, more effective consultants they worked with were those who were integrated with managers and involved in decision making. However, a certain degree of pragmatism appeared to accompany this view, in that the group seemed to accept the need to be involved in management and organisational issues and to work with managers rather than to particularly desire it.

In terms of how well prepared the group were for what they would encounter in the new role, all but one gone through a formal selection process involving an interview, such that one might expect that they had at least had some opportunity to discuss the projects and what was expected of them. However, the role and situation were completely new to all involved, which suggests that a lot of things would only become clearer once they began work. Amongst the group there was some insight into the fact that they might face difficulties in enacting change, and no-one appeared to have particularly high or unrealistic expectations of what they would be able to achieve.

However, given that the Fellows experience of leading and managing projects, working with non-clinical managers and even clinical leaders was minimal, a number of surprises at the encounter stage might be expected. The next chapter moves on to look at the encounter stage of the transition process.

Chapter 6: The 'Encounter' stage - Becoming a Darzi Fellow

Introduction

Chapter six focuses on the findings related to the second stage of the role transition cycle, namely the 'encounter' stage, defined as the first few weeks in the new role. This was the period when the group began to work as Darzi Fellows and encountered their new role requirements, new people and a new environment, outside of the clinical sphere (Nicholson, 1984; Nicholson and West, 1988). According to the theory of work role transitions, the encounter stage is the period prior to adjustment taking place, when a degree of reality shock is often experienced, as role changers encounter things that surprise them and look to cognitively make sense of what they are encountering. Three factors are proposed as likely to effect the degree to which sensemaking occurs: the level of change, contrast and surprise encountered in the new role. Change relates to objective differences between the old and new role requirements such as changes in status, work content and environment. Contrast is the difference between the previous and new role, in terms of whether any prior experience can be carried over. Surprise relates to the extent to which individuals' expectations are met. Findings at the preparation stage suggested that the Fellows would be open to the new experiences and to learning, had some insight into the fact that they might face difficulties in enacting change but were likely to encounter some surprises, as their experience of leading and managing projects and working with non-clinical managers and even clinical leaders was minimal.

This chapter focuses on the Fellows experiences of, and reactions to, taking on the role of Darzi Fellow and is structured as follows: Section 6.1 looks at the change and contrast experienced by the Fellows in relation to the following: the new work content; the new environment they found themselves in and finally, their perceived status in the new role. Section 6.2 presents the findings on the things that surprised the Fellows in relation to the content of the role, the context in which they were working and the impact on their sense of self. These include the complexity of making organisational change, the intensity of the reactions of some stakeholders, the calibre of senior management and some aspects of the educational

programme. Section 6.3 outlines the ways in which the Fellows made sense of the things that surprised them. Finally, section 6.4 summarises the chapter.

6.1 The change and contrast encountered in the new role

This section looks firstly at the change and contrast experienced by the Fellows in relation to the new work environment and job content and secondly, in relation to the status associated with the new role.

In terms of the working environment, eleven of the fifteen Fellows were appointed at Trusts where they were already known; nine in a Trust where they were already working and two in Trusts where they had worked previously. Of the other four (Ella, Mike, Zoe and Bina) who took up posts at Trusts where they had not worked, only one (Mike) also took up a post outside of his chosen speciality. To that extent, the majority of Fellows were working in environments that were in some ways familiar to them, which one might suppose would ease the transition process. However, in terms of job content the role of Darzi Fellow was an ‘intrinsically novel role’ (Nicholson and West, 1988, p. 142) in that it was created specifically for this first Fellowship. In requiring the Fellows to work to shape service improvement, through managing projects, the role was a complete contrast, as Nina describes:

“doing projects was the central thing of this whole year. I don’t know anybody that had prior project management experience. We’ve all sort of done, I don’t know, an audit or a research project but it’s quite different when you’re delivering something for the organisation” (Nina, Hospital Fellow)

Table N provides an overview of the change and contrast between the Fellows usual clinical role and their new role.

Table N: Differences in job content and status

Aspects of Role	Clinical Role	Fellowship Role
Content	<p><i>Sense of routine and a full day</i></p> <p>“we normally turn up on the ward with our junior doctor team and we go round and we do a ward round and a clinic and then our day’s over and the next day we start again” (Zoe)</p>	<p><i>Fluid workload, with peaks and troughs of activity</i></p> <p>“You get peaks and troughs of activity, and people are just, especially because they are so large and their timescales are so long, are seeing flurries of activity followed by troughs of complete inactivity” (Mike)</p>
	<p><i>Regular interaction with other doctors and nurses</i></p> <p>Largely within own speciality</p>	<p><i>Sense of isolation and discomfort</i></p> <p>Office based and working alone outside of meetings or educational modules -need to work with lots of new people and establish relationships</p> <p>“this is very much you’re on your own and its long term things which don’t happen quickly and that initially took a lot of getting used to” (Zoe)</p>
Status	<p><i>Role clarity</i></p> <p>“In six months you can learn an entire speciality....you are doing the same thing, and it’s clear that you are getting what you need to be getting from it” (Lisa)</p>	<p><i>Role ambiguity</i></p> <p>“what’s my role in this? Is it - I can’t put myself at the centre of this because in a year’s time I’ve gone, and also I’m a novice” (Mark)</p> <p>“I guess when I look back on it, they didn’t really know what my role was and really how to best utilise me” (Bina)</p>
	<p><i>Established position within the medical hierarchy</i></p>	<p><i>Lack of authority within the system</i></p> <p>“we haven’t got any authority” (Zoe)</p>

As table N shows, there were differences between the clinical role and Fellowship role, in relation to both job content and job status. These are now looked at in turn.

6.1.1 Job content

In terms of job content, two particular issues were highlighted. Firstly, there was a need to manage a more fluid workload. Secondly, there was a need to engage with a wide variety of people, particularly managers, with whom the Fellows had little experience of interacting.

Dealing with, and balancing, a more fluid workload was a particular challenge for nine Fellows (Mike, Bina, Majid, Nina, Ella, Dev, James, Mark, Zoe) related to a number of factors: the evolution of the projects; the structure of the educational component; personal commitments and knowing how to say no when it came to taking on tasks. All of this married with documents issued by the CIHM, which suggested that the Fellows might encounter time management issues.

Seven Fellows (Majid, Nina, Lisa, Mike, Louis, Caroline and Lucy) reported that the number of projects they were involved in varied considerably over time. For example, Majid's project grew to take in another site:

“my project base is growing and growing, it's now touching on a whole different site, a whole different Trust as well....and it's kind of oh balls, but oh cool.....The project has gone into directions where there is push, where there is momentum”
(Majid, Hospital Fellow)

Nina started with “three [projects], which went to seven and then to one”. Her main service development project proved so unbounded and political that it was “put on the back burner” and effectively abandoned. Six months into the Fellowship Nina was working purely on her quality improvement project, which took up all her time. Similarly, Lisa found that her project to develop skills in other junior doctors was “multiple and varied, and about five or six different little projects evolved into several projects,” which ultimately became part of a collective project with other Fellows.

Balancing the workload became particularly difficult for six Fellows (Ella, James, Nina, Zoe, Majid and Dev) in the second half of the year, as the projects started to develop at the same time as the academic essays were required. In three cases (Majid, James and Dev) personal commitments added to the pressure felt. Majid and James both became fathers during the year and James was also finishing his MSc. He highlights the difficulties he faced:

“...it became a bit of a conveyor belt because you were going to a course, you had to write your essay, and then you went on another course and then you had to submit that essay from the first one while you’ve been set the second essay.....it was probably my own fault as well for doing an MSc and finishing it off at the same time, so there were too many things going on in September and October time” (James, Hospital Fellow)

Over this period Dev was working on a unit that was understaffed as a result of swine flu, and so worked a considerable number of clinical shifts alongside his project work, whilst also fulfilling prior commitments to give talks to GPs.

Part of the issue of balancing the workload was knowing when and how to say no to tasks. Four Fellows (Nina, Majid, Zoe, Ella) found this tricky at times. For example, Nina felt that she had taken on too many things in order to grab opportunities to gain experience and found that at times she was working late into the evening, or early hours of the morning, to get reports finished and meet deadlines:

“.....very quickly people knew that I was around and I was doing these bits of work and they would come to me saying, ooh would you be interested in helping us with this.....I ended up just taking on far too much and I just wished that I’d handled that a bit differently and not been so keen and accommodating..... It really brought home to me the challenges of managementPart of that might have been me not managing my own time and not being very good at it, but I think a lot of it was related to, that’s the realities of organisational life” (Nina, Hospital Fellow)

Majid highlighted that it took some time to learn how to say no to requests to take on tasks:

“...I feel like I’m potentially going to swamp myself and knowing how to say no as well as is what I’d also like to know how to say, big time.....more and more things are being sort of thrown in my direction, which I’m now more able to say, actually, these are things that need to be done, absolutely, but I don’t know if I have the necessary time or skills or need to do that for my requirement here”(Majid, Hospital Fellow)

The second issue facing the Fellows was the need to engage and work with a much wider variety of professionals than normal, particularly non-clinical managers who few had any experience of interacting with (as discussed in chapter one). This created some initial problems of communication, as Louis describes:

“when you first work with a manager, first meet a manager, it’s difficult to know what they are talking about or what they really mean so I think there is that barrier to cross” (Louis, Hospital Fellow)

Mark summed the situation up as “effectively you are in a world where you don’t speak the language.” Louis and Mark highlighted an issue previously encountered by clinical directors, that of different professional groups speaking in different ways, almost different languages (Thorne, 2000). While the Fellows also encountered a wide range of health professionals, their experiences in relation to this will be discussed in more detail in section 6.2 as they encountered some surprising reactions.

In summary, the Fellows found that they were undertaking a very different role to their usual clinical role, one requiring new skills and new relationships to be built, such that they experienced a degree of uncertainty. The next section looks at the issues in relation to the change and contrast in status encountered.

6.1.2 The Fellows’ status

Taking on the role of Darzi Fellow effectively involved making a functional and horizontal move within the hierarchy, from a medical role to what was essentially a project management role. As table N demonstrated, this created two issues related to the Fellows status. One was role ambiguity, on their own part and that of other stakeholders involved in the projects. The other issue related to their authority within the system to lead others. These are considered in turn.

Role ambiguity occurs when individuals lack a clear definition of what is expected in their role and of the ways in which their job tasks might be accomplished (Rizzo et al, 1970). There were various issues related to lack of role clarity. Two Fellows (Mark and James) were personally concerned with trying to define what the role entailed and how it should be positioned. Mark,

a GP Fellow, was considering what the role actually meant in terms of ways of working and came to the following conclusion:

“The job is really about your presence, but also can you put that person together with that person, because you’ve had an informal talk with both of them and they’ve said the same sort of thing that they wouldn’t have necessarily said to each other if you hadn’t been there” (Mark, GP Fellow)

Whereas Mark demonstrated signs of considering the purpose of the role and what he might realistically actually achieve within a year, James was engaged in discussions with his supervisors as to how he should position himself:

“The thing that we’ve been debating this week is, what’s my job title? ‘Cos if I say Darzi Fellow, nobody knows what that means – I have to give a big back story to it, and nobody knows that I’m a doctor if I say that” (James, Hospital Fellow)

Ultimately James and his supervisors settled for calling him a ‘Leadership Registrar’, to indicate that he was a doctor but doing something different at that point. However, the above quote suggests that there were identity issues for James, with concerns as to whether he would be recognised as a doctor.

Other stakeholders’ lack of clarity about the role was raised as an issue by eight Fellows (Lisa, Lucy, Bina, Ella, Amanda, James, Zoe and Caroline). Firstly, as the following quote from Ella highlights, they all found that they needed to engage in discussion about the role and how it had come into being before being able to move on to discuss the project:

“most people just have no idea what it is, so if you say you’re a leadership fellow, they’re like a Leadership Fellow, and who’s Darzi, so then you can’t just introduce yourself, it’s like have you got five minutes, this is what I’m here for” (Ella, Hospital Fellow)

Secondly, there were issues related to uncertainty amongst mentors/supervisors and some key stakeholders involved in projects. For instance, two Fellows (Amanda and Zoe) experienced delays in getting embedded within their organisation as their mentor/supervisor was uncertain as to their role and how to begin implementing it. In Amanda’s case her mentor, the medical director, left her to find her own way. The project manager involved was also unsure as to

what Amanda's role should be, but they gradually worked this out between them. In Zoe's case she was mentored by a clinical lead rather than a medical director and found that her mentor lacked understanding of what needed to happen, which had an impact on what she needed to do:

“my lead sort of knew what had been described that we were meant to do, that was about as far as it went and it took a while to get started and required you know some back in ways to try and meet the important organisational leaders and things, so it took a while” (Zoe, Hospital Fellow)

The backtracking Zoe had to engage in was in complete contrast to the experience of Will, who had meetings set up with all the key people in his organisation by an administrator whilst undertaking the initial module.

In two cases, those of Ella and Bina (and possibly Caroline) key stakeholders involved in the projects appeared to lack understanding of the Fellow's role. In Ella's case it was consultants involved in the A&E department where she was trying to set up a Paediatric Assessment Unit:

“I think some of the consultants are a bit confused by my role, 'cos some are just like, ooh I'd quite like this project to get done, do you think you could do that, thinking that I'm just some generic research person here for a year” (Ella, Hospital Fellow)

In Bina's case, her project straddled primary and secondary care and she encountered problems when it came to trying to work with the PCT. She came to realise that they did not understand her role, and so did not know how to work with her when she approached them:

“...they didn't know what the role of the Fellow is, which is completely understandable, but for me, my impression was well everyone would know, otherwise why would you do this project?” (Bina, Hospital Fellow)

Bina's quote highlights that she had expectations that the PCT would be aware of what she was there to do, which were not met. Caroline, a GP Fellow, was involved in a similar project as Bina, to improve access to urgent care and reported similar issues when it came to trying to establish any rapport with the PCT, despite the fact that they were effectively funding her post.

Whilst everyone was happy to initially meet her, no progress resulted. Caroline attributed to this to a long term lack of clinical engagement on issues.

In terms of issues related to role status, the medical profession has been observed to be hierarchical (Powell and Davies, 2012; Sinclair, 1997), such that in the Fellows usual role as a Registrar they have an established position that is understood by their clinical colleagues. In the hospital scenario, consultants and clinical leaders are above them, with junior doctors (usually referred to as house officers) below. Within a GP practice, partners decide how the practice will run and salaried GPs and GP Registrars comply. Being a Registrar in the role of Darzi Fellow created new issues of authority for eight of the group (Lisa, Bina, Caroline, James, Zoe, Ella, Majid and Louis) in terms of difficulties with engaging some stakeholders in their projects. These included consultants, GPs, fellow Registrars, nurses and to a lesser extent general managers. Both very junior and experienced Fellows experienced this. For example Bina, a very junior Registrar, was involved in the setting up of an urgent care centre and struggled to get the A&E consultants to listen to her:

“I also had these barriers where people in the acute setting thought, especially when I was dealing with the A&E Consultant, that I was just a Registrar and therefore how would I know how management works.....it was just who are you, why are you bothering me? (Bina, Hospital Fellow)

Likewise Caroline, an experienced GP, struggled to engage particularly senior GPs who she most needed to be involved in interacting with the A&E department to make her ideas work:

”I think in our position, as Fellows, we’re not in the most senior positions, so you know I’ve struggled a lot. A lot of GPs have got 20 years’ experience on me, so to try, and they don’t know me, so to try and make, so I had to use my supervisor in a way to engage people a lot of the time” (Caroline, GP Fellow)

Zoe, a senior hospital Registrar, also felt that she struggled to engage other professionals such as GPs and nurses, because “I can’t tell the nursing staff what to do, like they couldn’t tell us what to do.” She was involved in a project to improve management of chronic obstructive pulmonary disease (COPD) in the local population which included facilitating the education of primary care staff on spirometry (a way of measuring respiratory capacity) and disease management.

In addition, Zoe, and another hospital Fellow Ella, struggled with the idea of asking those above them in the hierarchy to do things, and generally with relating to people more senior than them. Ella perceived that “some people feel the Fellows are very junior to be leading these kinds of projects”. However, over time, both she and Zoe started to overcome this feeling. Ashforth (2001) suggested that role identities limit role holders’ perceived ability to influence others and this appears to have been the case for Zoe and Ella.

Interestingly, the four men (Majid, Dev, Louis and James) who remarked on their authority and position did so in a slightly different way to the women. Dev stated that he was “....used to respecting the people for having been here twenty years,” but felt that this worked positively as people seemed to feel that he was approachable and be open with him. While Louis expressed that his position and authority in the system created a need to have the support of senior people, he felt that even those in higher authority positions could struggle to get their objectives implemented by clinicians:

“when you’re working with professional groups you know they find ways to sort of, to think about something that’s been given to them by someone in higher authority then somehow circumvent it” (Louis, Hospital Fellow)

There is support for Louis’ view, as clinical directors have reported that they lack authority to get things done (Willcocks, 1994) and feel disempowered within the system (Davies et al, 2003). Empirical evidence has also found that doctors can find ways around management initiatives, such as the implementation of risk management procedures (Waring and Currie, 2009). In Majid’s case, while he reported a lack of authority within the system he also reported feeling more like an actual change agent and some benefits of this, in terms of being able to have more open conversations:

“I still feel a bit of an outsider really, because I don’t have any authority to make decisions, but I do feel more like a lubricant or catalyst, which in some ways fits in with the descriptions of what a change agent is really.....” (Majid, Hospital Registrar)

Authority issues arose in a different way for James. Working as a Fellow in the hospital where he had previously been working clinically, alongside the same group of psychiatrists, James found that he was attributed greater authority and influence by some of his Registrar

colleagues than he actually had. He describes how his name became attached to a big reconfiguration of services introduced by managers, which was not planned at the time he was trying to implement other changes, and had nothing to do with him:

“some people see it as I set that all up and people became very frightened in June and July that I was doing things that I had no authority to do, but it was amazing what I’ve been attached to. The number of times people have attached my name to some of the massive projects in the Trust. It’s almost like you become a bit of a scapegoat” (James, Hospital Fellow)

The response of James’ peers is interesting with regards to Ashforth’s (2001) ideas about perceived opportunities to influence being associated with role identities. In this situation, others with the same role identity (Sluss and Ashforth, 2007), as Registrars, perceived that James had more authority and influence as a Fellow than he actually had. Their reaction, along with the fact that he was being told what he needed to do by the medical director, affected James’ response. He reported “by the end of the year I’d fitted into this middle management role.” Having seen that the Fellows experienced a radical change in terms of role content, which created issues, related to their role status, one might expect that they experienced a degree of reality shock, or a number of surprises. The next section moves on to consider this aspect of the role transition cycle.

6.2 Surprises encountered by the Fellows

In their work with job changing managers, Nicholson and West (1988) surveyed the extent of surprise encountered around three main areas: job content; work context and self. Job content related to the nature of the work, the people the role changer was working with and the supervision they received. Work context related to the general atmosphere and the formality of relations between people. Self related to the role changers own reactions, in terms of how integrated and competent they felt in the new role. Respondents were also allowed to respond in open format about what had surprised them and why (Nicholson and West, p.101). In this case, the Fellows were asked ‘what has surprised you in the new role?’ and ‘what are you learning from the experience?’, given that Ashford and Taylor (1990) suggested that this is a learning stage. The findings that emerged related to the three areas explored by Nicholson and West (1988): role content; work context and self. These are now presented in turn.

6.2.1 Surprises related to the role content

What emerged inductively from the Fellows was firstly, surprise at the complexity of the change management process, and secondly, surprise at the nature of the reactions they encountered amongst some stakeholders in their attempts to effect change. These two dimensions are now discussed in turn in the following sections.

6.2.1.1. *The complexity of introducing change*

At the start of the year, based on their prior experiences and concerns expressed, there were signs that the Fellows were not all expecting an easy time when it came to trying to implement change. To recap, three (Mark, Louis and Mike) specifically related that they did not expect making change within the system to be easy. Louis felt that his position in the hierarchy would mean he lacked authority to implement certain things, and as has already been outlined this was an issue. Both Mark and Louis had observed attempts to introduce change which had failed to have any impact. Mike, who was one of only three Fellows (Zoe and Majid being the other two) to have any experience of introducing change, had learnt that even a relatively small change such as trying to introduce a clinical pathway within one area was complicated and time consuming. He and two others (Lisa and James) expected that they might meet some resistance from their medical colleagues. One Fellow (Dev) suggested that success would depend on the relationships that existed between all the relevant parties and whether there was a willingness to work together and accept change.

As the year progressed the Fellows came to recognise that successful change was based around three factors: firstly, having a coalition of support for the change idea; secondly, adopting a flexible approach and thirdly the value of incorporating the various stakeholders' views into plans and implementation. These are considered in turn.

Firstly, the need to build a coalition of support for a change idea was recognised by eight Fellows (Lisa, Lucy, Caroline, Bina, Zoe, Mark, Majid and Mike). This is highlighted by the following quote from Caroline:

“It’s all about building relationships and networks around you, ‘cos that’s the only way you’re going to make things happen. I think one of the big learning curves this year is to realise that there is only so much you can do, and you can only make offers and if the systems not ready to change there’s not much you can do about it and sort of having the persistence to keep going but not take things to heart” (Caroline, GP Fellow)

Secondly, three Fellows (Louis, Zoe and Dev) came to recognise the need to have an adaptable and flexible approach to different problems and different people. Dev had anticipated this might be the case, but not the extent he encountered:

“it just shows that two different places, though they are part of the same Trust, you approach them quite differently and I think that for me was revolutionary. I knew it was going to be different but I didn’t realise how different” (Dev, Hospital Fellow)

Louis describes how he came to recognise that different people in the NHS have different agendas and hence need to be approached differently:

“I’ve also learnt that there are many different approaches to take to try to deal with a problem and I’ve also begun, or rather I’ve learned over the course of the year that actually the NHS and hospitals are very complex organisations and there are lots of different people, stakeholders if you like, a lot of different parties with different agendas...and that you have to think about taking different approaches to dealing with these problems (Louis, Hospital Fellow)

This was an interesting insight on Louis’ part as he had not expected change to be easy. Similarly, Zoe had some experience of service development type projects but came to recognise the need to be flexible when approaching different types of people over the course of the year:

“the thing over the whole year has been about doing lots of little projects. the way I’ve done each one has changed depending on the results of the one before, so if I didn’t succeed in one method of meeting people, getting the right people involved, I tried to learn from that and do different things.....I think you’ve got to be very flexible about what project that you’re doing and the people that you’re working with” (Zoe, Hospital Fellow)

Thirdly, the value of incorporating stakeholder views in the process is best described as a revelation to three Fellows (Will, Lisa and Louis). Will had never worked with patients and their

relatives in the way he did in his project, which was to improve life for long term patients and their families in a high dependency unit. He designed a questionnaire and held meetings with patients' families, involving them in determining the priority areas to be worked on and describes his reaction to events below:

“The things that I’ve seen that have taken me by surprise and that I’ve welcomed were actually that there are very many perspectives, and I can see the value now of having people in the room who are not even involved within medicine at all or with the hospital because that provided a very different perspective. Patients relatives for example, who have never been a customer of the hospital but have a very unique view on how things should be” (Will, Hospital Fellow)

While Will was surprised at the value of working with relatives, Lisa found it enlightening that by seeking the opinions of those health professionals who worked in the area affected, and involving them, that far more workable and sustainable ideas emerged than she had come up with by herself. In a project to develop a protocol for dealing with neutropenic sepsis Lisa involved the A&E nurses and describes the insights this gave her:

“...because I’m not an Accident and Emergency nurse I wouldn’t have thought of it. It’s just little things like that, it’s like, you don’t know what you don’t know, and so, there were a couple of occasions when things that I thought were fine can be done better. So it’s just sort of illuminating, and there were quite a few of those” (Lisa, Hospital Fellow)

Similarly, Louis found having the opportunity to actively involve an entire ophthalmic team, when setting up a first ophthalmic polysystem in a PCT in one project, and the whole surgical team on another, revealing in terms of how valuable this was:

“...actually it makes you realise that other members of the team, they do have important things to contribute but you need to give them the opportunity to do that and you need to be open to that and you know, I think this year has opened up my mind a bit in terms of being more receptive to you know, other people’s views and trying to, you should proactively seek that because even you know in daily working life you work with multiple health professionals butsomehow you tend to do it in your own little groups. Doctors do it on their own, nurses do it on their own; it doesn’t really make a lot of sense” (Louis, Hospital Fellow)

The previous quotes from Will, Lisa and Louis reveal how they drew on principles of whole system working underpinning the educational programme and how insightful it was for them to have the opportunity to work with both professionals and service users in new ways.

The next section looks at the surprises encountered with regard to others' reactions to the Fellows in their new role.

6.2.1.2 The reactions of stakeholders involved in the projects

Professional cultures have been noted as being resistant to change (Abbot, 1988) and there is evidence of attempts to transform healthcare, which involve the medical profession, proving difficult (Bate, 2000; McNulty and Ferlie, 2002). In leading the projects the Fellows had to get other health professionals to support change ideas and the majority (twelve) reported experiencing resistance in at least one of their projects. This included: resistance to getting involved from clinical colleagues (Ella, Zoe, Mark, Caroline, James, Mike, Louis, Majid); apathy and lack of engagement from PCT staff (Caroline and Bina); lack of engagement from business managers (Lisa and Lucy); refusal by a consultant to pass on information that only he had (Lucy) and finally, managers blocking the Fellow meeting with key people and engaging in political manoeuvring (Nina). In the main, however, this resistance did not appear to be a particular surprise to the Fellows.

With regard to non-clinical managers, Nina appeared most surprised, in terms of being disappointed by the actions of some managers:

“ I'd been in a meeting with a couple of the managers who'd asked me if I'd like to do a particular piece of work, and I said yes I'd do that but isn't [a colleague] actually doing that piece of work and they say oh, no, no, we're giving her something else to do, so I agreed to do that piece of work and then about half an hour later found that other colleagues was actually being asked to leave and I just felt very uncomfortable and there was a lot of uneasiness between us. You know, I just thought she obviously thinks that I've stolen her job” (Amanda, Hospital Fellow)

Nina suggested that this disappointment may have been “about me not having that political savvy” as to how managers and organizations operate. Stryker (2004) has noted that unmet expectations tend to lead to disappointment. However, not all of Nina's experiences with managers were negative. She was also pleasantly surprised as the way in which, as time went on, they reported how useful it was having her around, and began to look for increased clinical input:

“A lot of people said that me being with them was a really good opportunity for them to sort of understand it [clinical involvement] and they welcomed more doctors coming in and spending some time at headquarters with them on things. Also there was some restructuring going on in the Trust, in terms of the clinical governance structures, and I noticed the managers were saying, we need some clinicians in here, we need some doctors input, where are the doctors? We need some nurses as well...” (Nina, Hospital Fellow)

Likewise, six other Fellows (James, Dev, Amanda, Ella, Caroline and Bina) were pleasantly surprised by the level of support they received from non-clinical managers. For example, James reported on entry that he had come to recognise over the course of his specialist training that managers now had a big role, but remained slightly sceptical about the need for the number there appeared to be. While he experienced a number of problems with his clinical colleagues during the year (which will be discussed shortly) he reported that he received a lot of support from everyone on the management side:

“I was helped with the GP project by a project manager at the beginning. It was very useful to have somebody who had extensive knowledge of the Trust. She’d worked here years before for a long period of time and knew it really well, so that was really helpful. A lot of the management staff have been really supportive and the clinical governance team were very helpful and very supportive. So the management side were very supportive” (James, Hospital Fellow)

When it came to reactions from clinical colleagues, two Fellows (Mike and Louis) were pleasantly surprised at the positive reactions they encountered. For instance, Mike had to get his fellow Registrars to do a lot of the work on one of his projects to introduce clinical pathways, because he was from outside the speciality. He remarked that this was “easier than I thought” and that he had never had an outright refusal to do something, which he had expected. Likewise Louis, who had a seemingly complex project to introduce the first ophthalmic polysystem in the local PCT, was surprised at how smoothly this went:

“I mean the polyclinic to be honest has been quiet seamless, there hasn’t been, even though that’s one of my big, headline projects that hasn’t been particularly challenging to be honest because it’s something that the primary care Trust wants doing, it’s something that the hospital wants doing, you know, had agreed to set up so” (Louis, Hospital Fellow)

In contrast, five Fellows (Ella, Lisa, James, Dev and Louis) experienced a level of conflict with clinical colleagues which they had not anticipated. For Lisa and Ella this was with key

consultants associated with their projects. In Lisa's case she had predicted that her junior colleagues might not engage with her attempts to develop opportunities for them to interact with managers but it was with the new oncology consultant that she ran into problems with.

The following quote describes what happened:

"I remember at the start I did feel like my toes were being trodden on. So I was doing this big audit, looking at all the data, talking to everyone, and I *did* actually out of that think that I would start coming up with the plan, and then the new oncology consultant started and she was doing similar things and when I did present the data she had kind of already decided what she wanted to do, which as it happens fits in really well, because she had been going around having very similar conversations. But I was a bit like, you know I was half way through the audit and she had already decided that she was going to run a rapid access clinic. I mean we are warming up now, but we had a real issue at the start. (Lisa, Hospital Fellow)

The stance that Lisa took was to pursue what had been agreed, work with the consultant and then to move onto other projects. She decided that it was not worth treading on the consultant's toes and upsetting her in terms of her career prospects, "because if she bitches about me on the oncology circuit then that will not help me." While Lisa took this stance she still seemed to feel that the consultant was treading on her toes when interviewed at the end of the year:

"I've worked really hard on it, I've got some good results, I'm writing up, I've got before data, I've got after data, we've got statistical significance, so that's a win. It's a bit more of a win for the consultant than it is for me. She's now presenting it nationally and making a bit of a name for herself" (Lisa, Hospital Fellow)

In terms of unmet expectations, Lisa had entered the Fellowship feeling that the project would be something that she could talk about at a later stage, and had not expected to encounter a new consultant working on the same things as she was. Ella found that a key consultant in the A&E department where she was trying to develop a Paediatric Clinical Decision Unit appeared to think her territory was being encroached on, and sought to defend what she saw as her area of jurisdiction (Abbott, 1988), as she relates:

“In terms of the main project there was some conflict with one of the consultants, the main A&E consultant...She just didn’t engage and was a block on trying to do things and there was some conflict there. She seemed to think that Paediatrics was trying to take over A&E which is not the case, and it should all be seen as one. There was an episode after presenting some data and proposals for the future that she called me into her office, the other consultant left the room and it felt like being locked in, and she just went on and on. She was saying, well it’s not acceptable for you to be presenting this and us not to be seen to be involved in it” (Ella, Hospital Fellow)

Ella did find ways to cope with this situation, which will be discussed in more detail in the next section on sensemaking. For James and Dev the conflict they experienced was with members of their Registrar peer group. For James, difficulties arose when he identified that two psychiatric teams were not hitting the target of seeing ninety five per cent of patients within twenty eight days of referral from a GP. One of the two teams (the one he had previously been working in) was performing particularly poorly. This led to discussions about how the situation could be improved and an idea that some people from each of the two teams could work together to clear the backlog, while the other members of each team carried on with other work. This provoked a strong response from James’ colleagues:

“They said that I was a spy at one point. They said that I had, ‘cos they’d recently moved into this office together, and they said that the Trust management had set it up on purpose so that they could merge the two teams..... and I think by people doing that I automatically fell into the middle management role, because you have to fight your corner and say, actually no, what I’m doing is this” (James, Hospital Fellow)

James had predicted that some of his Registrar peers might oppose the changes he was likely to have to make at the start of the year. However, the extent of their hostility surprised him, such that it drove him further towards a managerial position. In contrast, the conflict that Dev experienced was with a peer who he was working alongside on the projects:

“I came across a situation where I, I wasn’t sure I was going to come across, so I had a very difficult working colleague or I had difficulty with the colleague, who works differently from me and that’s just the way it is and I didn’t realise that I was going to have that much of an issue, because I became very vulnerable” (Dev, Hospital Fellow)

Dev ended up consulting, and being guided by, his coach as to how to deal with the situation and felt that the learning and insight he gained from this episode was huge. Indeed, all the

Fellows who experienced conflict with their colleagues felt that, whilst difficult at the time, it had been a very useful lesson for them.

Finally, Louis experienced considerable resistance in one of his projects which involved trying to improve ways of working amongst a surgical team, which culminated in a heated argument with a theatre nurse manager. He engaged in considerable discussion, provided her with all the information she required and spoke to a number of other people involved, eventually managing to get her on side. The next section looks at the surprises encountered in relation to the work context.

6.2.2 Surprises related to the work context

Surprise related to the work context was examined by Nicholson and West (1988) in terms of the general atmosphere, communication and decisions taken at a senior level and training/learning opportunities. What emerged inductively from the Fellows was surprise at the calibre of senior managers and at some aspects of the educational programme. The findings in relation to these are presented in turn.

6.2.2.1 The calibre of Senior Managers

Seven Fellows (Lisa, Lucy, Amanda, Dev, Will, Caroline and Bina) were pleasantly surprised at the calibre of senior managers (executive board members) they encountered. This was with regard to the following: the extent of alignment between their own goals and motivations and those of senior managers; the openness to feedback of CEOs and senior managers and the level of political influence demonstrated by CEOs.

For example, Amanda had expected that “managers would be different” but found that “the people I’ve met have all been interested in doing the same things that I’m interested in, they just come with different skills and a different approach.”

Likewise, whilst at the start of the year Lisa had felt that there were tensions between doctors and managers which were “not all the managers fault”, she described being impressed with the whole of the executive team at her hospital:

“I’ve really, really been impressed by the executive here....One of my reflections was that I need to try and meet some people....to go and find the charismatic chief exec, hang out with the finance director.....I was being facetious because I thought I’d never find a charismatic chief exec, and who the hell wants to hang out with a finance director. Now the chief exec is just a legendary guy and the finance director is just great fun, and very bright, and was explaining all this stuff to me. We were at this business planning meeting yesterday, and....he was saying we haven’t got the money for this but we have to make this work because it’s quite clearly a really good project that is going to save actually time and money and reduce the length of stay for patients.....they are all on the same side. I think they are really painted a bleak picture” (Lisa, Hospital Fellow)

The above quote highlights Lisa’s surprise at the calibre of the chief executive and finance officer and the fact that like doctors they are interested in improving life for patients. Others such as Crilly and Le Grand (2004) have also found Trust managers to be primarily motivated by service quality, in the same way as consultants, although they found senior managers also showed greater concern with breaking-even financially than consultants.

Bina was similarly impressed with her executive management team, particularly her CEO and medical director, in terms of how open to feedback and welcoming they were:

“I was very, very fortunate, it was a very supportive team and even if I wanted to speak to my chairman I had the opportunity to do so, or any of the non-executive directors I could....there were many times when they would go up to the wards unannounced, just to see how things were, talk to people. And my chief executive has two half days dedicated, where people can come and talk to her about any problem.”(Bina, Hospital Fellow)

This experience contrasted with Bina’s views at the start of the year, when she remarked that she had “always found that the management, it was very top down led, where we just got told what to do”. Others described their surprise at the level of political influence their CEO has. For example, Amanda describes her growing respect for her CEO:

“The more I’ve done this year the more involved I perceive her to be in the broader political landscape, because she is involved in vast numbers of different groups and organisations, and her influence upwards, is I think quite considerable, much more so than I was expecting, and I think that’s because she is a very astute politician as well as being a very passionate leader of her organisation” (Amanda, Hospital Fellow)

Likewise, Dev was inspired by his CEO’s intellect and ability to negotiate:

“I was talking to my chief executive yesterday...no Monday....a very insightful man I might add, who’s highly intelligent - an aside is, I aspire to be of that calibre to be honest with you..... he’s a genius - that is his ability to negotiate is phenomenal” (Dev, Hospital Fellow)

It seems that having the opportunity to work with the senior management team and observe them at close quarters challenged some existing perceptions and led to positive impressions of senior managers. A recent review of leadership development programmes for junior doctors conducted for the Kings Fund (Bagnall, 2012) has reported similar findings. The next section looks at surprises experienced in relation to the educational inputs.

6.2.2.2 The educational inputs

As outlined in chapter five, the educational programme was a mix of taught modules, peer learning opportunities in the form of action learning sets and communities of practice and finally individual coaching. With a couple of exceptions amongst the Fellows (Mark and James), and one exception in terms of the modules (co-production) the programme appeared to meet expectations. In fact, it appears that the Fellows were very impressed by the programme leaders, in that thirteen of the fifteen interviewed signed a letter in support of them, which stated:

“...’David’ and ‘Susan’ have stretched and challenged our perspectives and views on organisations, questioned our assumptions and promoted new approaches for us to tackle complex issues. They have fostered a culture shift and succeeded in having a huge impact in shaping our attitudes, beliefs, approaches and ultimately, we believe, our behaviour and impact, much of which is not readily measurable or demonstrable at this stage” (letter in support of the CIHM tender for a second Fellowship)

Two Fellows (Will and Louis) were surprised at the depth that was gone into in some modules, as Will, who had led teams and done various bits of management previously, describes:

“I don’t think I ever realised that I need to know it to this depth. I don’t think I really expected that side, the sort of nuts and bolts theory teaching side of it to be as great as it has been” (Will, Hospital, Fellow)

Likewise, Louis was initially surprised at how much management theory there was, being also slightly sceptical as to whether it would work in practice. However, as the year progressed he felt that “the theoretical learning was useful in parts.... depending on the type of scenario and the project you’re involved in and the different stage of your career,” and remarked that he was reassured by the fact that scholars had thought and written about management, and that his actions were grounded in some kind of evidence base.

In terms of the two Fellows who expressed some disappointment at the educational programme, James stated that at times it had felt like the group were “guinea pigs”, and that “how useful it was, was sometimes debatable.” As the only person to fail an essay, James appeared quite angry about the fact that other Fellows had handed in essays late for various reasons and then had their marks modified, stating that he felt “victimised.” However, he expressed more positive views on other aspects of the programme, such as the coaching element. Mark had taken part in the first shortened medical degree programme at St George’s Hospital in London, for people who were already graduates. Early in the Fellowship year he related that the staff there had taken a far more radical approach to teaching, and that the programme leaders on the Fellowship could have circulated more things beforehand, checked the Fellows’ level of knowledge and that there could have been “less of them.” However, by the end of the year he rated the programme overall quite highly, whilst describing the experience as being somewhat surreal:

“It has been a bit like being at Hogwarts though, in that you are well very treated. I worked out that we had 30 days in the city in a very nice venue. We’ve had good food...we’ve written essays and we’ve had feedback. It’s a bit like being at a British public school really. You can see why David Cameron has emerged thinking he can run the country. There’s no surprise that you feel you can then do it. A lot of it is about the psychology of it, feeling that you can do it, but it has been boy scout leadership really. We’ve had the benefit of coaching at a cost of £500 a time, design surgeries. There was nothing life and death about it. No-one else would get the luxury of all that. I saw an Assistant Medical Director job advertised and I was thinking, in that sort of job people are going to expect you to achieve and deliver on things straight away” (Mark, GP Fellow)

The comments of the group about their behaviour change not necessarily being demonstrable until later and Mark’s comments about the extent of support do raise questions as to how far the Fellows might succeed in future efforts to lead change when less support is available, and as to how related to reality experiential learning as part of a development programme actually is.

The one academic module which did not meet expectations was that of co-production, which aroused particularly strong reactions amongst four Fellows in group A (Lisa, James, Lucy and Mark). This was reported as being due to the way that it was taught, as the following quote from Lisa highlights:

“it was disgracefully badly taught. The concepts were fine, and I think actually we all sign up to them, it was just the teaching was disgraceful....really, really nice guys, just clearly not educationalists, didn’t know about how to teach a group. I think also because we have quite high expectations and everything else had been so good. I was furious at the end of that module, we were all” (Lisa, Hospital Fellow)

This quote from Lisa suggests that the module did not meet the high expectations that the group had developed as a result of the way the other modules were delivered. Dev, who was in group B, for whom some amendments were made, loved the concept and values behind co-production. However, he supported the idea that the tutors could have engaged the group more:

“I know some people didn’t take, especially in group A, they didn’t take to the co-production module and I could see why not. I’m not sure they missed the point, but I think some of the things they taught were to a generation of doctors who do that anyway. So when they said take a history and got a person to take a history from a patient, who I’ve got to be honest is the best people I’ve ever seen take a history - she was brilliant and they still managed to find holes in what she did - well that I found deplorable.....I just felt that guys to some extent you are losing time here and what you could be telling us is a different issue.” (Dev, Hospital Fellow)

While Dev suggested that bringing in more medical staff that use co-production principles would have given the module and module leaders more credibility, he also felt that the concept was alien to some specialities. He cited surgery and anaesthetics as being more “numbers oriented.” This idea that the concept itself may have taken some by surprise was supported by Mark:

“It was radical stuff and as soon as I heard it I knew that some people would go nuclear. There are a few Attila the Huns in the group who are very vocal” (Mark, GP Fellow)

Mark’s suggestion that the group was vocal was corroborated by a letter, signed by thirteen of the fifteen, in support of a CIHM tender to deliver a second programme, in which it was stated “as a vocal group we have been quick to highlight our views.” However, Lucy and Ella (neither of whom was perceived as Attila the Hun like by Mark) also expressed that they had initially been slightly sceptical about the module. They had perceived that co-production meant talking to patients more and that it was another example of tokenism in relation to patient involvement. However, both came to see that it was not and became very interested in the idea.

The individual coaching sessions were a pleasant surprise for three Fellows (Nina, Zoe and Dev) in terms of how helpful they were. Dev found that his coach’s guidance with regard to dealing with the conflict he experienced with a colleague was one of the most beneficial aspects of the year:

“What she did she gave me a fantastic way.....and I’ve now learnt to use that - to find a level at which you both respect each other, what’s worked in the pastshe said, go back to that, keep the communication professional and almost formal....and keep it there, and do you know Kathy, that worked.....That to me was huge. If I had to say one thing which is not tangible; I can’t write this on my CV, I can’t hang it on the wall, but you know, pick up the signs and then you go to a level where you can deal with it and you keep it there...and that for me is very powerful ” (Dev, Hospital Fellow)

Zoe also found that the coaching provided insight on how she thought about things, and led her to realise that this influenced her approach and the response she got from others:

“ I have really enjoyed the coaching; I’ve got a lot out of the coaching because I think a lot of how you think, and it really influences this kind of work, whereas our kind of work you can be in a bad mood and it’s just the job, you know what you’ve got to do” (Zoe, Hospital Fellow)

Nina, a psychiatrist, was surprised at how well her coach understood her. She related that she was quite stressed in the first few months of the Fellowship and that the coaching was “really, really fantastic”, and the aspect of the programme that helped her the most:

“I really, really loved the coaching and that was useful in terms of understanding, actually developing techniques as well, but understanding my responses to certain people that I was working with, why I was finding certain things challenging. That really helped me develop as well. I was actually quite spooked by how she just got me straight away, in terms of understanding, and then when I was talking, just to pick up on really subtle things, and say I notice you said this. It was just wow! It felt really good. It just feels like therapy, it’s brilliant” (Nina, Hospital Fellow)

These quotes from Nina and Zoe suggest that the coaching helped them gain self-insight into their own responses to situations. Ella’s coach was also helpful in terms of helping her assess her position within the medical hierarchy and realise that she would soon be a consultant who was expected to contribute her views. The next section moves on to look at surprises related to the Fellows own ‘self.’

6.2.3 Surprises in relation to own self

In their work with role changing managers Nicholson and West (1988) found that a considerable number were surprised at their own reactions to the new situations they

encountered. This was in terms of how integrated they felt, and how well they felt they were coping. Some were surprised at how competent they felt, while several complained of a lack of free time in their new job, although few were surprised at the impact on their home life. The Fellows expressed surprise at how isolated they felt from their usual social group, with only one (Amanda) expressing surprise at her level of competency and three (Nina, Ella and Dev) at the impact of the role on their home life. These are looked at in turn, beginning with feelings of discomfort and isolation.

6.2.3.1 Feelings of discomfort and isolation

Eight Fellows (Caroline, Ella, Lisa, Nina, James, Mike, Mark and Majid) reported feeling out of their comfort zone, and in some cases isolated from their medical peer group. For example, Ella describes how she felt homeless and at sea:

“sometimes you can be in your trust and feel a little bit at sea and feel oh god I’m not doing this and like, defining your role and how you work your working day. So I go to meetings and then in between I’ve been a little bit homeless in the hospital. I think I’d feel slightly better if I had a definite space that was mine that I could just sit at and work...I mean I’m not expecting my own office but.....when I’m not at meetings I don’t have anywhere I need to be specifically” (Ella, Hospital Fellow)

Ella also found that there were things that she had to keep to herself when socialising with colleagues, having been party to discussions that were not ready for wider consumption. Having previously seen good leaders as being approachable and part of the team, she began to realise that being a leader meant that one could not always be part of the team in the same way as when was not in a leadership role. While the managers she had met at this stage were friendly, she did not really feel part of the management team either. James also found that in relation to some aspects of his projects he was unable to be as open with his Registrar colleagues as he normally would have been (having worked in the team previously). This was again because certain things were still in the process of being decided.

These feelings of being not fully attached to either the previous role or the new role have been reported previously (Ibarra, 2003), and described as ‘liminality’ (Van Gennep, 1960), in terms

of feeling betwixt and between roles. While Majid felt “a bit out of it” he felt that there were also some positive effects of this in that he did not have “overt alliances or loyalties” which allowed him to “have more frank and open discussions.” He felt that because the role was new, he was not seen as being attached to a particular team or group of colleagues, which meant that he did not need to demonstrate a particular allegiance to any group of clinical colleagues. This was interesting because Nina perceived that she was being treated slightly different by her usual peer group of Registrars:

“...there is a slight kind of, the atmosphere has changed slightly. You know they are interested in what I’m doing, they ask about it, but when we’re in meetings and a management issue comes up, it’s, you know if I offer something, it’s almost like, look at her, or is she trying to management bash us, you know sort of turn us into future medical directors sort of thing” (Nina, Hospital Fellow)

Nina’s experience reflects other reports that doctors who move into management positions feel the profession is suspicious of them and sees them as working with the enemy (Thorne, 2000; Fitzgerald, 1994; Riordan and Simpson, 1994; Montgomery, 1990). However, she did not report feeling as isolated as Caroline, a GP Fellow, did:

“most people have been employed by a Trustwhereas I really haven’t had that experience, so my experience has been very isolated from the PCT. I don’t work within an acute Trust so I’ve had to make my own network and find my own place... I’ve not been part of working on a project, I’ve formulated my own thing, which has made it really difficult - it felt very isolated at times” (Caroline, GP Fellow)

While Caroline felt isolated because she was not attached to a Trust, Lisa was embedded in a Trust but missed the social aspects of her clinical role, such as the banter with medical colleagues and other staff on the wards. In contrast, Mike was integrated with other Registrars, as his medical director had sited him in a room with other Registrars. As such, he did not feel socially isolated, just uncomfortable in the new role. Likewise, Mark felt outside his comfort zone, although he had worked in a public health role during his GP training which involved lots of office work and meetings, and he had expected that the role would “feel a bit different.” Whereas the majority of Fellows suggested that they drew on the support of their Darzi peers, Mark suggested that he did not. The next section looks at the surprise of one Fellow at her level of competency in the new role.

6.2.3.2. Self-competency

Interestingly, compared with the job changing manager studied by Nicholson and West (1988) only one Fellow, Amanda, expressed particular surprise at her level of competency with regards to leadership:

“I didn’t think that my personality fitted in with that image of a leader. Now I feel very differently, and I think that’s because of appreciating how you can influence and improve things without actually dominating and completely taking over, because I wouldn’t be able to do that very well, that’s not how I work with people. I didn’t really think I’d be any good at it, and I didn’t think I’d enjoy it and I didn’t think I’d want to do these kind of things, I thought they would be, perhaps just an element of my job that I just had to put up with as a consultant, whereas I feel completely differently about it now” (Amanda, Hospital Fellow)

For Amanda, the experience of leading was far more pleasant than she had expected, and the above quote suggests that she started to think differently about being involved in organisational issues as a consultant. While Amanda was the only Fellow interviewed that specifically expressed doubts about her leadership capability, as discussed in chapter five (preparation for the Fellowship), others expressed initial concerns regarding whether they would be able to progress the projects as they hoped. The next section looks at surprises related to the demands of the role and the impact on home life.

6.2.3.3 The impact of the role on home life

Three Fellows were surprised by the way in which the demands of the role impacted on their home life. Two (Nina and Ella) spoke about finding that they were taking project related work home with them, working at weekends and late into the evening at times which they had not particularly expected. One, Nina, felt quite stressed during the first half of the year and recognised that she had underestimated the commitment needed in a management role:

“I think I underestimated the commitment I was making in terms of my own health to this year and it really brought home to me the challenges of management in terms of the days where I would go without lunch because of something that was urgent or needed doing, or sitting up ‘til the early hours of the morning desperately trying to finish a report because it was needed for a meeting the next day. Part of that might have been me not managing my own time and not being very good at it, but I think a lot of it was related to, that’s the realities of organisational life” (Nina, Hospital Fellow)

In contrast, while Dev worked until the early hours to get the essays completed, as a result of multiple other commitments, he was pleasantly surprised at being able to work from home on some occasions, which was in complete contrast to his usual clinical role.

As the previous sections have demonstrated, the Fellows were surprised by aspects of the role content and work context in particular. According to role transitions theorists (Nicholson, 1984; Louis, 1980a) the surprises that people encounter during the early weeks and months in a new role will provoke a need to rationalise, interpret and 'make sense' (Louis, 1980b) of what is occurring, in order to adjust. The next section moves on to look at how the Fellows made sense of their experiences.

6.3. How the Fellows interpreted and explained their experiences

According to Nicholson and West (1988), in making sense of new encounters and the things that surprise them, role changers are likely to draw on the following: their own past experiences; the interpretations of significant people around them and the shared interpretations that are prevalent in the local sub-culture or environment. They also suggested that attributions, or the way in which experiences are related to either one's own actions, those of other people or circumstances, are an important part of the process. Weick (1995) also suggested that sensemaking is about constructing meaning and plausible explanations for new situations that are encountered, with the sensemaking that occurs dependent on what is important to people and what they notice.

In order to explore what the Fellows noticed and their sensemaking the Fellows were firstly asked, how they would describe the role and their experiences to others? Secondly, they were asked if there was anything they felt had helped or hindered them in their role. Thirdly, the interview text was examined for signs of who the Fellows were using as reference points in reaching their interpretations.

In terms of *what* was important to the Fellows, reports focused on their ability to make progress in their projects, with those who experienced conflict also focusing on the conflict

they had encountered. Table P provides an overview of the attributions made by the Fellows regarding their ability to progress their projects.

Table P: Attributions made in relation to progressing the projects

Factors to which the Fellows attributed their ability to progress their projects	No of Fellows
1. Having support for the project from senior figures across the Trust	n=11 Lisa, Lucy, Ella, Louis, Amanda, Will, Dev, Mark, Nina, Bina and Zoe
2. Having a supportive mentor	n=13 (all except Nina and Amanda who received little support from their mentor)
3. The type of professional the Fellow needed to engage	n=5 Zoe, Caroline, Mark, Mike, James
4. The size and type of NHS organisation the Fellow was working in	n=4 Lisa, Zoe, Ella and Mark
5. The extent to which the Fellow worked clinically	n=3 Dev, James and Zoe
6. Own ability to mobilise support	n=4 Ella, Zoe, Nina, Dev

The six factors outlined in table P are now discussed in more detail, beginning with the extent of support for a project across the Trust.

6.3.1 The extent of support for a project across the Trust

Eleven Fellows (Lisa, Lucy, Ella, Louis, Amanda, Will, Dev, Mark, Nina, Bina and Zoe) felt that having the support of the senior management team and figures such as the medical director was important for the projects to have a chance of succeeding. This was related despite the

fact that nine of the eleven felt that they had been well supported by such figures, as Lisa highlights:

“I think you do need to have, at this level, you need to have the senior backing”
(Lisa, Hospital Fellow)

This quote from Lisa suggests that being at Registrar level necessitates having the support of senior people. Will also spoke about the need for support for a project and the Fellow leading it, to be widespread, not just located with their mentor/supervisor:

“I feel it is also dependent on whether a Trust has embraced the scheme, you know with open arms and sees you as an opportunity, or whether they, you know - certainly talking to some people it sounds as if some of our colleagues are having disasters in terms, in the sense that their immediate supervisor has resigned and the Trust has never really been for the project, it was just a single person who was promoting it and so on” (Will, Hospital Fellow)

Will demonstrates that he was drawing on the wider experiences of the group of Fellows in reaching this conclusion. The following quote from Dev also suggests how important and beneficial the backing of senior managers was when it came to tackling a difficult scenario:

“My Fellowship hasempowered me to go and lead the change, but lead it from within, which is what I would naturally do, but you wouldn’t necessarily have the confidence to go and knock on *anyone’s* door. The people who were mentoring me gave me that, power is too strong, they gave me the confidence to do that, and they said ‘go, we’re here’, because they are very powerful within the hospital, within the Trust, and some of the areas they wanted me to go they knew were jungle territory.” (Dev, Hospital Fellow)

The need for such support is backed by Nina, who had little support from the medical director and experienced resistance from some senior managers to trying out new ways of doing things:

“I have ideas and I have this sort of new way of seeing things, but the organisation is so obsessed with control and they’re so risk averse, they just don’t want to take any chances or try to do things differently” (Nina, Hospital Fellow)

For Nina the lack of support from her medical director was an issue as he was formally her mentor. These findings support those who suggest that distributing leadership throughout an organisation does not negate the need for formal leaders (Freidrich et al, 2009; Spillane and Diamond, 2007), in this case particularly CEOs and Medical Directors, who have the authority

and power needed to facilitate progress when it comes to organisational change. The next ion looks at the ways in which other mentors were felt to have helped the Fellows progress their projects.

6.3.2 Having the support of their mentors

Mentor support has been highlighted as important in leadership development interventions for school teachers who are not yet leaders (Brown-Muth and Ferrigno, 2004). These findings support this, as thirteen of the fifteen attributed their success at least partly to their mentor. Table Q gives an overview of the ways in which the Fellows believed they influenced and enabled progress.

Table Q: Attributed ways in which mentors helped influence progress

Ways in which the mentor influenced progress	Number of Fellows
Used their authority and position within the system to influence tricky and important stakeholders/bypass them	n=4 Caroline, Mike Louis, Ella
Interacting extensively with the Fellow - introducing them to their contacts and openly discussing their own experiences -helping them to tackle difficult situations	n=5 Bina, Ella, Lisa Mike, Louis
Provided support and backing for the Fellows actions across the Trust	n= 8 Will, Dev, Lisa Louis, James Majid, Mike, Lucy
Giving advice and direction about how to proceed	n=3 Mark, James Mike

As table Q shows, eight Fellows attributed the progress they were able to make to their mentor providing backing for their actions. For example, Louis highlights the overall importance of this:

“I think first of all how effective you are depends on who’s supporting you and my medical director was very supportive and there are a small group of clinicians who are very keen on clinicians being involved in management so it’s been good having that support and sometimes you do need that because you have periods of doubt where you wonder, well actually, I’m not quite sure what’s going on here” (Louis, Hospital Fellow)

Louis draws attention to the fact that he experienced periods of doubt about what he was doing, as did other Fellows, and that having the support of his mentor was very helpful at such times.

Four Fellows (Mike, Caroline, Louis, Ella) attributed their success in overcoming resistance to having a supportive mentor with authority and influence within the system, in terms of counteracting their own lack of authority which has been discussed previously. For example, Mike found that his medical director was particularly helpful if he was struggling to get a response from a key person:

“This is where my medical director has been useful in that way, ‘cos he’s gone, yeah we need to get this done and sopped someone in the corridor and gone would you mind looking this over, so having somebody in a higher position” (Mike, Hospital Fellow)

Likewise, Caroline, a GP Fellow, attributed some of her ability to engage GPs to her mentor’s authority:

“A lot of GPs have 20 years’ experience on me, so to try, and they don’t know me, so to try and make, so I had to use my supervisor in a way to engage people a lot of the time...she’s a GP that’s been in the PCT for 25 years, everyone knows her” (Caroline, GP Fellow)

In contrast, Zoe attributed some of the problems she had in engaging people and gaining agreement to the fact that her mentor was not a medical director, and so lacked authority and credibility within the wider system:

“...so where other people have had the medical directors, because they have I suppose more authority in the organisation, when it comes to big projects that involve lots of specialities, that agreement and this is what we’re going to do hasn’t been there” (Zoe, Hospital Fellow)

The above quote suggests that Zoe was comparing her situation with that of her peers and looking at what might have made the difference in terms of her struggles to engage people.

Five Fellows attributed their ability to establish themselves to having mentors who were highly interactive, in terms of allowing the Fellow to shadow them at meetings and being willing to discuss their own leadership experiences. For example, Ella's medical director discussed difficulties he was having with other consultants and problems he had encountered:

"My mentor is my clinical director, he's been phenomenal. I mean he's very busy but he will always, if I need to see him, give me time and a lot of what I've learned this year has been out with my project work, has just been shadowing him at meetings and then him talking to me about difficulties he has with managing people, but he's been really open and honest about that and I've really been party to lots of sensitive information which has been a really big learning" (Ella, Hospital Fellow)

Ella felt that a lot of what she had learned about dealing with difficult individuals and situations was down to the conversations she had with her mentor. Likewise, Bina attributed her ability to integrate herself within the hospital Trust to her mentor allowing her to shadow him for the first three months and introducing her to his contacts:

"I had a very supportive medical director who, literally in the first three months I was with him the whole time, and it was very good to see how all those meetings worked and it was a very good starting point for me because then he enabled me to formulate my own networks regarding my projects" (Bina, Hospital Fellow)

Bina had a project which straddled both the hospital and PCT and while she attributed some of her success in making progress within the hospital to the support of her mentor she encountered more difficulties when it came to establishing herself within the PCT. She attributed this to the staff there having no understanding of her role and its purpose.

Two Fellows (Mark and Mike) attributed their success in engaging stakeholders to the direction they were given by their mentors. Mark related that he had learnt from his mentor, the PEC Chair, about how to think and question GPs in a more strategic way. He found this useful as there was a lot of history amongst the GPs in the PCT where he was working and he needed to persuade them of the benefits of working together. Mike describes how he was given advice

by his medical director about how to engage his medical colleagues:

“My medical director told me this, he said this is how you do this Mike, find out their problem and tell them you’ve already got the answer, so if they got involved in this, they’ll have the answer. So I remembered that and it’s always worked”
(Mike, Hospital Fellow)

Both Mark and Mike suggest that having their mentors pass on their experiences of making change proved to be useful. Having looked at ways in which mentors were perceived to have influenced the Fellows’ ability to make progress with their projects, the next section looks at the way in which some Fellows attributed their ability to make progress to the type of professionals they needed to engage.

6.3.2 The type of professionals the Fellows needed to engage

Differences amongst specialities, in terms of their reactions to management, have previously been noted. For example, Willcocks (2004) and Harrison and Pollitt (1994) have related that acute specialities such as medicine and surgery tend to be less managerially oriented than others, such as pathology based specialities. Sinclair (1997) also observed a perceived hierarchy of specialities amongst the profession. Those such as medicine and surgery perceived themselves to be at the top, on the basis of requiring most knowledge and expertise, whilst psychiatry was perceived to be at the bottom, on the basis that it works in a more open and collaborative way and uses lay language.

Five Fellows attributed their ability to make progress to the type of professionals they needed to engage (Caroline, Zoe, Mark, Mike and James). Three of these (Caroline, Zoe and Mark) attributed difficulty in engaging GPs to the fact that they are independent practitioners. Zoe, a hospital doctor, felt that this made it difficult to engage them in a project which had been designed by the PCT, particularly when they had a lot of other targets to reach. Caroline, a GP Fellow, suggested that the senior GPs she wanted to get involved in working in the hospital A&E department were generally GP partners who are wedded to their own practices and patients. Whilst there “are some excellent things about that” she felt that this tended to make them less concerned with a whole system perspective and working together to improve overall access to urgent care. Likewise Mark, also a GP Fellow, reported that some GPs raised

questions about what difference a polyclinic would make to their patients:

“There are times though, when you have got used to thinking and talking about things in a more strategic way when a GP say will ask you, ‘what does that mean’ or ‘what difference will that actually make to my patients’ and I do find it difficult sometimes to answer that” (Mark, GP Fellow)

This implies that having got used to thinking in terms of the bigger picture it was not always easy to deal with the individualism, or tendency to focus on their own set of patients, noted amongst doctors (Degeling, Kennedy and Hill, 2001; Freidson, 1989).

The existence of intra-professional boundaries, between different medical specialities, has also been noted previously (see for example Martin, Currie and Finn, 2009; Currie, Finn and Martin, 2008). Two Fellows (Mike and James) attributed the level of medical engagement with management to the fact that doctors in some specialities had more time than others to get involved. James felt that the one ‘special interest day’ per week which the psychiatric trainees had enabled their involvement and partly explained the growing interest in it they showed. Mike attributed the willingness of the oncologists he was working with to get involved in his projects partly to their having the time to do so. He believed that the next Fellow coming to the Trust would have more difficulty in engaging anaesthetists and surgeons who “tend to hole themselves up.” Interestingly, a clinical lead for liver surgery, interviewed as part of the comparison group, felt that certain specialities such as anaesthetics were perhaps more motivated to seek opportunities for wider system involvement at a local level on the basis that they do not need to build and market a service in the same way as, for example, specialist surgeons. The next section looks at attributions related to the particular organisational context that the Fellows were working in.

6.3.3 The organisational context

Four Fellows (Lisa, Ella, Zoe and Mark) felt that the type of Trust (acute, primary care or mental health) and its size affected the ease with which things could be done. Lisa felt that she had been able to achieve more than some Fellows because her hospital was a smaller, district general:

“I think *this* hospital is a very good example of a small hospital that’s run very well. Everyone’s very proactive, everyone’s very approachable, there’s a lot of can do attitude. I think that if I had done this in a *big* teaching hospital where people are far too busy with other things, I think it would be a very different story” (Lisa, Hospital Fellow)

Zoe and Ella who both worked in large teaching hospitals reported more difficulties. Zoe felt that it took a long time to get things done because there were more layers of bureaucracy and “even finding out who the right people are is quite a challenge.” Similarly, Ella felt that the fact that her Trust was a large, tertiary and academic unit partly explained why there was such disengagement amongst the consultants:

“I mean it’s a very academic, tertiary unit....there’s only a handful of general Paediatricians.....Even amongst consultants I’ll mention one of the executives names that I’ve, not necessarily worked with but was going to, and they wouldn’t know who they were. So it’s such a massive organisation there’s a lot of disengagement amongst certain people. Whereas I’ve chatted to other Fellows who are in smaller organisations and it seems a little bit less” (Ella, Hospital Fellow)

Ella shows signs of relating her experience to others in coming to this understanding of why things were as they were in her Trust. Mark, a GP Fellow, felt that there were more issues in some of the acute Trusts than there was in primary care:

“I think that the way it worked with me was the way that it was envisaged a Fellow would work, and I think that this type of work particularly suits GP work. Where there were issues they seemed to be in acute Trusts. Some people had poor mentors or unsuitable and unrealistic projects. Some Trusts thought they had got a doctor on the cheap to sort things out” (Mark, GP Fellow)

Mark added that hospital doctors had made the choice to work in hierarchical institutions and appears to have drawn on his identity as a GP (Ashforth, 2001) to explain why his experience was better than that of some other Fellows.

Given that different types of organisational structure, and the pros and cons of each, were covered within the educational programme, it might be that these Fellows were making sense of their experiences in relation to this new knowledge and understanding. Certainly as a result of working in different types of Trust on different projects the Fellows had different

experiences, highlighting the importance of considering actions within the context in which they occur (Sayer, 2000). The next section looks at attributions relating to the impact of not working clinically on ability to make progress with the projects.

6.3.4 The impact of not working clinically

Two Fellows (Zoe and James), who both struggled to engage clinicians in their projects despite having prior experience of representing doctors in change situations, attributed this in part to their not working clinically during the year. James suggested that if he repeated the experience this would be the thing that he would do differently. Whilst acknowledging that clinical work might be the default position for doctors when things get tough, he felt that it would have enabled him to have maintained a more balanced approach. Zoe also felt that being out of the clinical situation took her away from the way in which she would normally influence clinicians, through having built credibility with them:

“I think one of the things that I have noticed about this is that I’ve done very little clinical work this year, and in other organisations that I’ve worked in, your personal rapport with your peers, your nursing staff, your colleagues, means that then if you’re well thought of then when you suggest things that you are going to do, then people are much more receptive than having a stranger coming along. So I think I may have had, while there’s not time, doing the same things while working, may have been a little more successful” (Zoe, Hospital Fellow)

This view is interesting as Dev, who stated that he worked clinically around fifty per cent of the time at some points, attributed his success in getting the junior doctors and nursing staff on side in his project to this. While Dev expressed that the nature of his project enabled him to work in that way, this approach also fitted with his preference to “lead from within.” Ashforth (2001) has suggested that role identities provide frameworks for resolving ambiguity and tension, and that individuals are likely to seek opportunities to enact identities that are important to them, which appears to have been the case in these instances. The next section moves on to look at the self attributions, or ways in which the Fellows attributed their ability to make progress with their projects to their own level of competency or approach.

6.3.5 Self attributions

Interestingly, only four Fellows attributed progress to their own abilities to engage stakeholders, three of whom were women and women who had expressed issues in relation to confidence and assertiveness (Zoe, Ella and Nina). While Zoe also attributed difficulties in making progress to external circumstances she felt that she could have been better at engaging and mobilising some people:

“...it’s been quite difficult on some of the projects, trying to get other people really involved in it and I think that on some of them I could have done better at trying to say, well are you going to take part in this and what are you going to do and how do you want to do it” (Zoe, Hospital Fellow)

Likewise, Ella came to realise that she had not really been engaging people so much as telling them what to do and expecting them to respond positively:

“I talked about engaging people by telling them what things were like and what they could be, rather than working with people, you know so just my naive way of thinking” (Ella, Hospital Fellow)

Similarly, Nina reported that she sometimes struggled to get the information she needed from people when she asked questions, but that a session on asking good questions in one of the communities of practice helped with this. In contrast to Fellows such as Mark and Mike, who were guided by their mentors in this area, Nina received little support from hers.

Interestingly, from a gender perspective, only one man, Dev, made any comment on his own abilities and he felt that his respect for others, linked in part to his ethnic background, helped him gain people’s confidence:

“...that’s a subjective thing but that’s also what other people tell me. So they say to me, you’re very respectful and actually people therefore feel very happy to confide in you. My peers, it isn’t always the same, and that’s not a slur, it’s a different approach and style and I find I’m comfortable with what I do and it works, and if I want to get the best out of people without even thinking about it, it happens” (Dev, Hospital Fellow)

The fact that Dev referred to his own abilities in a more positive way than the women discussed above is interesting, as Nicholson and West (1988) found that women managers were more anxious than men at the preparation stage and less sure of themselves than men at work. The chapter now moves on to look at how the Fellows who experienced conflict made sense of it.

6.4 How the Fellows made sense of conflict

Difficult situations are said to cue sensemaking (Ashforth, 2001) and five Fellows (Ella, Lisa, James, Dev and Louis) encountered some conflict during the year, as discussed previously in chapter six (section 6.2.1.2). To recap, Ella and Lisa both had difficult relationships with a consultant involved in their projects. James had conflict with his peer group of psychiatric Registrars, Dev ran into conflict with a Registrar colleague he was working with on the projects and Louis ran into conflict with theatre nurse manager. These five reflected on these experiences without any prompting and the way in which they made sense of these situations is outlined below.

In reflecting on the conflict she had experienced with one of the A&E consultants, Ella drew on various aspects she had learnt on the educational programme:

“you know, even for example the A&E Consultant I’ve had trouble with, she’s obviously forward thinking, striving to provide a really good service, but she’s just so sort of shackled by her, her upbringing almost, that she can’t see that there needs to be a slight change in thinking” (Ella, Hospital Fellow)

This quote from Ella suggesting that the consultant’s ability to see the bigger picture was hampered by her “upbringing” suggests that she related to discussions on the programme about professional socialisation. In addition, she drew on what she had learnt about different personality types, suggesting that she and the consultant were very different personalities in Myers-Brigg terms. This understanding helped her realise that she tended to take things personally. Ella experienced ongoing issues with this one consultant and was helped to cope by something she heard Sir Bruce Keogh, medical director for the NHS, say at an event she attended. This was along the lines of ‘if you want to make change you cannot care about taking

the credit for it'. She drew on this the next time a situation with this consultant arose and expressed that rather than thinking "well I want the credit for it" she reframed things and thought that it did not really matter who presented the information so long as it was communicated. Ella found that "that eased tensions and I think then I wasn't competing anymore, so there wasn't an issue". This suggests that Ella attributed some of the conflict to her own reactions and desire to prove herself, which was one of her goals at the start of the year, whilst ultimately concluding that "sometimes you are just a victim of circumstance."

Lisa made sense of the conflict she experienced with a consultant in her department, who was involved in similar things as she was, by concluding that the tension was a result of the consultant being new role and trying to establish herself, at the same time as Lisa was trying to change things:

"...with hindsight I think she was just a bit insecure about starting a new job. She had been somewhere for years before she started here and it was all just very new and very insecure, and I think my presence was threatening. I think she just wanted to establish things; she is doing very nice things with an oncology tilt but / am the consultant and / am the clinical lead for oncology here..." (Lisa, Hospital Fellow)

Reflecting on the situation, Lisa attributed the tension in her relationship with this consultant to the fact that the consultant was insecure, rather than any action on her part, other than being there and trying to do things at the time.

Dev related how he initially felt that the Registrar colleague whom he had issues with was being less than honest about what he had done and playing a political game. However, his coach helped him make sense of the conflict in another way, as he describes:

"she said, have you ever thought of the fact that the reason they react in that way is that you make them feel insecure, and I, because I'd always felt like the victim in the situation and I said I don't know, and she said you walk around the whole hospital, we've been sitting here twenty minutes...and she said everybody who's walked past has stopped and how do you think that makes that person feel? Have you stopped to think? And I said, okay I take that on board" (Dev, Hospital Fellow)

Dev was helped to overcome this issue by his coach who told him to “keep the communication professional and almost formal” which worked. He ultimately concluded that “maybe there was a feeling of competing interests on the other side, there wasn’t on my side...but people think differently.”

What is interesting is that in the three cases discussed so far (those of Ella, Lisa and Dev) an element of competition between the Fellow and the clinical colleague they had difficulty with was alluded to. In James’ case he experienced difficulties with members of his Registrar peer group when he had tried to instigate discussion about the performance of the team. He attributed some of the problem to the fact that he had “slipped into the management role”, using the management language he had picked up and losing his usual way of communicating with people. In Ashforth’s (2001) terms he doffed one persona and donned another, but came to feel that assuming the management persona had led to conflict in this context. He drew on his experience and understanding of the relationship between doctors and managers to explain why his peers attributed blame for change to him:

I think partly....because I had a, people knew me, so I had a face, and I think sometimes they don’t know, they don’t have a lot of contact with the senior managers in the Trust and the execs and they don’t see them on a day to day basis necessarily, so it’s easier to blame the person they know and they’ve seen and attach all these things to them.”(James, Hospital Fellow)

James related that he was being told by the medical director and by various people, ‘this is what you must do, this is what needs to be delivered and this is how it needs to be delivered’. When he tried to implement this “they’d just say, well I’m not doing it, so you felt squashed”. James’ experience supports the findings of Bate (2000) where some consultants stated that at times they simply refused to do what was asked of them.

Louis experienced conflict which culminated in a heated argument with a theatre nurse manager over his attempts to improve working relationships amongst surgical teams. He attributed this to the fact that she was very closely connected to the issue. He concluded that when people feel strongly about things it can lead to arguments, especially amongst professionals groups who are used to coming to decisions in isolation rather than all working together as a team. Many writers have reported the existence of a number of occupational

groups within the NHS, each with their own value system, such that sub-cultures operate (Hafferty and Hafler, 2009; Jorm and Kam, 2004; Willcocks, 2004; Degeling, Kennedy and Hill, 2000, Bate, 20001). Others such as Fitzgerald and Teale (2004) have also found that even when working together in teams, which Louis was trying to engender, different health care professionals maintain different ways of looking at things. The next section summarises the findings in the chapter and their significance.

6.5 Summary

This chapter has presented the findings in relation to the encounter stage of the role transition process. The Fellows took on an “intrinsically novel role” (Nicholson and West, 1988, p.142), where the workload was much more fluid and unpredictable than their clinical role, which created some issues in terms of time management and balancing of tasks. This was compounded by the structure of the educational programme, in terms of the essays being required at the same time as the projects started to gain impetus. A degree of role ambiguity was also present, amongst the Fellows themselves and key stakeholders they were working with. While the Fellows experienced no permanent or formal change in status, the new role highlighted their lack of authority within the wider system. A small number of Fellows also had particular problems relating to people above them in the hierarchy, in terms of voicing their opinions and feeling able to ask for things to be done.

In relation to the role itself, the Fellows were surprised by two things. Firstly, by the complexity of the organisational change process and the need to establish a network of relationships and a coalition of support for change. Secondly, by the nature and intensity of some clinical colleagues’ reactions to their efforts to introduce change. In relation to the work context, a number were surprised at the calibre of the senior management team. As such, it will be interesting to see how all of this impacted on their attitudes, in terms of future involvement in service development and working in partnership with non-clinical managers.

When it came to making sense of all these things, the Fellows focused on how far they, and their Darzi Fellow colleagues, had been able to progress the projects, and on the conflict that had occurred. Interestingly, they largely attributed their ability to make progress to external

factors: the extent of support for a project across the Trust, having a supportive mentor; the type of health professional they needed to engage within their particular project and finally, in three cases, to the extent that they worked clinically, and so were able to build respect amongst clinicians they needed to engage. Only a small number of Fellows attributed their ability to make progress at least partly to their own ability to engage people. This is interesting as Waring (2007) found that in relation to the patient safety culture being fostered in the NHS that doctors readily attributed potential threats to patient safety to system factors, as a way of mitigating any individual wrongdoing and protecting their own credibility.

When it came to the five who experienced conflict, it was conflict with medical colleagues, and in one case another health professional, that was reported. The attributions in relation to these cases are interesting as competition amongst colleagues was certainly alluded to. In his ethnographic study of doctors in training Sinclair (1997) frequently observed a mix of co-operation and competition in professional relationships, noting that unpleasant experiences were rarely attributed to such things as the doctors own reactions or existing social and political relations. In relation to the conflict experienced these Fellows appeared to draw on their new understandings of medical socialisation, the way in which systems work and individual personality differences to make sense of these experiences. However, through the guidance, coaching and reflection they received three of the five came to recognise and attribute conflict at least partly to their own behaviour.

These findings raise interesting questions as to how the Fellows might adjust to the new role and what impact this might have on their orientation to their ongoing clinical role. Attributing their ability to make progress on their projects largely to situational factors, and the extent of support they received from others, suggests that the Fellows may not have perceived a need to engage in personal change. On the other hand, they may have perceived a need for change but felt that change on their part would not, on its own, be sufficient to enable organisational change to occur. In the latter case, rather than committing to new attitudes, beliefs and practices, the Fellows may have adopted a pragmatic approach. That is to say, according to the theory and model of role transition (Nicholson, 1984) many may have adjusted in the form of 'determination,' engaging more in role innovation, in terms of shaping the projects and role to achieve as much as they felt they could in the circumstances, and to meet their own needs during the year, with limited change in their own attitudes and beliefs.

However, given that some Fellows did attribute their progress at least partly to their own abilities and approach, this suggests that some, if not all, may have adjusted through personal change. The next chapter goes on to look at the ways in which the Fellows did adjust to the role of Darzi Fellow.

Chapter 7: The Adjustment and Stabilization stages

Introduction

This chapter focuses on the third and fourth stages of the role transition cycle, namely those of adjustment and stabilization (Nicholson, 1984). The adjustment stage is a key stage within the role transition cycle, as it is the time when role changers begin to find ways to cope with the new role and its requirements. Two forms of adjustment are proposed within the existing theory. One form of adjustment is that of role innovation, defined by Nicholson and West (1988) as 'the process by which people mould the role to meet their personal requirements' (p.98). The other form of adjustment is personal change, which is when individuals change their own approach to fit the new role and its requirements. According to Nicholson's theory, taking on an "intrinsically novel role" (Nicholson and West, 1988, p.142), as the role of Darzi Fellow was, tends to result in personal change. Whether, and how, personal change occurred is core to this research, given that leadership development is perceived by policymakers and the medical academy as a way of achieving a new sense of professionalism and increased organizational involvement in doctors. The fourth stage of the cycle, stabilization, is a stage of consolidation of any new attitudes, beliefs and practices that have developed in the adjustment stage. Nicholson and West (1988) found that job changing managers frequently bypassed this stage, moving straight from the adjustment stage to preparation for another transition. Given that the role of Fellow was time limited, and all were approaching another transition, whether stabilization, began to occur amongst the Fellows is highly relevant, in terms of how successful leadership development as a strategy for sustainable intra-role transition might be.

This chapter is structured in three parts. Section 7.1 begins by looking at ways in which the fellows adjusted to their new role through role innovation. Section 7.2 then considers evidence of the Fellows adjusting by engaging in personal change, in terms of altering their orientation towards organisations and leadership and their attitudes towards working with non-clinical managers and a wider group of stakeholders. Section 7.3 then looks at the stabilization stage, approached in terms of the extent to which all of the Fellows planned to maintain new ways of thinking and behaving they had developed during the year and their orientations towards medical leadership in their future career. Longer term data collected from four Fellows, twelve

months post completion of the Fellowship, with regards to their attitudes and practices once re-established in clinical work, is also presented here.

7.1 Adjustment through role innovation

Role innovation is perceived in the theory as a proactive form of adjustment, occurring when individuals carry out their new job differently from previous role holders, or other equivalent role holders. In being an 'intrinsically novel role' (Nicholson and West, 1988, p.142) created for this first Fellowship all the Fellows were role innovators in the sense that they were creating meanings and expectations amongst people they encountered, which were likely to impact on any future Fellows. However, their service development and quality improvement projects were designed for them by their sponsors, with guidance as to how to approach them given by the educational programme leaders, and in some case mentors. There is evidence that all the Fellows attempted to follow the guidance they received from the programme leaders, although some had more successful outcomes than others in progressing change.

One example of success is that of Lisa. She had some experience of trying to introduce change for junior doctors and had entered the Fellowship keen to find ways to achieve sustainable change. Lisa had come to recognise that this would require those affected by change taking some ownership for the implementation but on one project still initially had clear ideas about what she would do. Following discussions in one of the communities of practice she decided to seek the ideas of those on the front line and found this very successful:

"I had a project on neutropenic sepsis. I knew what I wanted to do...we needed to set up something in Accident and Emergency. I had a plan, we'll just do this, very straightforward. I went on one of these things, we talked about diverse perspectives, sustainability, why things hadn't worked before and came up with some new strategies about getting the people who are going to be delivering it to come up with their own solutions and use their wisdom and so I just thought, you know I'll try anything, why not just go and have a few meetings, and it ended up with these guys coming up with a *much* better idea than I'd come up with on my own, and that they were really enthusiastic about, and they therefore took ownership of and therefore have put into their teaching programme and because I'm not an Accident and Emergency nurse I wouldn't have thought of it" (Lisa, Hospital Fellow)

Two Fellows (Ella and Louis) tried using an 'appreciative inquiry' approach (Cooperrider, 1997), which was raised as a possible tactic in a community of practice, with mixed results. This approach involves inquiring about what is working well in a situation and using positive language, rather than focusing on aspects that are not working, or asking questions framed from this perspective. Ella had great success using this with junior doctors in Paediatrics when trying to determine how their ways of working could be improved. She found the group coming forward with ideas and volunteering to do things. However, Louis had less success when he tried this approach in a project he developed himself, aimed at improving how surgical teams (surgeons, anaesthetists, theatre staff and nurses) work. He met with much more resistance and concluded that for surgeons this was perhaps not the best approach:

"I'm not sure, maybe it's too management, too much of a management approach, not problem solving, which is the point of an appreciative inquiry, to move away from a problem solving approach....they all either seem to think they know the solution, or the solution is obvious or they don't see the point of it or whatever"
(Louis, Hospital Fellow)

Louis persevered and invested considerable time discussing the issues one particular nurse manager had, eventually managing to persuade her to engage with his ideas. Louis, Lisa, Ella and a further eight Fellows (Dev, Mark, Majid, James, Ella, Caroline, Bina and Mike) all demonstrated signs of being proactive and persistent when it came to trying to implement projects designed by others. This raises an interesting question as to how well the existing definition of role innovation as a proactive form of adjustment to meet one's own requirements fits with this type of situation. There were, however, examples of Fellows moulding the role to suit themselves in particular ways, in terms of re-shaping the aims of a pre-designed project or designing their own improvement project. The next section outlines these.

7.1.3 Re-shaping projects and designing new ones

In one case a Fellow did relate that she had re-shaped a project designed by her sponsor in a way that was more in line with her own interests. This was Caroline, who had a project to look at reducing attendance and emergency admissions to A&E in her PCT, with the idea being that some of the things patients were attending A&E for could be treated in the community in a

different way. Her original brief was to set up an urgent care centre. However, she started to look more widely at how GPs responded to the demand for urgent care:

”we looked at setting up an emergency care centre in the community.....so that was again in the initial brief, that changed quite quickly because ...where they want to set it up, the resources weren’t really there, and I wasn’t, I didn’t really have my heart in that because there isn’t really a lot of evidence that reduces emergency admissions and as yet there’s not a lot of evidence its cheaper, so instead we changed things a bit and started to look more at the wider system ...we did some work around GP access and how to respond to the urgent demand in general practice” (Caroline, GP Fellow)

The above quote suggests that there may have been good reason for Caroline to amend her original brief, and that she drew on principles of whole systems working underpinning the educational programme in re-shaping her project in ways which suited her own interests.

Three Fellows (Lucy, Louis and Mike) designed projects of their own during the year. Louis’ project to improve working amongst surgical teams has been discussed previously. Mike introduced two projects of his own and found that these were the most satisfying aspect of the year for him:

“the thing I’ve found most satisfying has been my own projects, because ...those [the designed projects] were very much given to me as an introduction to the Trust, as a way of starting the ball rolling, getting to know people, and from there other work comes along and I’ve set up other projects and I’d say that’s been more satisfying because that’s been something that I’ve started” (Mike, Hospital Fellow)

One project involved introducing a scoring system to monitor patients in hospital who were at risk of deteriorating, designed to act as a guide for nursing staff as to when they should contact the doctor. Mike collected data on the existing situation and then went to see another member of staff, who he found was supposed to be already working on this. Working together they set up a think tank, came up with a policy and protocol, put these through the necessary committees and gained approvals. They then began piloting the system on intensive care and certain wards and had to deal with issues of non-compliance amongst the nursing staff in order to gain usage of the system as intended.

Lucy had an idea which she hoped would lead to a change in doctors' behaviour and a reduction in the amount of money spent on blood tests. She describes her reasoning behind it:

“We have all these complicated patients here, and when they are on the ward or in clinic we, the junior medical staff, order an awful lot of tests on the computer, just in case we need them, just in case the consultant asks for them...and what we are going to do is audit how many blood tests are ordered over a month period, and then add in...the price of that investigation ...so that they can see how much it costs... and then...we'll audit how many blood tests are ordered for the month afterwards, to see if people's awareness of how much things costs changes how much they order” (Lucy, Hospital Fellow)

Lucy made some progress with this project but despite having the support of the CEO it got delayed from an I.T perspective, in terms of getting the costs listed on the computer system. She felt that it was “a good lesson in how long things take”.

The examples cited in this section suggest that role innovation in the form of moulding and reshaping the role in line with the Fellows own interests did occur, in line with the way role innovation is conceptualised by the existing theory (Nicholson, 1984; Nicholson and West, 1988). In addition to this, a number of Fellows approached their third project which involved helping their Trust to train junior doctors in an organisational skill by taking the decision to develop something on a much wider scale.

Rather than approach training for their peers individually, eight of the fifteen Fellows interviewed decided to work collectively to develop more substantial initiatives which would reach doctors beyond the boundaries of their own Trust. Six Fellows (Amanda, Lisa, Caroline, Will, Dev and Mike) joined together to develop a series of online modules entitled 'Leadership and Management for All' (LeMA). This included five modules with slides and podcasts recorded by experts on the following: the history and structure of the NHS; clinical governance and patient safety; leadership; finance and commissioning in the NHS and finally policy. The modules were designed to be hosted on the deanery website and accompanied by social learning tools, based around case discussion in groups. Mike describes the group's intentions and the way in which they tried to introduce an experiential angle:

“...we felt that as well as having podcasts we would need extra material to expand on it and that they should have the opportunity to get into groups with their peers and discuss what was said, or do an exercise, or have a manager come down and tell them about certain aspects to make it more experiential, so that they have an experience to associate with. Now whether any of them will ...actually look at the podcasts, I’ve no idea...all it’s meant to do [is] to spark an interest and just open a door and start something” (Mike, Hospital Fellow)

Two others (Nina and James) also sought to bring experiential learning into an intervention they developed along with the other psychiatrists on the Fellowship, as Nina describes:

“three trainees from each of our Trusts will be doing projects in their organisation and getting action learning and coaching to support that, so kind of a mini Fellowship experience.” (Nina, Hospital Fellow)

This initiative for psychiatric trainees across the city was in the form of a mini leadership Fellowship, entitled ‘Experiential Learning in Management and Systems’ (ELMS). Nina was heavily involved in getting funding, which for the first year came from the deanery’s ‘Dragon’s Den’ initiative in which the Fellows could pitch for money to launch their training ideas. The LeMA project also received funding this way. While both of these projects drew on educational principles of experiential and social learning which they had encountered, the design of the programmes was shaped by the Fellows.

Two other Fellows (Louis and James) also set up mini leadership Fellowships on an individual basis, for Registrars within their own Trusts. For example, James’ developed an initiative which involved live service development projects designed by him and a project team, supported by formal educational sessions. He describes how this came into being and what it involved:

“last summer I basically got an email through [which] mentioned about a course at ‘Northlands’ University which is just up the road, which is about leadership and management. So I went to meet one of the professors and said look, would you be able to do any teaching, how would you do this, and he was very enthusiastic but we didn’t have any money. So we put it to one side and when the Dragons Den bid came out I met with him again and we put together a proposal for a training programme for the SpRs. So they’ve got four training days, they’ve to do assignments, they’ve to do a presentation and at the end of it they get thirty credits towards a postgraduate certificate” (James, Hospital Fellow)

James recruited twelve trainees working on projects, seven of whom presented at a Trust wide event at the end of the period to a panel of judges, including “multiple directors” and he was delighted by feedback he received:

“it was especially good because the nursing director said that there is a management programme set up for directors within the Trust and for other people and they haven’t delivered on any projects and they could see that these SpRs had delivered on projects within a year and one of the projects was saving the Trust a significant amount of money. I think it was about a quarter of a million. So quite amazing work” (James, Hospital Fellow)

If such a sizeable saving was made it is perhaps no wonder policymakers are championing clinical leadership across all levels. Other Fellows pursued different initiatives on an individual basis. For example, Ella joined the then existing BAMMBino (the junior doctor branch of the British Association of Medical Managers) and got involved in shaping their ‘Learn to Lead’ programme.

Having looked at ways in which Fellows engaged in role innovation in the way that the existing theory of role transition suggests, through shaping what they did within organizations to match their own interests, the chapter moves on to consider whether there were any signs of the Fellows adjusting through personal change.

7.2 Adjustment through personal change

According to Nicholson and West (1988), a high level of job novelty is likely to act as a stimulus for personal change, which may be broad, “embracing both the minor and fundamental parameters of identity” (Nicholson and West, 1988, p. 117) and including the following: new behaviours and habits; different ways of relating to people; new attitudes and values; altered cognitive capacities and reformed dispositions. Exploration of whether and how personal change occurred amongst the Fellows was operationalised through the use of longitudinal interviews. At the end of the year the Fellows attitudes towards organisational involvement, the role of NHS managers, making change and being a leader were explored. The Fellows were also asked if they had formed any views about junior doctor’s involvement in organisational issues and their ability to show leadership. In terms of altered cognitive capacity, the group

was asked about the key things they had learnt and, in terms of new behaviours, what practices they intended to take forward. The responses were analysed for signs of change and the Fellows were also asked as to whether they felt they had changed in any ways.

All the Fellows reported that as the year progressed they acquired a much broader understanding of the NHS context, recognising how limited their understanding had been at the start. This new understanding included the following: the overall structure of the NHS; the link between primary and secondary care; the way money flows around the system; the roles of the executive board and managers; the role of medical and clinical directors; the way decisions get made and how processes such as clinical governance work. The following quotes from a junior Registrar (Bina) and an experienced GP (Caroline) are provided below to reflect how far knowledge and understanding had altered. Bina describes how limited her understanding was at the start and the insight she developed:

“I’ll be honest with you, I didn’t even know there was a thing called ‘NHS Southlands’, actually getting to know that and then who the people responsible were and how, you know who the overall person responsible, and how it gets fed into the health secretary and governmentbut also to then understand at a local level, the roles of Medical Director, Clinical Director, how that was different, what was expected, what you needed to do, even you know in board meetings. What was the role of the Non-Executive Directors versus Executive Directors and then who had the voting powers and you know very much like, I never really understood that, and that was a big insight into how management works” (Bina, Hospital Fellow)

Likewise Caroline, a GP who had been practising for around five years, describes how limited her understanding of the way in which the overall system worked had been on entry:

“I had such limited understanding of how the NHS worked, how my local healthcare economy worked, things like commissioning, where the money came from, how the money flows, how different organisations, you know the acute Trusts and primary care, how they all come together” (Caroline, GP Fellow)

It is, however, the way in which these new insights impacted on the Fellows attitudes towards the running of organisations and their practice as doctors that is of particular interest. The next sections focus on this, beginning with the new attitudes towards the running of organisations and doctors’ involvement that emerged.

7.2.1 New attitudes towards the management of organisations

In terms of attitudes towards organisations, the medical academy has suggested that doctors must show a sense of corporate responsibility, and that while their first priority is to care for patients “doctors must be conscious of the need for prudent management of limited resources across an entire health service” (Royal College of Physicians, 2005, p.9).

Specific changes in attitudes with regard to use of resources include new attitudes towards the financing of the NHS. Two Fellows (Dev and James) expressed that they had much greater concern with financial probity as a result of their experience. By the end of the year Dev felt that it was important to put forward robust business cases and monitor the effects of actions:

“One thing I’ve come across and realise is, we have a financially restrictive scenario, okay, and to justify how we use every penny of the tax payers money, which is yours and mine, we all pay it, everyone else’ does, we need to have a very good case.....let’s do it properly and doing it properly means ensuring there’s sound, economic sense to it” (Dev, Hospital Fellow)

Dev recognised that that this way of thinking was “alien to my lot,” that is to say his medical peers within cardiac intensive care. He believed that the senior managers within his Trust had come to see him as “someone who thinks a bit differently”. For instance, he had been influenced by learning about clinical governance and suggested that he would in his new role, as a consultant on the cardiac high dependency unit, ask questions to ensure that a process was in place:

“I enjoyed learning about governance...I gained a much better idea of thisto ask that question ...have we got a process that manages this, that runs this ethically, proactively, efficiently, tax payer money justifiably and all the rest of it, and I wouldn’t have asked that question before you see; this made me think in that way” (Dev, Hospital Fellow)

Like Dev, James related that “my understanding of the NHS now is completely different to when I started”. He had come to recognise the need for the NHS to save money and of the need for changes such as the closure of units:

“I do think I understand things and recently I was driving down ‘Newton Road’ and there was a march about the ‘Mornington’ A&E closing and I was able to argue on the side of the managers why the A&E department should close, and that’s not something I would ever have done before. So I’ve completely shifted....I’m more okay with the idea of an A&E department closing because I think if you need to save money, the options I see it are you either save money or the NHS doesn’t work and it doesn’t provide the service that it needs to and it simply has to become private, which for mental health services would be a disaster” (James, Hospital Fellow)

James also reported that his new way of thinking was very different to many of his peers, such that he had “had difficulties with some of my friends who are other medics who work in the NHS who’ve said, ‘why’s your opinion so different now?’” He suggested that when it came to saving money “then we’re reasonable people to try and save money from.” He felt that cuts should be across the board, including management, but that it was obvious that this was happening and as a result “you become more okay about things happening to you.”

Three other Fellows had come to recognise that costs need to be reduced and that there was great concern within organisations about the need to save money (Mark, Bina and Ella). Mark, a GP Fellow, recognised this was an issue if all of policymakers’ plans were to be achieved:

“...If I were running the country I guess I would want the best health provision for all, but if we are also going to do all these other things like fight wars then we have to reduce costs somewhere and how much we should be paid is an issue” (Mark, GP Fellow)

Mark felt there is a genuine question as to how much GPs are paid, in terms of whether some are overpaid for what they do. He had, however, also become a little more cynical over the course of the year about doctors’ involvement in organisational issues, having “learnt that they are trying to engage doctors to do some of the dirty work.” He suggested, for example, that when reviewing whether A&Es should stay open it was easier for doctors to say that they should close than managers, as doctors had more public credibility. Harrison and Smith (2003) have noted how the individual relationship doctors have with patients can actually enable them to present resource based issues in ways which are acceptable to patients.

While Ella had started the year feeling concerned that doctors' autonomy was under threat, and having some concern about the greater standardisation within medicine, she ended it recognising that efficiency within the system made sense:

“you know we get annoyed when people say you can't do this and you can't do that, when actually it makes sense to be efficient as well as, as well as good” (Ella, Hospital Fellow)

Recognition of the importance of targets and measures was reported by six Fellows (James, Nina, Bina, Lisa, Dev, Mike). However, there were signs of some disagreement with the measures used or being introduced. For example, Bina suggested that she now recognised that the Trust was paid on the basis of meeting certain targets and therefore they were of importance. However, whilst she felt that they were useful in terms of making people want to do better, she also felt that some were not the best way to judge performance:

“I know that the targets are there for a reason, and like I said, I appreciate that a lot more, because from their perspective of you know, how your hospital or Trust then gets rated, generally. I mean obviously I don't think necessarily that that's the right way of showing that. However, it's a way for people to actually compare, or at least make people want to do better. So in some ways I can see it working, but then on the other hand, yes targets are very difficult” (Bina, Hospital Fellow)

Likewise, while James now felt that he understood and could see the point of some targets more, he still felt that “quite often they're not joined up.” This conclusion was due to the fact that the commissioners of mental health services had set a target for putting all patients into a cluster by a certain date, for purposes of introducing payment by results. However, this was unrealistic as no-one had been trained in the tool that would enable them to do so, because the Royal College of Psychiatrists, who would be delivering the training, had only just developed the training programme. Overall, mixed feelings were displayed about targets and performance measures. This might imply that the Fellows did not fully accept the need for them, or reflect a genuine need for greater coordination and collaboration amongst the various parties affected and involved.

Other new attitudes towards the running of organisations which emerged which were in line with the whole systems approach underpinning the educational programme. Nine Fellows had projects which straddled organisational boundaries. Six (Amanda, Bina, Caroline, James, Majid

and Zoe) had projects which straddled primary and secondary care and three (Dev, Lucy and Mike) had projects which straddled more than one hospital site. By the end of the year four Fellows (Bina, Dev, Caroline and Majid) had come to the view that there needs to be greater co-operation across boundaries and less competition between different areas of the NHS. For example, Bina suggested that there was a sense of reinventing the wheel on some issues, citing the fact that every Trust was developing its own set of flu guidelines. She used the network of Fellows to access what other Trusts were doing and felt that this sort of sharing of knowledge needed to be more widespread. Dev felt that there was an existing element of competition between primary and secondary care, as a result of the allocation of money, which hampered patient flow through the system:

“I think the other important thing I think is that it shouldn't be seen as a competition, that here's the primary care money. This competitiveness is a huge barrier.....the word vertical integration is used a lot but what I mean is they're all part of the same organisation, so no-one's competing for that interest, it's all part of the same process.... it's [the barrier] been put there. Medical people didn't put it there, government put it there. And if we take that away, patient flow will just improve” (Dev, Hospital Fellow)

Similarly, Majid who was working across the PCT and hospital found that everyone tended to come with their own agenda, related to their own part of the system and that not having overt alliances or loyalties allowed him to have more frank and open discussions, “which is not what you see when all those stakeholders get together.” For Majid and others (Louis, Caroline, Ella, Lisa, Mike, Dev, Zoe and Mark) this adherence to individual agendas meant that there was a lot of time spent negotiating in order to firstly find some common viewpoint. Several other Fellows also reported the need for such negotiation.

Overall, ten Fellows (Lisa, Dev, Caroline, James, Ella, Bina, Majid, Mark, Nina and Mike) showed some signs of a shift in attitudes, in terms of having empathy with the need for effective management of NHS organizations, in one or more of the ways discussed: the need for financial probity and efficient use of resources; the need for a certain amount of targets and the need for less competition and a whole systems approach. The next section looks at the attitudes towards medical leadership which emerged.

7.2.2 New attitudes towards medical leadership

Medical leadership, according to the Royal College of Physicians (2005), includes not only showing a sense of corporate responsibility, or concern for the system of care, but also a willingness to work in partnership with other professionals, particularly general managers. In terms of attitudes towards this, by the end of the year eleven Fellows (Caroline, Amanda, Will, Nina, Dev, Louis, Majid, Lisa, Ella, Zoe and Mike) related that all doctors need to have a wider understanding of the system that they work in and some exposure to management. For Caroline, such understanding made her work more interesting and meant that she was also able to explain decisions to patients in a more informed way:

“I think every doctor should have an understanding of the system they work in, because I think that’s really important to understand that, because it does affect the way you work clinically, and it should. I think down to rationing decisions - you have to have that understanding or else you don’t understand why you’re doing things. So when NICE guidelines say that you can’t, that you should not be giving this drug, you should be giving this drug, because it’s too expensive, you have to have an understanding of where that comes from, or it’s very difficult otherwise, with that patient sitting in front of you, to say no you can’t have that” (Zoe, Hospital Fellow)

Caroline demonstrates having shifted from an individualistic attitude, concerned purely with her own set of patients (Freidson, 1970) to having the wider understanding of the system that the medical academy advocates. Nina also suggested that to be a better doctor, one needs to understand their own behaviour, in terms of how they interact with others, and also the context in which they work:

“To be a better consultant you need to understand yourself and understand how your team works, but also understand the wider context that you work in” (Nina, Hospital Fellow)

Two Fellows, (Bina and Will) saw the value in having medically qualified people heading up a Trust. Bina felt that her Trust ran well because it had a medically qualified CEO and a medical director who maintained a high level of clinical involvement. She felt that having this kind of medical input was what made the difference. Will also felt that having a deputy CEO who was medically qualified was beneficial for a Trust in a number of ways:

“when you have a system where you’ve got a clinician who is a [deputy] Chief Executive of a trust, a clinician whose a very powerful clinician, both in a management field....but also in research - his research pedigree is outstanding, clinically he’s still active, he’s still working - then that really holds sway with a lot of his consultant colleagues, even the really senior ones. I mean, he’s not crossed, and that’s important, not only for getting engagement if you like, it’s important for the trust as well, because the trust can achieve its objectives by having somebody who’s essentially a doctor in a senior management role”(Will, Hospital Fellow)

Seven Fellows (Lisa, Caroline, Mike, Amanda, James, Louis and Bina) felt that all doctors needed to have an understanding of the wider system, but that this was not the same as all doctors needing to be leaders, either in the formal sense of taking on CEO, clinical or medical director roles, or being continuously involved with organisational issues. In fact one, Louis, expressed some concern that the emphasis on doctors taking on management and leadership might lead to the link with improving patient care being lost, which he felt was the main purpose of their involvement:

“One of the things that has sort of struck me recently is doctors sort of involvement in leadership and management and the purpose of it and I think sometimes it’s easy to forget that you are actually doing it for the purpose of improving patient care, and I think there is a danger with so much emphasis on doctors being involved in management and leadership, to be focused on doing that, doing the leadership and management, but then ...that link is lost between that and quality improvement of patient care. I think that could so easily happen and if that happens then it sort of defeats the whole purpose” (Louis, Hospital Fellow)

The aforementioned seven Fellows all showed signs of having re-shaped their thinking as to what leadership was about over the course of the year, as the following quote from Lucy highlights:

“I think I now understand the difference between a leader and a rep. Before I thought of it as a junior doctors rep, who collects different opinions from people and goes back and forth but now I see that a leader has to understand the bigger picture, to present that and get people engaged” (Lucy, Hospital Fellow)

Likewise Amanda, who had started the year thinking that leadership meant “dominating” situations and people, came to see that this was “erroneous,” while Bina had come to the view espoused by some noted writers (Bennis, 2006; Yukl, 2009) that leadership is not a purely top

down activity as she had originally perceived.

In terms of leadership across the various levels of the hierarchy, consultants were viewed as needing to work with managers on service development, to identify problems and solutions and help implement these. Leadership in this situation was seen as putting forward the clinical perspective, influencing colleagues and getting them on board with ideas (Caroline, Mark, Lisa, Lucy, Dev, Zoe) as Zoe highlights:

“in my mind a clinical leader would be getting involved in a team of people and putting the clinical perspective forward and helping that go forward” (Zoe, Hospital Fellow)

For Mark, this involved “making people feel uncomfortable to an extent and...having to see things through.” For Dev, it was about motivating and empowering others. He describes this in relation to a doctor starting with him as a consultant at the end of his Fellowship year:

“...to get her to be inspired to move to the next level, that will be such a major lift, and for me that’s the leadership” (Dev, Hospital Fellow)

The overall view emerging was that medical leadership is fundamentally about doctors being proactive, in terms of standing up for what they believe is right, not ignoring bad practice or things that are not working, and acting as a role model. Bina sums this up:

I think clinical leadership is about standing up and it doesn’t matter which level you are at...if you feel that something’s not working you should actually be brave enough to say right, I think there’s something wrong here and to take that step or at least make someone aware that this is not working, and I think that’s very much what clinical leadership is about. I think a lot of time people think that *but* they don’t know how to go about it” (Bina, Hospital Fellow)

Lisa gave an example of how this might be enacted in practice:

“a nurse on a ward may tell a doctor that one of their colleagues was being rude to patients and that the doctor could do something about it, which would be showing leadership, or they could ignore, and whether you do, that’s leadership. It’s not being medical director, but it is setting an example, doing the right thing, improving the working life” (Lisa, Hospital Fellow)

However, Lisa raised the issue that it would be difficult for others to know whether a doctor is demonstrating leadership on all occasions where they might. She suggested that in the type of case cited above, only the nurse was likely to know whether the doctor had done something about what s/he had told them, and that the medical culture may prevent doctors from taking a stance:

“the braver way is to stand up and do something, but you can’t fight them all. If it’s your consultant you need a reference from, sometimes discretion is the better part of valour. You can’t be pigeon holed as a trouble-maker” (Lisa, Hospital Fellow)

Lisa’s view reinforces the idea that medicine is a hierarchical profession in which juniors take a lead from their consultants and senior doctors, whether their behaviour is worthy of emulation or not (Sinclair, 1997). Four Fellows (Nina, Ella, James, Zoe) suggested some ways in which junior doctors could begin to show leadership, such as by doing audits more and taking the results forward, rather than seeing them as a tick box exercise and looking at whether best practice was being implemented. Ella felt that many junior doctors are “very disengaged....from the actual business of running a hospital.” She felt that all doctors should attend briefing meetings of the sort run by her clinical director, as these generated a better understanding of why decisions were taken and more of a team spirit towards addressing issues. However, Ella and others highlighted issues which they felt needed to change if more juniors were to get involved in organisational issues which the next section moves on to consider.

7.2.2.3 Views on the factors affecting doctors’ involvement in management

Six Fellows (Bina, Ella, James, Majid, Mike, Will) felt that a different type of medical training is needed if doctors are to get more involved in organisational issues. Ella felt that doctors needed more practical examples of what they could be doing to show leadership. Similarly, Lisa felt that medical leadership needed to be more clearly defined. She felt that few junior doctors understand what is expected of them, yet leadership is being portrayed as the “the answer to everything.” Lisa was concerned that many doctors are put off being involved in organisational issues because they associate leadership purely with having a formal role and that “actually the message that I think needs to come out is that we need more step-wise, in the middle ground.”

Lisa supported the idea of formalising leadership requirements, suggesting that if doctors are to work in a new way this needs to be assessed. Bina felt that more training on the system is needed at undergraduate level, so that doctors develop this understanding at an earlier stage. She felt that this would help them know who to go to and how to approach them if there were issues they wanted to raise. Others felt that the postgraduate stage is when this starts to make more sense. For instance, James wanted to see an end to the short, four or five day courses that Registrars go on prior to applying for consultant posts, in favour of more substantial interventions involving management projects. He felt these have much greater impact and more meaning for doctors. James view was based on the fact that he saw a shift in Registrars attitudes towards management amongst those participating in the mini-Fellowship he had developed. Likewise, Majid felt that the short management courses contained nothing practical and resulted in limited change. Four other Fellows (Lisa, Zoe, Mark and Lucy) felt that the structure of clinical rotations and doctors continual movement during their specialist training make it hard to get involved in implementing change without taking specific time out of their training programme.

Greater support for involvement in organisational issues was felt to be needed at consultant level by six Fellows (Lisa, Louis, Lucy, Ella, Mike and Will) if junior doctors are to become more widely engaged. Lisa felt that if the consultant did not show leadership or any interest in organisational issues then Registrars and other juniors were unlikely to. Likewise, Louis felt that trainees would become disillusioned if consultants did not show their support and that a cultural change was needed at consultant level:

“I think first of all there needs to be more sort of organisation wide in terms of doctors and consultants thinking this is important. If the consultants are not saying it or not showing their support of it then trainees lose their enthusiasm...Whilst it's important for the development to come from the bottom, from trainees and even medical students and so on, I think in the short to medium terms there needs to be probably more work on getting consultants on board, because I think that there needs to be a huge change in culture in terms of how consultants feel about the importance of trainees involvement...” (Louis, Hospital Fellow)

Others supported this view. For example, Mike felt that there is “still certainly a taboo to be overcome” amongst established consultants with regard to juniors being involved in and Ella suggested that “it's going to have to wait for a new batch to slowly come in.”

Interestingly Lucy, who at the start of the programme had felt that anyone who wanted to get involved could do so, became a little more sceptical over the course of the year, believing that wider support at a local level was needed:

“I think that there has to be the right atmosphere within the organisation for it to happen. There needs to be leaders who promote it, who will be a source of reference and who people can go to with ideas” (Lucy, Hospital Fellow)

This view that cultural change is needed reflects that of many commentators, including Lord Darzi (Department of Health, 2008) and is supported by a recent report published by the Kings Fund (2011). Having said this, six Fellows (Mike, Ella, Louis, James, Amanda, Lucy) did report that they had encountered some signs of a shift in attitudes amongst the profession. This was in terms of seeing greater enthusiasm for being involved and learning about management amongst younger consultants and Registrars, as Ella highlights:

“people’s enthusiasm on the whole is ripe, and all of my friends who I’ve spoken to about this year who are doctors as well, are all like really, you know would relish the opportunity for something similar” (Ella, Hospital Fellow)

This supports other recent findings (Griffiths et al, 2010; Levenson et al, 2008) which have suggested signs of a shift in attitudes. The next section moves on to look at new attitudes which emerged towards non-clinical managers.

7.2.3 New attitudes towards non-clinical managers

At the start of the year the Fellows attitudes towards non-clinical managers were explored and whilst these were found to be mixed, eleven of the fifteen showed some concerns about this group, summarised below:

- Four were sceptical as to whether managers were needed in the numbers perceived to be present.
- Three felt that managers did not always consult with doctors, or if they did then they did not take account of their views when taking decisions.
- One had heard that managers would call new consultants into meetings and were able to outmaneuver them.

- Four perceived that non-clinical managers would have different aims, being less interested in patient care than doctors.
- Three felt that managers did not understand how clinical care operates as well as doctors do.

Despite this scepticism, six Fellows on entry felt that doctors need to be integrated with managers and take some responsibility for getting involved in decision making.

By the end of the year, in terms of scepticism towards the numbers of managers in the system, the four who perceived this had altered their views. Bina had moved from a view that there were more managers than professionals on the shop, stating that “I don’t think there’s any surplus of managers within the Trust”. Majid and Mike felt that they had come to understand the roles of the various managers much better, although Mike still perceived that there was a large group of people involved in management. James now understood the different roles better. However, he felt that if cuts were to be made “yes they should be doing it in management,” although he also felt that it was fair to target doctors with cuts too.

In terms of the view that managers do not consult with doctors or take their views on board, eight Fellows (Bina, Dev, Will, Majid, Amanda, Lisa, Lucy, James) came to feel that their senior management teams were open to feedback from doctors, as this quote from Lucy demonstrates:

“within my hospital there is very strong leadership at the top, but, in the Chief executive I mean, she seems pretty open to getting feedback from other people and there’s a very good structure there already” (Lucy, Hospital Fellow)

Bina described how her CEO had two half days a month, where anyone could go to see her about anything. She frequently went to the wards unannounced to talk to staff and patients and sent regular emails communicating what was happening. In Caroline’s case she felt that some senior managers were open to consulting with doctors, such as the CEO of the Primary Based Commissioning Group with whom she did most of her work who was “a great believer in clinical leadership,” whereas others at PCT level were less open to it.

It has to be stated that the Fellows did not all interact to the same level with their executive team. In some cases, the medical director or supervisor was the Fellow's main point of contact (Mike, Ella, Louis, Zoe, and Mark). In one case (Nina) interaction was predominantly with specific business managers. Both Nina and Mike felt that their being in place as a Fellow opened up the managers' eyes to what clinical involvement could do for them. Mike highlights this:

“the feedback I've had from middle managers, I think I've been somewhat successful in starting to get out and start to encourage and open the eyes of other Registrars to what management can do for them. I think it's on the reverse as well, the managers sort of realise how useful it is to have doctors, registrars or whatever and clinical engagement” (Mike, Hospital Fellow)

Three Fellows (Zoe, Lisa and Lucy), however, felt that some departmental level managers could do more to relate to doctors and their ideas. Zoe related that while her general manager said that he was very open to Registrars coming to him with ideas he did not seem to understand that the reason no-one did was probably because they did not know who he was, or how to go about it:

“Like the general manager here says, well if a Registrar came to me and said this, this and this then I'd think about it. I'd love them to get involved, but nobody has he says, so they're obviously not interested. Whereas, maybe if you asked the Registrars they might not even know who he was, or how to go about it” (Zoe, Hospital Fellow)

Zoe implied that there was a gap in the understanding this manager had with regard to their own profile within the wider system. Lucy also felt that more needed to be done to get business managers at departmental level to interact more with doctors, but that they had a difficult job. Lisa suggested that the calibre of middle managers was more mixed than the calibre of senior managers, who she felt were very open to feedback in her Trust. She suggested that while there was a lot of emphasis on doctors understanding the managers' role and perspective it was rather one-sided at present. She felt that middle managers tend not to want to invest time in getting to know junior doctors, as they rotate so frequently:

“I think there are also managers that don’t meet us half-way, and certainly from a junior doctor perspective, the managers don’t make any effort because there’s no point, because the doctors are moving on quite soon, so why invest in the relationship, and because they don’t do that, the junior doctors get quite disaffected, and therefore it sort of cycles. So there’s a lot of emphasis on doctors learning about management, learning about leadership, learning the other side, there’s no emphasis on managers spending more time on the wards, understanding the perspective of the junior doctor” (Lisa, Hospital Fellow)

By the end of the year, two of the four Fellows (Bina and Mike) who initially felt that managers do not always listen to doctors had come to the view that they are open to medical input. Additionally, having had virtually no prior exposure to executive managers, eight Fellows now felt that this particular group of managers was very open to ideas.

In terms of the view initially held by four Fellows (Majid, Lisa, Amanda and Louis), that managers would have different aims and not be as interested in patient care as they were, by the end of the year they felt that managers’ aims were not that different to those of doctors, they just approach things from a different perspective. Edwards et al (2003) have argued that this different perspective is needed to make the system work, and that there should be no pretence that doctors and managers think alike. The findings here suggest that these Fellows came to recognise that the two sides were broadly interested in the same thing. Louis still had some concerns about the fact that managers are removed from clinical work and so can lose sight of the patient, although he ultimately concluded that the two groups probably had more in common than they thought:

“sometimes when you are working with management they can become too sort of management focused and sort of lose the focus on what’s best for the patient. Having said that, I think now that I have done this year I think it’s, it’s not that doctors and managers always have different goals and different aims and perspectives, it’s just that they’re coming from different angles, but they probably have more in common than they think, but there is an issue about language” (Louis, Hospital Fellow)

Louis felt that it took time for doctors to acquire the management language and to be able to start to understand the managers’ perspective and that while he now had he could also see why tensions between doctors and managers arose:

“you do start to see things differently actually, and when clinicians react or make certain comments about various management projects or management approaches you do realise why they’re seeing that actually, because you have a better understanding of the other side and actually you start to realise well I can see why they say that, but actually that’s not quite right, but I know where the problem lies” (Louis Hospital Fellow)

In terms of the view that managers do not understanding the way that clinical care operates as well as doctors, five Fellows (Caroline, Lucy, James, Mike and Ella) came to feel that managers bring valuable skills which doctors’ lack. They saw this as being useful in freeing up time for clinical work and enabling things to happen, as Mike highlights:

“...managers are experts in their field. They’ve had the undergraduate or postgraduate training in order for them to manage...it’s not an easy job, there are ways of doing it correctly and making it a lot more efficient and successful, so they are required. To abandon them all and say that clinicians should do it I think’s naive, and we know that hasn’t worked in the past. To expect, for clinicians to expect managers to completely come on board into clinical understanding is also naive” (Mike, Hospital Registrar)

At the start of the year six Fellows (Lucy, Amanda, Lisa, Will, Nina and Majid) had expressed a view that consultants needed to be integrated with managers to deliver a good service. The year essentially just strengthened this view, with eight others (Mike, Dev, Louis, James, Caroline, Zoe, Ella and Bina) expressing this by the end. Only Mark did not specifically express this, but he had come into the year feeling that it was “just different people, different jobs” and continued to see no need for a ‘them and us’ scenario throughout. The next section looks at the new attitudes that emerged towards working with a wider group of health professionals and patients.

7.2.4 New attitudes to working with other health professionals and patients

During the Fellowship five Fellows (Dev, Will, James, Nina and Majid) had projects which involved working with service users. Both Dev and Majid had already shown interest in working differently with this group. In fact, Majid had come into the Fellowship particularly to be involved in the community aspect of his project, which involved working with nurses, patients, local network groups and service users. James also had a potential interest in setting up a liaison service in the future, which involves staff and service users. However, Will had

little prior experience or thought of this. As a result of their experiences during the Fellowship, these five Fellows all became very interested in utilising ideas of co-production further. For example, Will came to see how valuable it was to seek and incorporate relatives' views when trying to improve family satisfaction for relatives of long stay patient in a high dependency unit. Dev was thinking about how he could use co-produce with his staff and relatives on the cardiac intensive care unit were he had been appointed as consultant, even though patients were likely to be too sick to be involved in decisions or organisational design:

“I'd use it in my job as a cardiothoracic-intensivist. How do I co-create, what I am doing with my patients? Do you see what I'm saying? It's just not feasible at that stage, but I can co-create with my staff, I can co-design with my relatives, I can take a different intervention. I can use that principle in so many different ways” (Dev, Hospital Fellow)

Nina really enjoyed working with the Local Improvement Network Groups (LINKS) and service users and put practice ideas of co-production into practice:

“I think that was kind of the bit that I enjoyed the most. Particularly, I mean I went out to user groups and to some of the LINKS, the local involvement networks, and I really enjoyed that. I mean for a start people were saying to me, this is a really new way of working with the Trust because nobody's ever come out like this before. When we've been asked to consult on something it's usually been sent as an email, and presented to us and give us your comments back, thank you very much. So they kind of you know, somebody actually taking the time to come and see them and say, how would you like to consult, not here's the document, tell us what you think. They really, they found that very refreshing and you know positive sort of sign from the organisation” (Nina, Hospital Fellow)

Nina felt that working in this way fitted with the community aspects, which she had always enjoyed most out of her clinical placements. Majid also went out to local LINKS meetings and spoke to patient groups in the community about diabetes, which according to minutes available on the internet were well received, and is known to be continuing to maintain links with the community since becoming a consultant. James also took the opportunity to involve service users in selecting a company to gather information about patient satisfaction in mental health and developing a pilot questionnaire. A written report by the Assistant Director of Governance and Assurance suggested that he had taken his project forward by doing so:

“James has ...personally driven forward the work to implement systematic capture of and learning from service users’ experience, ensuring buy-in from clinical staff and service users” (‘Marie’, Assistant Director of Governance and Assurance)

In addition, by the end of the year four other Fellows (Zoe, Mike, Lucy and Ella,) who had not had the chance to involve patients in their projects, expressed that they could see the benefits of co-producing services. For example, Zoe felt that the idea fitted well with respiratory medicine:

“I liked co-production ideas, partly because it sits quite well in respiratory medicine, as in it’s a lot of chronic disease, and I think I’d think along those terms in the future, especially making sure everyone’s involved in designing or suggesting how things are done” (Zoe, Hospital Fellow)

In terms of working with other professionals, all the Fellows worked with non-medical staff. While four Fellows (Mark, Nina, James and Lucy) worked predominantly with medical professionals from their own speciality, eleven had the opportunity to work with medical and health professionals that they did not normally encounter. Five of these (Lisa, Louis, Bina, Ella and Dev) reported that this was a particularly valuable experience and that they came to see the benefits of collaborating with a wider group of professionals. For example Lisa, describes how after one of the communities of practice which talked about the sustainability of change she approached the A&E nurses with regard to developing a protocol for neutropenic sepsis in that area. She found it illuminating that they came up with far better ideas than she would have done and realised that she did not have to be the one who came up with all the ideas. This attitudinal change was one of the main ways in which Lisa felt that she had changed:

“It’s not a specific skill, it’s the interpersonal or the, it’s more attitudinal. It’s more about just having a much better awareness that I don’t just have to go off and do it myself, and it will be far better in fact if I can spend more time getting other people to, you know, really come up with these things themselves, and having it far more along the co-production lines than Lisa’s newest idea that I’m just trying to ram home, which might not be the best thing” (Lisa, Hospital Fellow)

Similarly, Louis recognised how valuable it was to include all members of a team. He suggested that having the opportunity to do so opened his eyes to the need to proactively involve all professionals involved in an issue:

“..actually it makes you realise that other members of the team, they do have important things to contribute but you need to give them the opportunity to do that and you need to be open to that and you know, I think this year has opened up my mind a bit in terms of being more receptive to, you know, other people’s views and trying to, you should proactively seek that. It’s given me the opportunity to work with many different groups of people that I had never encountered, never thought of working with, and actually showed me that if you want to get things done in a service or a hospital or a department actually it is essential to involve all these people, and I think a lot of junior consultants sometime struggle to get things done and they haven’t had the sort of extra experience that I’ve had in this year and I think that will be very useful for me when I become a consultant, to make changes to services, to improve services” (Louis, Hospital Fellow)

For Louis, working with a wider group of professionals was one of the most beneficial aspects of the year and made him realise that it was essential to involve a wider group of professionals as a consultant when he came to try and improve services. Different professional groups have been noted to work “in parallel” (Lewin and Reeves, 2011, p. 1599) rather than as a cohesive group. This has been observed previously to restrict learning (Currie and Suhomlinova, 2006) and the spread of innovation (Ferlie et al, 2005). Like Louis, Ella came to recognise how narrow a range of perspectives she had included at the start of her projects, and how directive as opposed to consultative her approach had been:

“when I did my temperature reading at the start of the year David critiqued it for me and I remember being a bit disgruntled by it, and then actually reading it now...it makes massive sense to me.....He said, interesting you’ve said multiple perspectives, yet you haven’t asked X, Y and Z, and of course now I am, but at the beginning it had been not even on my radar, and also I talked about engaging people by telling them what things were like and what they could be, rather than working with people” (Ella, Hospital Fellow)

Dev also recognised that he did not necessarily have to agree with everyone he worked with but that there was a benefit from including different perspectives in discussions. This was a change for him as he had always tried to avoid conflict:

“What I have learned is there are people who I don’t necessarily have to get along with, but actually, you get another viewpoint on this, another angle, and I really value it, really value it. Don’t get me wrong, those figures can be quite destructive otherwise. However, for me, if people are really noisy and they’ve really got a bee in their bonnet about something, let’s use the energy” (Dev, Hospital Fellow)

Bina came to see that working across structural boundaries with primary care contacts was very valuable, and to feel that all her hospital peers should have some exposure to primary care, and vice versa.

Overall, eight Fellows (Dev, James, Nina, Majid, Will, Zoe, Lucy and Mike) related that they had come to recognise the value of including service users in initiatives to improve services, while five (Louis, Bina, Lisa, Dev and Ella) had come to value collaborating with a wider group of health professionals. In addition to this, three others (Amanda, Will and Caroline) related that working with Fellows from across a number of specialities, and being able to draw on their knowledge and perspectives, was one of the most beneficial aspects of the year. In summary, having the opportunity to work with a wider group of professionals than they normal would, and in new ways with patients and other service users, was illuminating for the Fellows and something they perceived as beneficial. The next section moves on to look at alterations in the Fellows sense of self.

7.2.5 Alterations in the Fellows sense of self

According to Nicholson and West (1988) job changing managers reported more changes in what they termed personality, defined as ‘what sort of person I am’ than they reported changes in attitudes. They asked managers the following question: ‘do you think that adjusting to your new job has changed you in any way? The Fellows were asked whether they felt they had changed at all, and if so, how. Five (Amanda, Bina, Nina, Dev and Zoe) reported changes in levels of confidence. Three of these (Nina, Zoe and Dev) along with three others (Ella, Mark and Lisa) also reported increased insight into their own selves.

In terms of increases in confidence, change was largely in relation to ability to lead and contribute to discussions. For example, on entry to the Fellowship Amanda had felt that there was no way she could possibly be a leader. By the end of the year she came to feel that there was no reason that she could not be, and that she had the new perspective on her career she had sought. She said, jokingly, that “I will now come forward and say that I am brilliant” and that the role of Darzi Fellow had been “potentially the job of a lifetime.” This change in Amanda was supported by another Fellow, Mark, who commented on how much she

appeared to have grown during the year. Towards the end of the Fellowship year she obtained a consultant post, and so had the role she had hoped for in order to put her new found skills and confidence into effect.

Both Nina and Zoe reported feeling more confident and having become more assertive in terms of voicing their opinions, particularly with senior colleagues. Ella was pleased, for example, that during the year she had managed to stop her clinical director introducing her at a big meeting and had introduced herself. She related that she had also come to recognise that senior people and experts were “just people”, and that as she grew her own network she actually knew experts who sat on committees. Zoe now felt that she had more experience than many new consultants when it came to implementing change, and therefore had a right to be involved:

“I think I always thought it was important to get involved, but I think I definitely have more confidence to do that now, because people can't say any longer well you don't know what you're talking about, coz you've had at least some experience, that's a lot more than some consultants when they start, about doing this kind of project work” (Zoe, Hospital Fellow)

Nina also felt that her confidence had developed and that she become more assertive. She attributed this to having to ask for what she needed in relation to the projects:

“I see a difference in myself and it's been noticed by other people. I think the biggest area is being able to reflect....on what you do for other peopleshow you can draw on your strengths and work to your potential and those kind of things, that's been probably the biggest development and also, I think the other thing is about assertiveness and before this year I was very much a follower....I was happy to go along with what was happening and just do things, whereas I've noticed now that I will just challenge more. I will sort of be a bit more assertive, and I don't mean aggressive or critical, it's just actually about being more direct and initiating things and not shrinking back.....and actually feeling more confident about becoming a consultant” (Nina, Hospital Fellow)

Dev reported an increase in confidence to say when he had got something wrong and felt that this was very important in order to develop a culture where people felt able to act. Bina felt that she had regained the confidence she had lost in her previous role, where she had felt bullied whilst pregnant by her consultant and fellow Registrars. She left the Fellowship feeling like a different person:

“Like I said my confidence was shattered.....but now I’ve come out a completely different person, so perhaps it was a good thing for me in hindsight because perhaps had I not felt that way, perhaps I wouldn’t have gone for this Fellowship. I no longer see that it’s all about prejudice or racism, it’s all about, you know we all work together.... You can achieve it, and I think that’s the biggest thing I’ve learnt, that it can be achieved” (Bina, Hospital Fellow)

Bina left the Fellowship feeling that she was working in a city where even as an ethnic minority woman anything was possible and was considering changing specialities. Cardiology was her first love but she had missed out on a training place during the shift to the online ‘medical training application scheme’ (MTAS) process.

In terms of self-insights, Nina came to recognise that there were times when she had been stressed but had ignored this, not wanting to look like she was not coping. She related that she had learnt from this experience and that the coaching had been particularly helpful in helping her recognise her own reactions. Likewise, Zoe found the coaching helpful, and through it had come to recognise that she had a tendency to think negatively about things, which affected her ability to influence others:

“I’d say I’ve noticed that I tend to look on the negative side of things very easily, so one of the ways that I think I’ve changed is to try and think of the positive outcomes first” (Zoe, Hospital Fellow)

This was an interesting insight on Zoe’s part as during the interview she appeared slightly disillusioned about the responses she had encountered from stakeholders in her projects and her ability to make progress. Another Fellow, Mike, also commented that his impression was that she had not had a very good time. Both Ella and Caroline, through understanding their Myers Briggs Type Indicator (MBTI), that is to say their personality profile, recognised that they tended to take difficulties they encountered personally. Dev came to realise that he tended to do things very quickly, without thinking about them, and felt that the time for reflection had been highly beneficial. He felt that he had also learnt how to recognise and deal with personal conflict and was now mentally stronger. Mark came to recognise that he responded to the way in which he was treated by others, suggesting that “when people start to treat you like a leader, you start to act like a leader.” Finally, Lisa came to recognise that she “need[ed] to be around people” rather than to be working alone on things.

In summary, eight Fellows experienced a change in their sense of self, in terms of increased

confidence and/or self-insight. These changes were highly valued and had a significant impact on how they approached their project work, other people and, in the case of Bina and Amanda, how they felt about their career. Having looked at the various changes in the Fellows attitudes the chapter moves on to look at the final stage of the cycle of role transition, the stabilization stage.

7.3 The Stabilization stage

The stabilization stage of the role transition cycle is the fourth and final stage, albeit one which Nicholson and West (1988) found many of the job changing managers they studied did not reach. As stabilization is the stage in which valuable elements of the role begin to be maintained and minor adjustments are made emerging attitudes and behaviours it has implications for the sustainability of any personal change that may have occurred and the transfer of new attitudes and behaviours to the workplace. These are issues that are recognised as being potentially problematic in relation to leadership development (Raelin, 2006; Tyler 2004; Storey and Tate, 2000; Day, 2001). In order to address the issue of whether personal change was sustained four Fellows were interviewed twelve months on from completion of the Fellowship and those findings are discussed later in the chapter, in section 7.3.3. However, all Fellows were asked at the end of the year about any aspects of the role they were maintaining and intended to take forward, how they felt at this point about taking on a leadership role and their career plans, given that they were all approaching another transition, either into a consultant post, a temporary role whilst they found a consultant post or the next placement in their specialist training scheme. The next section looks at these aspects in more detail.

7.3.1 Maintaining aspects of the Fellowship role

At the end of the year two Fellows (Dev and Amanda) took up consultant posts and were keen to remain involved in organisational issues. Amanda picked up the mantle in terms of leading the within Trust Fellowships developed by one of her Darzi peers. She has since taken on a clinical lead role for tuberculosis. Dev took up a consultant post in the cardiac intensive care unit he had helped to set up. He was keen to develop a fully inclusive team environment which included the business manager, and to utilise his newly acquired understanding of the need for

robust governance processes, in terms of finance, quality and safety.

Two qualified GPs, Caroline and Mark, both planned to maintain involvement with their projects. Caroline also took up a clinical lead role for maternity and child health, which was more in line with her interests than urgent care. Mark, who had qualified just before participating in the Fellowship, was continuing to work half a day per week with the PCT on his project to establish a second polyclinic, alongside his fixed term post as a GP in the polyclinic he had helped to establish.

The eight senior Registrars (Nina, Will, Louis, Mike, Ella, Majid, James and Zoe) all returned to their clinical training programme, although Majid took up a consultant post within six months of the Fellowship ending. He had done a lot of work with patients and service users during the Fellowship and appears to be continuing along these lines. For instance, he held a live chat on diabetes on the social networking service 'Twitter' in November 2011 (<http://www.stgeorges.nhs.uk/press273.asp>). The others all left the Fellowship maintaining an interest in establishing training for their peers. Louis was continuing to work on the initiative for Registrars that he had developed within his Trust, and was planning to look for another Fellowship if he could not find a consultant role. Nina planned to continue her involvement with the ELMS project for psychiatrists over the following twelve months. Will and Mike were continuing to work to establish the online LeMA programme, in terms of getting the pilot off the ground and the modules launched on the deanery website. James was also continuing to work one day a week for the Trust he had worked at during the Fellowship, using his 'special interest day' to embed a second cohort of Registrars on the training programme he had established. Alongside this he had been asked, and had agreed, to help establish payment by results in his new Trust.

Beyond this, these eight were looking to finish their training and establish themselves as consultants before they got involved in further change, although Ella and Will felt that they would still try to influence things through work with their professional associations. Ella had three years of sub-speciality training to complete and planned to continue to "look at the bigger picture and to think about how things could work a bit better" and to "speak out a bit more."

In terms of the more junior Registrars, Lucy, a part-timer who was around two thirds of the way through her training, was hoping to be able to get involved in organisational development projects in the hospital where she next worked:

“I’ve got another three years of training to go, but hopefully I can get involved in change projects where I’m working. I would like to do something around patient safety stuff. I will try to take on service design when I get to be a consultant”
(Lucy, Hospital Fellow)

Lisa was moving to a post for two months, prior to going on maternity leave. Despite being very enthusiastic about staying involved with leadership and organisational issues she was concerned that time constraints would render it very difficult to do so. Bina was hoping to assist her colleagues on her return to clinical work, in terms of understanding how the system work, knowing who to go to and how to voice any concerns that they had in relation to organisational issues. The next section looks at orientations towards being a future medical leader.

7.3.2 The Fellows orientations towards being a future leader

At the start of the Fellowship only two of the fifteen Fellows (Lucy and Lisa) expressed interest in being a future leader in the formal sense, as a medical director, with two others (Mike and Louis) being interested in exploring whether a future leadership role might be something they wished to pursue. The other eleven expressed no interest in being a future leader in the formal sense. By the end of the year, both Lucy and Lisa felt that the experience had dampened their enthusiasm for being a medical director. Lucy describes feeling that the role was too far removed and having missed clinical work. However, she was still open to the possibility of being a clinical director at some point:

“I’ve pulled back from that a bit. I have missed the clinical side of things and I’m looking forward to getting involved with patients more again, so I would say my short to medium term aim is to carry on and possibly be a clinical director at some point, maintaining some clinical, but I plan not to be a medical director at this stage” (Lucy, Hospital Fellow)

Likewise, Lisa felt that the medical director role was too removed from clinical work to contemplate at the present time. She felt that the Fellowship experience had enable her to get

a better understanding of the role and that it looked quite isolating, which was something that she was very keen to avoid at this stage:

“I think I might have been put off being Medical Director...it’s so far removed from clinical that it remains to be seen whether that’s something that I want. ...maybe in twenty years’ time I’ll have had enough of clinical, but it is quite isolating. Maybe I’ve got a slightly better understanding of what it’s like at the top, and it does look quite lonely, so we’ll see.” (Lisa, Hospital Fellow)

Lisa did, however, recognise that her thinking may change at a much later stage. She suggested that her medical director would argue that as a consultant you reach a stage where you realise that the role is the way to “make the real difference.” In terms of the two Fellows who were interested in getting some more insight into what a future leadership might be like, Mike felt that it was too far in the future to contemplate a particular role. However, overall he had enjoyed the Fellowship experience and felt that he would like to be involved in some way at a later date:

“No, too far away. Certainly five years in the future it would be nice to be doing some sort of leadership role or management role within the Trust that I’m working but where that would lead to I don’t know, but it wouldn’t be something I would discount” (Mike, Hospital Fellow)

Mike’s primary concern at the end of the year was doing everything he could to get a consultant post. He remarked that he was planning to do a Masters in Immunology, in a bid to “really wow them at interview”. He felt that if he did take on a leadership role in the future that he would like to do an MBA, but that it would be better to do this nearer the time as learning quickly becomes out of date. Likewise, Louis felt that he had enjoyed the role sufficiently to continue to be involved once he got his consultant role and felt that he could contribute in terms of training junior doctors, as this was done in variable ways. While he did not rule out having a formal leadership role of some sort in the future, Louis stated that “first and foremost I’m a clinician.”

In terms of the other eleven Fellows who had expressed no particular interest in being a future leader in the formal sense, none had altered their views by the end of the year. James reported that a couple of his fellow Registrars had assumed that he was headed for being a medical director, but that this was not in his sights. Like Lucy and Lisa, he had also not been

attracted by what he had observed and had no intentions in that direction at this stage:

“...a couple of the other SpRs have said well you’re just gonna be the next Medical Director aren’t you and I’m, what! I have to get a consultant post first. But now I’ve done this, I’ve spoken to a few other Darzi Fellows about this and we’ve all said, similar to what we were saying at the beginning, potentially doing some sort of leadership role within the clinical environment I’m working in, which you have to do as a consultant anyway, but medical director and things like that, it just looks horrible. I get emails from the medical director at ten o’clock at night, three o’clock in the morning, not that I’m checking them at that time....I just think that, that’s just not the life that I want, not yet.....” (James, Hospital Fellow)

James implies that the lifestyle issues he observed to be associated with the medical director role were unattractive, which supports other research that junior doctors are more aware of the negatives of the role than the positives (Giordano, 2010). Like Louis, James expressed that “first and foremost I’m a clinician and I want to do that to begin with.” He was very happy to be back in a clinical role and felt that was where he belonged, although as described previously he had agreed to help implement payment by results in his new Trust and was happy to be involved and help out with management issues.

Mark felt that “the obvious move” for him would be a part-time strategic role at the PCT and a part-time GP role. However, he did not appear particularly committed to this idea and expressed that he had other interests when the fixed term GP post he was about to take up came to an end, particularly a post in tropical medicine. Similarly, while Caroline, an experienced GP, was taking on a clinical lead role for maternity and child health she felt that it was too early to tell how her, or any of the other Fellows, leadership skills would develop:

“I mean, who knows how my clinical leadership skills will be in the future, how many of us will stay involved with that. You know, you won’t know that until 5, 10 years down the line, until we’re consultants or we’re partners or wherever we’re going” (Caroline, GP Fellow)

The remainder of the Fellows (Ella, Zoe, Mike, Majid, Bina, Lucy, Will) expressed a similar view, being keen to contribute to decisions and organisational issues where they could, but having no particular desire at this stage for a formal leadership role. As Ella stated:

“None of us are doing it because we want to rule the world. All of this group have done it because they want to improve things clinically and are still focused on that” (Ella, Hospital Fellow).

There was a belief amongst the group that they needed to establish themselves as consultants before they could start thinking about taking on leadership roles or making any significant change to the way the service ran, as this quote from Zoe highlights this:

“I think because of all the things about medicine and the hierarchy, you have to be very sensitive to that and you have to see how an organisation works and how receptive it is and how’s the best way of getting involved in that place. It’s not what you do this year it’s what you then do the rest of your career” (Zoe, Hospital Fellow)

Overall, there was no real shift in orientation towards being a leader in the formal sense amongst the group of Fellows, other than the two Fellows who had initially expressed interest in being a medical director being deterred from that particular role. Bina expressed a belief that there is “potential in all of us to achieve something,” in terms of becoming a clinical or medical director or even CEO, but felt that irrespective of whether this happened the training had been very useful for preparing them all for being a consultant. The attitude adopted by the group towards leadership at the end of the year was one of being open-minded and cautious.

In fact three Fellows (Caroline, Mike and Bina) expressed concern as to whether they would be able to sustain the new orientation towards organisations that they had developed during the year once they returned to clinical work. For example, while on leaving the Fellowship Caroline felt that “at the moment it feels like I’ve change a lot” she also expressed concern as to whether, when she was back seeing patients every ten minutes in a system in which multiple aspects require change, she would have the time she had enjoyed in the Fellowship to think about how things could be done differently. Mike expressed that he was interested to see how he thinks about doctors and managers working together on organisational issues once back working in an acute speciality. He had come to recognise that there are other people around

who feel that it is important for doctors to be involved in management, but also felt that his views will continue to evolve:

“the exposure that the Fellowship has given me to other medical directors, other chief executives, other people just in ‘NHS Southlands’ and around the deanery, I’m starting to see that there is more and more people who are starting to.... realise how much of an advantage it is to....get the clinicians involved in management, helping managers do the jobs that they want them to do. I’m sure my opinion will change in another year’s time and change again in a year’s time after that” (Mike, Hospital Fellow)

For Bina the concerns were more personal, in that she had experienced a difficult year before entering the Fellowship and hoped that she could retain the confidence she had regained and new outlook she had developed, “and not go back to where I felt last year.” It was for the above reasons, to assess the sustainability of change once back in clinical work, that four Fellows were followed up twelve months on from completion of the Fellowship, to ascertain whether the new attitudes and orientations established during the year were being maintained. The next section looks at these findings.

7.3.3 Attitudes and orientations in the longer term

Four Fellows were interviewed for a third time, twelve months on from completion of the Fellowship (Dev, Louis, Ella and Nina). Of these, one was known to be moving into a consultant post (Dev) and one was due to take up a consultant post (Louis), whilst the other two (Ella and Nina) were returning to their specialist training.

These interviews found that Dev had taken up a consultant post in the cardiac intensive care unit he had helped to establish, along with two leadership roles; one for research and one for education. He related that this was at the encouragement of his peers, and that he seemed to be taking on more than other Fellows who had moved into consultant roles:

“It seems I’m unusual, but six months in and I was the lead for education and the lead for research. I was asked to be the lead for clinical governance. It was assumed because I had done the Darzi Fellowship that I would be the best one to do it, but I haven’t taken that on. I would love to do it in the future but it needs a watertight process, planning process, it links with a broad range of people and you need a lot of support. But I have taken on education and research. I’m either

brave or an idiot, but no-one else was either qualified for this or willing” (Dev, Hospital Fellow)

In addition, Dev had been made chair of safety in the intensive care unit. This had involved forming a committee and he reported that he had “invited people who are not the most obvious” in order to get a range of perspectives, suggesting that he was continuing to work according to the principles of whole system working which had underpinned the Fellowship. Dev had also offered a new allergy service at one of the more rurally located hospitals within his Trust, in order to improve the service offered patients:

“I’ve offered an allergy service to them out there, in my non-ICU weeks, free of charge, so that patients can stop going all the way in. I said it’s good for me, it’s good for you and it’s good for the patients. When I started they had a waiting list of 8-10 weeks and I’ve got that down to 10 days, all by myself, which is a great result. I’m looking to set up allergy testing and I’ve organised the nurse training for that, ‘cos the one thing people are worried about is reactions, but I’m ICU and respiratory trained so I said would get them trained and then we can do them when I am around. All it has cost them is 400 quid and that’s for the kit.” (Dev, Hospital Fellow)

Whilst developing the service he offered Dev reported that he had “recognised the importance of recruitment, getting that right” in order that “some of it will start to run itself.” Beyond all of this he had concentrated on establishing himself clinically and had not been particularly involved with the senior managers, but was beginning to think that he needed to re-establish contact. During the Fellowship year he had established very good relationships but now relayed that staff in the out patients department had informed him that his desire to go on the ‘choose and book’ system, so that any patient in the UK could see him, had met with a sluggish management response. Dev also reported that he had been surprised since becoming a consultant at some of the decisions managers had taken in a bid to save money:

“One thing is, I think that I’ve assumed, always felt that they understood, maybe more than they do and the importance of making the cuts has had huge knock on effects. I’ve always thought, they won’t do that because that will have a knock on effect on that, and they have done that. I thought originally that I would give it 6 months to a year to take stock and then go to them with a plan and see what their ideas are, but it maybe that I need to go before then. Certainly when I left the Fellowship the managers said yes, come back and see us anytime, make an appointment, so it may be that I need to go (Dev, Hospital Fellow)

In addition to the dubious management decisions Dev felt had been made, he was also slightly disillusioned about the fact that having seen bids go in for new equipment and new staff

during his Fellowship year nothing had come to fruition:

“One thing’s for sure, nothing is on time and you can’t count on things to happen. I do wonder whose influence they’re under. Maybe I need to have their ear more regularly, but I’ve not wanted to undermine the Head of Department either because she’s new...so it’s trying to balance all the relationships and things that are going on” (Dev, Hospital Fellow)

Dev had been trying not to tread on the toes of a colleague who was new in the role of head of department but now recognised that he needed to re-establish contact with the managers himself. Despite these frustrations he continued to recognise that they were under a lot of pressure and that doctors needed to understand their perspective.

Louis was found to be working in the US, undertaking a clinical Fellowship while waiting for a consultant post to come up in the UK. He maintained an interest in management and had taken the opportunity to visit the Cleveland Clinic to see how their physician-executives worked. Having felt at the end of the Fellowship year that the purpose of doctors undertaking leadership and management roles was to improve things for the patient, he related that this visit had reinforced these feelings. He respected the fact that in the US clinical leaders were also expert clinicians with a lot of clinical credibility and had formed the impression that change was easier to achieve there as a result of less political constraint:

“I would say things seem to just get done and be easier and quicker in the US. I think one of the skills is to filter out what you can focus on and the things that you think are important. It’s getting the balance right, the right experience and right people” (Louis, Hospital Fellow)

Louis felt that he had greater system awareness since undertaking the Fellowship and now looked “beyond the doctor-patient interaction at what’s going on in the environment around”. He reported that “when the opportunity arises I will take it, to do management things.”

Nina had returned to her specialist training programme but had also maintained her involvement in the ‘Experiential Leadership and Management of Systems’ (ELMS) programme, set up by the psychiatric Fellows for their peers, and was at the time of interview evaluating the data from the first cohort. She reported that one of the teams she was working in clinically was going through a lot of change and that she had “been guiding the team and stepping up as

a consultant when he's away," as well as doing some coaching. The latter was with a patient, in terms of managing their medication, which she felt had enabled a different outcome and also with a junior trainee, helping them to deal with the changes occurring.

Along with Ella, Nina had attended a mentoring and coaching course put on by the deanery since the Fellowship had ended. She was looking forward to being a consultant and remained committed to being involved in organisational issues:

"I remain very interested about being involved and committed clinically. I think it's probably just strengthened that" (Nina, Hospital Fellow)

Nina reported that getting doctors to engage with management ideas was still difficult, despite non-clinical managers "embracing doctors to come in," and the fact that her peers were aware of the importance of being organisationally involved. She related that many were not taking active steps which she put down to "fear," and a lack of understanding as to "how to put the energy into effect."

Ella had also returned to sub-speciality training. She related that she was continuing to utilise skills and methods she had acquired during the Fellowship year, such as an appreciative inquiry approach, and that when it came to co-production she was "a big banger on about it". She reported that co-production ideas fitted very much with current government ideas, and that she had been thinking about partnerships between doctors and patients and how things could be done differently, implying that she has taken the idea of developing services into her sense of self, in line with policymakers' plans (Martin and Learmouth, 2012). Ella was also mentoring a nurse colleague, whom she had inspired to return to nursing after time out and reported that she was trying to involve patients more in decisions:

"I think I'm less paternalistic with patients now - I make them go and buy their Calpol whereas once I would have prescribed it, and get them to decide when they are fit to go back to work and no longer need to be seen" (Ella, Hospital Fellow)

Since being back in clinical work Ella had been invited to present on leadership themes and to attend events. She had given a talk on innovation which she "loved researching," a talk at a

medical school conference and was writing a module on health promotion. She reported that “you don’t realise the knowledge you have until you meet with others.” Whilst Ella had also been invited to be involved in organisational issues within her Trust, this had in some cases proved to be inappropriate, such as when she was invited by an A&E consultant into a meeting which turned into a discussion about another member of staff. She recognised that “there are things that are too big to get involved in now,” but was happy with the fact that she was working at a hospital where a lot of junior doctors were allowed to get involved with management issues. The friend who had initially encouraged her to participate in the Fellowship had moved into a consultant post at the hospitals where she was working and was involving juniors in management by getting them to run the ward rounds and sending them off to meetings. Interestingly, while Ella was not motivated by thoughts of being in a formal leadership role at either the start or end of the Fellowship, she reported that over the course of the following twelve months she had experienced “a subtle shift in attitudes” towards her career:

“I was a bit disillusioned before the programme and I’m more focused on what I want out of my career now. Being a good doctor is important but it’s no longer enough. I see a lot in the strategic management side, and it does fall into a consultant’s role anyway, but I think I’ve found a bit of a niche for myself. I would miss clinical work, so how it will all map out, who knows?” (Ella, Hospital Fellow)

Ella’s shift over this period, in terms of coming to desire a strategic management role supports the assertion by Nicholson and West (1988) that “the significance of a change may not be appreciated for some time ...as personal change is time-lagged, incremental and cumulative” (p. 117). Ella had developed an interest in doing an MBA, although she had come to the conclusion that she needed to concentrate on finishing her sub-speciality training for the next two years and wait until she had a consultant post before introducing change within the system. She saw that as the time when she could “get stuck in...[as]it’s very much a beginning.”

Overall, these four Fellows were found to be maintaining the attitudes and plans to be organisationally involved that had emerged at the end of the Fellowship year, which suggests that they did achieve stabilization. In fact, in a couple of cases the desire to be involved had, if anything, grown slightly stronger, which supports Nicholson and West’s (1988) theory that personal change is incremental and may not be recognized until a later stage. While a certain degree of disillusionment about managers had developed in Dev, he was very active in

developing his service and still recognised the need to understand the managers' perspective and to make contact with them. The next section summarises and reflects on the findings presented in this chapter.

7.4 Summary and reflections

This chapter has presented the ways in which the Fellows adjusted to their role as a leader of service development and quality improvement projects, in terms of the particular ways in which they engaged in role innovation in this situation and also changed their attitudes towards medical leadership, the management of organisations and working with non-clinical managers as well as other health professionals. As such, the two forms of adjustment outlined in the Nicholson (1984) model of role transition appear to be supported.

In terms of attitudes towards doctors' involvement in organisations and medical leadership, ten Fellows expressed that all doctors should have some exposure to management and a wider understanding of the dynamics of the system. However, seven felt that not all doctors need to be leaders in a formal sense. New understandings of medical leadership also emerged. At consultant level medical leadership was conceived as working with managers to implement change and contributing the clinical perspective to discussions and decisions. Across other levels it was conceived as being proactive, highlighting when things need to change and acting as a role model. In terms of the Fellows' intentions with regard to leadership roles, two Fellows moved immediately into consultant posts where they were involved in leading in various ways. One GP also took up a clinical lead post. Many other Fellows remained involved in developing training interventions for their peers along with certain other tasks. However, the original motivations of the group towards undertaking any future formal leadership role were largely unchanged by the Fellowship experience. The medical director role was seen as too removed from clinical work and too isolating, although the four Fellows who entered with a potential interest in a future leadership role remained open to the possibility of being a clinical director, or some form of part time medical leader, at a later stage in their career. All of this raises questions as to how successful the Fellowship might be judged to have been in terms of the formal goals of the Fellowship, although as demonstrated in chapter 5, whether a cadre of future leaders in the formal sense was expected to emerge was less than clear.

Overall, all the Fellows expressed and demonstrated by their answers having undergone some change in attitudes during the year. Change was certainly seen, in terms of attitudes towards non-clinical managers, particularly senior managers, becoming more positive by the end of the year. In fact, many Fellows were pleasantly surprised at the support they had received from managers at all levels. Managers' skills and contribution to health systems were recognised, and those Fellows who entered the role feeling that managers would have different aims amended their view, perceiving that it was more a difference of perspective. Essentially, the year strengthened the view initially held by six Fellows that doctors need to be integrated with managers. In terms of working in partnership with other health professionals and service users to improve services, five Fellows came to value a collaborative approach involving a wide range of health professionals. Eight came to the view that involving patients in service development was desirable. Follow up interviews with four Fellows, twelve months after the Fellowship had concluded, suggest that stabilization occurred and that in the medium term at least, a belief in the need to be involved in management and organisational issues was being maintained. The implications of these findings for medical professionalism and new ways of working will be developed in the next chapter.

Adjustment through role innovation occurred in terms of re-shaping an existing project in one case and designing new ones in line with the Fellows interests in others. Many Fellows were also proactive, which is in line with the concept of role innovation in the existing role transition theory, but occurred in this case in terms of being persistent in pursuing the aims of projects designed by others, rather than being proactive to suit their own needs. Possible explanations for the findings outlined in chapter 5 to 7 and the wider implications for theory and practice will now be discussed in the next chapter.

Chapter 8: Conclusions, contributions and implications

Introduction

This research explored whether doctors participating in a leadership development intervention underwent a process of intra-role transition (Louis, 1980a) and emerged with a new sense of medical professionalism, in terms of being willing and able to work with new groups of professionals in new ways in order to achieve effective delivery of healthcare.

The research pursued this by following a group of fifteen doctors undertaking a pilot and intensive leadership development intervention over a twelve month period. This intervention was based around working in a newly created role, leading and project managing live service development projects with the support of a mentor, whilst participating in an educational programme. The research explored the participating doctors' experiences and the way in which they adjusted to taking on a new, project management role, utilising the four stage model of role transition developed by Nicholson (1984) and elaborated further by Nicholson and West (1988). It sought answers to the following questions:

1. Will leadership development be able to act as a mechanism for role transition, in the form of personal change, amongst doctors not in a formal leadership role?
2. Under what conditions might it do so? That is to say, if role transition is seen to occur, how might leadership development have facilitated it? If role transition is not seen to occur, what factors might have hindered transition?

A review of existing theory and evidence found that arguments both for and against the likelihood of a change in professionalism being achievable. Those which supported the idea were firstly, that there is growing support within the profession for such development, both from senior figures at the helm and doctors at other levels. Secondly, involvement in management has the potential to be more attractive for doctors due to changes in the context in which they work, which has resulted in the profession becoming increasingly stratified and

needing to share control with non-clinical managers. Arguments against leadership development being able to facilitate change included, firstly, the culture of medicine being highly resistant to change and doctors involvement in organisational issues. Secondly, the lack of incentives for doctors to take on leadership roles and thirdly, the likelihood that medical identity is deeply embedded through early socialisation processes.

This chapter is structured around four parts. Section 8.1 considers the conclusions that can be drawn about the ability of leadership development to act as mechanism for role transition in the form of personal change. Section 8.2 begins by briefly outlining the three key contributions of the thesis. Section 8.3 then discusses contribution 1, the emergence of a new integrated model of role transition and identity transformation. It begins by presenting the model, including three new types on professionalism identified. Drawing on the contingencies highlighted within the model, possible explanations for these emerging new types of professionalism are then elaborated. Section 8.4 focuses on the second contribution of the thesis, in terms of the potential for new ways of professional working suggested by the findings, and the way in which the findings support and challenge existing theories on professions. Section 8.5 then considers the third contribution of the thesis, the recommendations for policy and practice. Section 8.6 outlines the limitations of the work and opportunities for further research. Finally, section 8.7 brings the chapter and thesis to an end, with a brief summary of what has been achieved.

8.1 Overall research conclusions

In terms of whether the leadership development intervention studies here acted as a mechanism for role transition in the form of personal change, the overall conclusion of the research is that it did. However, the type and extent of change varied, in line with the notion of individual differences in adjustment which underpin the theory and model of role transition.

As the findings (chapters five, six and seven) have shown, the Fellows went through the stages of the work role transition cycle (Nicholson, 1984) and all showed signs of having undergone some form of personal change. This was in terms of their overall orientation towards the

management of healthcare organisations and their attitudes and beliefs regarding non-clinical managers. New orientations towards the management of NHS organisations included recognising the need for financial probity and for efficiency and favouring a whole system perspective towards tackling problems and running organisations. More empathy with non-clinical managers and recognition of their skills and contribution to the effective functioning of organisations developed, with particularly positive opinions of senior managers such as CEOs and the executive team, who were previously an unknown quantity, emerging. This was with regard to their calibre, in terms of the political skills they had, their readiness to listen to medical views and ideas and their concern for the patient experience. Many Fellows also experienced supportive relations with non-clinical managers at lower levels of the organisation, although three came to the view that divisional level managers need to understand the doctors' perspective and to engage with them more. Two also felt that the calibre of business managers' skills varied.

In some cases the value of working in a more collaborative way with a wider group of professionals and service users came to be recognised. Four Fellows became in favour of involving a wider group of professionals when trying to find solutions to problems and establish new ways of working, based on their experiences. Eight Fellows also came to recognise the value of actively involving service users in the development of services. In addition to this, eight Fellows reported that participation in the Fellowship had altered their sense of self, in terms of increasing the confidence and assertiveness of four women who were lacking in these areas at the start, and increasing self awareness of their own personality type and working preferences of the others.

What has to be noted, however, is that whilst some form of change was seen in all the Fellows, the time limited nature of the role meant that all were approaching another transition as the Fellowship year came to an end, either to a new consultant or GP role or back into their specialist training programme. As such, at the end of the year they were only able to express hope that they would maintain their new attitudes and skills, with some feeling that these would continue to evolve. The final stage of the role transition cycle, stabilization, might therefore be concluded as being partial and the sustainability of the change seen questioned. It is here that the longitudinal data collected from four Fellows twelve months post completion of the Fellowship was very valuable. This suggests that stabilization did occur over the course

of the following twelve month period. New attitudes and orientations to organisations were being maintained, and in fact two of the four felt that their belief in the need to be involved in organisational issues. In fact, their desire to be involved, had strengthened over this period which provides some support for Nicholson and West's (1988) proposal that "the significance of change may not be appreciated for some time" (p.117) and in fact may only be appreciated when one is looking back over a lengthy period of time. The implications this has for research designs will be discussed later in the chapter good.

Undoubtedly all the Fellows had developed greater competency in relation to working in multidisciplinary teams, managing services, improving services and setting direction, the key areas of the medical leadership competency framework. However, no real commitment was demonstrated towards becoming a future leader, at least in the formal sense, by the end of the year, although one GP was taking on a clinical lead post. Generally, it was a case of being happy to have some form of organisational and managerial involvement once a consultant, with no-one keen at this stage on becoming a medical director. However, the four who had entered potentially interested in having a formal role in the future were open minded about the possibility of having a part-time role, such as that of clinical director, as were a couple of others. Eight Fellows demonstrated a desire for continued involvement in service development and improvement work, and thus might be said to have adopted an actively reforming orientation. However, only four Fellows reported, and demonstrated through their answers, that they had developed a substantially more corporate orientation. This was in terms of having a much greater concern for such things as the financial cost of running organisations, the need for robust business cases to be made when resources were sought and acceptance of the validity of corporate decisions such as the need to cut staff or close units. Having outlined the conclusions of the research, these findings contribute to knowledge in three important ways, which the next section moves on to discuss.

8.2 Three contributions of the thesis

Firstly, the findings provide evidence to support the proposition that leadership development be considered a process of role transition and identity transformation (Ibarra, Snook and Guillém Ramo, 2008). Three new types of hybrid professionalism have been identified as a result of participation in leadership development. As such, an emerging model of role

transition and identity transformation has been developed: (a) in terms of how adjustment occurs within a time limited new role in a professional development context, and (b) in terms of incorporating three types of hybrid professionalism.

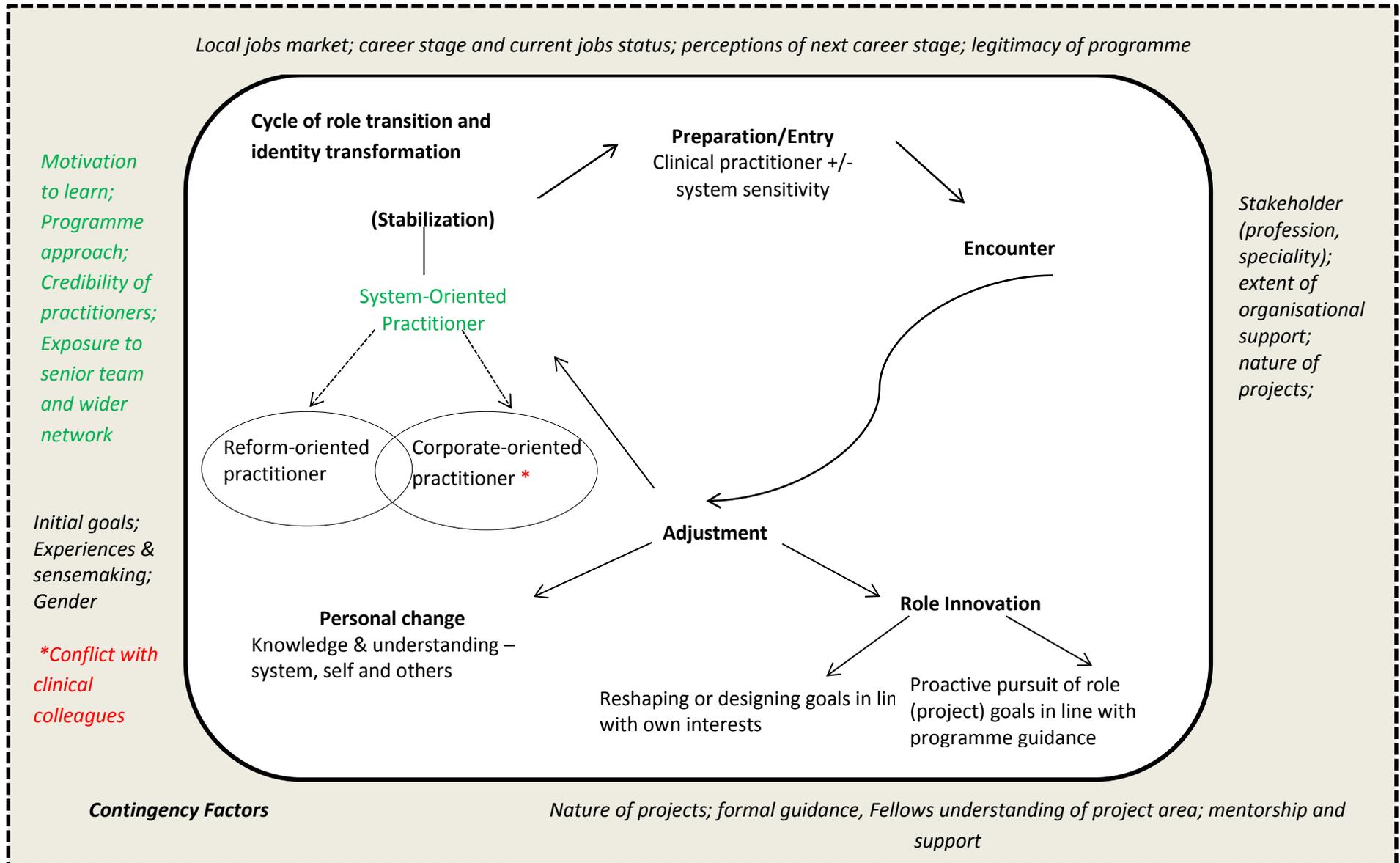
Secondly, the findings contribute to the literature on professions, in terms of highlighting potential new ways of professional working within public organisations. This is based on the fact that a more collaborative orientation emerged from some of the group studied here, and the fact that the findings suggest that more nuanced forms of professional re-stratification may emerge than Freidson's stratification theory (1994) suggests. The fact that the research suggests there may be unintended consequences associated with a strategy of developing future leaders through leadership development is also highlighted.

Thirdly, a number of recommendations are made for policymakers and leadership development practitioners within the medical arena. The next section discusses these contributions in more detail. It begins by presenting the new model of role transition and identity transformation which has been developed.

8.3 Contribution 1: An emerging model of role transition and identity transformation

This section begins by presenting the emerging model of role transition and identity transformation, including the three new types of professionalism identified as an outcome of the leadership development process (see figure 2, page 248).

Figure 2: An emerging model of role transition and identity transformation during leadership development



The new model of role transition and identity transformation, shown on page 248, will now be explained in more detail. Within the inner field of the model is the existing four stage role transition model developed by Nicholson (1984), with some additions. Within the outer field are the proposed contingencies; factors potentially affecting how role transition and identity change during leadership development occurs, based on the findings of this research.

Beginning with the inner field and the role transition-identity transformation model, firstly, there is an addition at the preparation/entry stage, in the form of including the incoming type of professionalism. Secondly, at the encounter stage, the line from encounter to adjustment is shaped and lengthened to show the fluidity of this stage of the process, and the fact that new encounters occurred from the moment of entry until, in many cases, around nine months into the role, with it being around six months before adjustment started to occur. As such, the stages appear to be more dynamic and blurred than the original model suggests, in line with Ashforth's (2001) suggestions. Presented as such, the role transition model has utility in highlighting the length of time change in professional ways of working may take, given that change amongst other health professionals is required, in the form of developing project management and reform skills, if the type of service reforms desired by policymakers and others are to be taken forward (Ham, 2009). The findings from this research indicate that developing project management and reform skills may take several months, even where individuals are motivated to developing such skills, concentrate on such tasks and where intensive support and guidance is available.

Thirdly, at the adjustment stage, two forms of role innovation are included (see page 248). One is the traditional form, in terms of re-shaping the role (in this the projects) in line with the role-holders' own interests, as Nicholson (1984) defined. The second is also a proactive form of adjustment, but related to active pursuance of the original project goals. These findings suggest that the concept of role innovation, as a proactive form of adjustment, may be more nuanced than the Nicholson theory and model suggested. As such, role innovation may need to be conceptualised in a slightly different way when applied in situations where role change is structured, supported and time limited. Contingency factors potentially associated with the type of role innovation seen are included in the outer field of the model, immediately below role innovation (see page 248). These include, firstly, the nature of the projects, as it appears that unrealistic project goals increased the likelihood of

the project being re-shaped, or even abandoned. In contrast, where a project was already well under way, in terms of implementation, and when it was perceived as realistic and valid, the original project goals were likely to be proactively pursued. Secondly, having a high level of support from mentors and senior figures within the organisation appears to be important, as this appeared to make it more likely a project would be re-shaped or a new one designed where a Fellow considered this necessary or that they could improve on existing plans, or in some cases where they had time to tackle another issue.

Finally, the stabilization stage, which is bracketed to reflect the fact that the group were heading straight into another transition, back into clinical work, includes three new types of hybrid professionalism identified. The professional identity change seen, or shift in sense of professionalism identified, was from being a 'clinically-oriented practitioner', which included having varying degrees of sensitivity towards the wider system, to becoming in all cases a 'system-oriented practitioner.' Some individuals also became 'reform-oriented practitioners' or 'corporate-oriented practitioners', with these two latter forms of professionalism not appearing to be mutually exclusive, such that they are shown as overlapping circles within the model on page 248. These three new types of professionalism are now described in more detail.

On entry, as 'clinically-oriented practitioners', the group had varying degrees of sensitivity to the system. This ranged from not even being aware of the existence of 'NHS Southlands,' to having a degree of political nous regarding implementation of change in a professional context and a good understanding of the Darzi review (Department of Health, 2008). In contrast, on leaving the Fellowship, they had all become 'system-oriented practitioners.' This consisted of having a continued concern with the core values and purpose of the professional role, but with a genuine acceptance of the following: the need for some degree of focus on organisational performance, including having some form of targets to monitor (albeit not all current targets were seen as appropriate); the importance of having non-professional managers with business skills within the system; the need for some change in professional ways of working and organisation, in terms of greater professional integration and finally the need for willingness to implement organisational change. All of this suggests that intensive forms of leadership development, as previously described, can alter the sense of professionalism of even a highly socialised group, committed to traditional notions of professionalism and keen to advance up the professional hierarchy.

These findings suggest that development interventions can move professionals from a state of pragmatic acceptance of the need to undertake managerial tasks and to be involved with service reform, to one of greater confidence, ability and enthusiasm for doing so.

In achieving this, there appeared to be no feeling of compromise or erosion of clinical values (Ackroyd, 1996) or problem reconciling this with the professional identity (Noordegraaf, 2007; Reed, 2007). Waring and Currie (2009) have suggested that hybridization can include such things as risk management processes being incorporated into professional practice. In fact, the group studied here felt that their outlook was the result of having new understanding and that this enhanced their clinical role and enabled them to be better clinical professionals. This new professionalism was similar to that seen amongst those identified as 'pioneers' by Waring and Bishop (2011) in a group moving into the independent sector, who were positive about the opportunities it gave them for delivering an excellent service and working in new ways. The change seen amongst the doctors studied here appears, in fact, to be in line with the new professionalism outlined by the medical academy (Royal College of Physicians, 2005), which melds a sense of professional and organisational responsibility, with readiness to work in partnership with non-professional managers. Noordegraaf (2011) has previously suggested that the new professionalism had yet to be achieved in the UK.

In some cases this 'system-oriented' sense of professionalism extended to being a 'reform-oriented' or 'corporate-oriented' practitioner. In the first case, 'reform-oriented practitioners' were those who left the Fellowship committed to actively working to reform services. For example, some were continuing to work on their projects or had agreed to help implement change in their next role. This 'reform-oriented' sense of professionalism also includes a commitment to changing the way organisational change is approached and implemented in the future, in terms of valuing and being committed to involving other health professionals and service users in the process. In the case of patients, collaboration extended in some cases to working with them in a more equal way on clinical issues. For example, one Fellow noted how she had become less paternal, getting patients to decide when they no longer needed medication.

In a few cases, a 'corporate-oriented' sense of professionalism emerged. This included greater financial concern and engagement with the need for a robust financial case to be made when an increase in resources is sought, or a new way of working developed. It also included acceptance and support for taking difficult decisions, such as closing a unit or making redundancies across the board, for financial or wider system reasons, even when such decisions might impact on their own situation or service. Kurunmäki (2004) has previously argued that UK doctors have not accumulated accounting principles, or a concern with finances, into their sense of professionalism in the way that Finnish doctors have, and so have not become hybridised in the way Finnish doctors have. The 'corporate-oriented' group identified here, albeit the smallest group, do appear to have incorporated concern for financial issues and the need for system oriented decisions associated with performance within their sense of professionalism. Finally, the 'reform-oriented' and 'corporate-oriented' forms of professionalism do not appear to be mutually exclusive.

In terms of why three types of hybrid professionalism emerged, there are a number of possible explanations and potential contingency factors (as demonstrated in the outer field of role transition-identity transformation model on page 248). The next section looks at these.

8.3.1. The emergence of three new types of professionalism: Potential explanations and contingencies

In terms of why all the Fellows developed a 'system-oriented' sense of professionalism by the end of the year there are a number of possible explanations. Firstly, as individuals they were clearly motivated to acquire leadership and management skills in preparation for taking on the consultant role. This was based on their perceptions of that role and an apparently pragmatic acceptance of the way in which traditional career paths are changing, seen previously amongst doctors undergoing development (Kuhlmann, 2008; Domagalski, 2007). Motivation to gain leadership and management skills suggests openness to feedback (Nicholson and West, 1988 and ultimately identity change (Ibarra, Snook and Guillém Ramo, 2008). In this case, motivation may have been linked with the Fellows' particular career stage (Ibarra, Snook and Guillém Ramo, 2008), as five were at a critical juncture (Ibarra, 1999) in terms of being at the end of their specialist training and preparing to

become consultants, or a GP in one case. Three of these five also had no job role to move in to, suggesting that career stage and job status may be contingent factors influencing participation in leadership development (see the model on page 248). However, the level of motivation to acquire leadership and management skills seen amongst this group may also have been down to factors which were unique to the particular context in which they work. They were all training in an area where there are a high number of specialist and high profile hospitals, potentially making competition for jobs particularly intense. The Fellowship also followed swiftly on the heels of the Darzi review, in an area where Lord Darzi practiced as a surgeon. As such, the Fellowship had his backing, which perhaps gave it added legitimacy, thereby providing an impetus for the Fellows to take the process seriously. However, other Registrars interviewed as part of a comparison group also showed interest in gaining leadership and management experience, although whether others would be as motivated to invest a year in acquiring such skills is a matter for debate. Other writers (Clark and Armit, 2008; Griffiths et al, 2010) have suggested that they tend to attend the short management courses that are available in order to tick the management box on applications for consultant posts, rather than out of a genuine desire to acquire these skills. Whether or not it was career stage and/or the particular context that motivated the Fellows to acquire leadership and management experience and skills, what all of this does suggest is that the Fellows were open to learning and therefore likely to be open to feedback and adjustment in the form of personal change (Nicholson and West, 1988).

In relation to the leadership Fellowship itself, it was designed in such a way that an anxiety producing element was introduced, with the creation of the new role, accompanied by a variety of support mechanisms to balance this and encourage the Fellows to take action. Nicholson and West (1988) found that a level of anxiety was associated with personal change amongst job changing managers they studied, and suggested that if one wants individuals to change and conform to particular ways of thinking and behaving, then one should strive to make them anxious. Whereas, if one wants individuals to engage in role innovation, shaping the ways things are done then one should provide them with support.

At the encounter stage the new role produced feelings of ambiguity, uncertainty and isolation, referred to as a 'liminal' state and suggested to be part of the transition process (Ibarra, 2003; Ashforth, 2001). This suggests that a possible new identity was starting to

exist side by side with the established identity (Ibarra, Snook and Guillém Ramo, 2008; Ibarra, 2007) and reflection on existing values and beliefs was encouraged by the educational programme leaders. The level of protected time for reflection which the Fellowship provided was highlighted by a number of Fellows and may have contributed to greater self-awareness and new ideas about how they might behave, in line with the suggestions of Ibarra, Snook and Guillém Ramo (2008). Covering the social and political aspects of organisation and professional socialisation also appears to have been important, as these were drawn on during sensemaking and appear to have highlighted problems with the existing medical identity, potentially leading to a level of dis-engagement from the old identity (Ibarra, 2007).

The background of the educational programme leaders also appears to have been important in that they clearly engendered trust amongst the group, which potentially enabled them to challenge existing ways of thinking and influence the way the Fellows came to view things in a way not all practitioners may have been able to do. The fact that they were former Kings Fund Fellows and consultants with wide experience of working with clinicians and other NHS staff appeared to engender trust, enhanced by the fact that they were able to present the group with a depth of leadership, management and change theory which convinced them that the guidance they were giving was evidence based and robust.

The Fellowship also provided unique exposure to managers, particularly the executive team, or the necessary gurus, as Ibarra, Snook and Guillém Ramo (2008) refer to them. While levels of interaction with executive teams varied, it appears that being able to spend time with the likes of the CEO or chief finance officer, and/or to observe them at close quarters over a period of time, generally led to positive views regarding the calibre and motivations of these individuals. Exposure to non-clinical managers of any level is clearly limited as a Registrar, as evidenced by not only the Fellows but also doctors in the comparison group. Where interaction exists it appears to revolve around operational issues, particularly related to the work rota. In addition to these opportunities for within-Trust networking, the Fellowship also provided opportunities to meet with medical directors and other leaders from across the city. This meant that the Fellows were exposed to a new role set, in the form of a range of people who view medical leadership as important. They were able to observe the things that concerned this group, such as the financial crisis and how they could work within the limitations it created. Such networking

opportunities have been recommended as part of leadership development interventions aimed at developing collective capacity (Allen and Hartmann, 2008) but are only just beginning to be achieved. A recent review of leadership development interventions conducted for the Kings Fund (Bagnall, 2012) supports the idea that exposure to senior managers leads to junior doctors developing a “healthy respect for their roles and responsibilities across complex systems” (Bagnall, 2012, p.10).

The importance of having mentors and role models has been highlighted previously (Coulehan, 2005; Hafferty, 2009). In all but two cases the Fellows had supportive mentors, which may have played an important role in opening their eyes to the need for personal change. Mentors who were willing to be shadowed to discuss difficult situations they faced and to support new ways of doing things were valued and respected, such that they were potentially particularly influential as fellow medical professionals in terms of exposing the need for new ways of thinking and behaving. Many of the Fellows attributed their ability to progress their projects and learn about what medical management involved was attributed to having such supportive mentors, and the medical director’s authority and credibility within the system was recognised as particularly important for counteracting resistance. This partially supports the view of Brown-Muth and Ferrigno (2004) who proposed that having supportive mentors in the workplace would enable ideas to be converted and would positively influence the whole socialisation experience. However, the findings do not support the authors’ view that this would increase the number who wanted to be a future leader in the formal sense.

Finally, Ibarra, Snook and Guillém Ramo (2008) advocated creating a network of peers experiencing the same process. This appears to have been important in the way they suggested, helping to counter the sense of isolation and discomfort experienced by the change in social environment and relationships and provide opportunities for feedback on the provisional selves being experimented with. The network of Fellows created a reference group for all of them as individuals, with the findings suggesting that they monitored their own reactions and behaviour as well as their peers, noticing personal changes such as increases in confidence and enthusiasm for leadership.

Potential explanations as to why a 'reform-oriented' sense of professionalism emerged in some include the fact that an ethos of whole system working, which involved such things as fostering collaboration, and encouraging participation of all stakeholders with knowledge of a situation and affected by change, was encouraged throughout. The inclusion of a module on co-production, which while attracting arousing some discontent, also appears to have had an impact on how a number of Fellows began to view interactions with other professionals and service users. Of course, all the Fellows were exposed to this ethos and yet not all developed a particularly 'reform-oriented' sense of professionalism. Doing so may be contingent on a number of factors (see the model on page 248). One is the nature of live experiential learning projects, in terms of whether they provide an opportunity to work with new groups, such as other health professionals and service users, which some of the Fellows' projects enabled more than others. Another is related to individual motivations, in terms of whether a participant enters particularly keen for personal development, as a few Fellows were, or with an interest in working with new groups. Some Fellows entered interested in working with patients in different ways, or in parts of the system they were unfamiliar with. Other factors which may influence the development of a 'reform-oriented' form of professionalism potentially include reactions encountered when attempting to engage others in the change process, and the individual's own reactions to this.

Stakeholder reactions encountered in this differed, possibly as a result of the level and type of stakeholder, or in the case of doctors the medical speciality involved. Some medical specialities have previously been suggested to be more willing to engage with management and organisational issues than others (Willcocks, 2004). However, some Fellows came to realise as the year progressed that the way in which they had approached people in the early days had partly contributed to negative reactions amongst stakeholders, such as resistance and conflict. Interestingly, it was predominantly women who interpreted resistance and conflict this way, with all who did developing a 'reform-oriented' sense of professionalism, focused both on changing services and their own ways of working. Wider work on women in leadership and management suggests there may be a gender element to professional identity change associated with the leadership development process. Ely, Ibarra and Kolb (2011) suggest that "subtle forms of gender bias may impede women's progress by obstructing the identity work necessary for taking up leadership roles" (p.475). Others suggest that women perceive that there are greater barriers to their progression than to the progression of men (Sealy, Doldor and Vinnicombe, 2009; Wirth, 2001), due to

sex stereotyping of women as passive and timid, juxtaposed with leadership as involving male characteristics such as aggression, forcefulness and decisiveness. These findings suggest that women may focus more on their own behaviour than men, and so possibly be open to changing their self in certain ways. Recognising that one's own behaviour can influence how others react, which in turn can influence one's ability to achieve change, might then lead to greater enthusiasm for implementing change in the longer term. Role changers' own reactions and sensemaking are suggested as likely to play a part in how their own sense of identity develops (Ashforth, 2001). In this case, the 'reform-oriented' sense of professionalism that emerged fitted well with the partnership aspect of the new medical professionalism (Royal College of Physicians, 2005).

Finally, the need for support within the workplace for new ways of working to be implemented has been noted previously (Raelin, 2006; Tyler 2004; Day, 2001; Storey and Tate, 2000) and in this case implementation of projects partly depended on their being supported across an organisation, particularly at senior level. As such, where projects were not supported and perhaps needed to be re-shaped, this may have impacted on those leading them, resulting in them being less committed to actively pursuing reform on leaving the Fellowship.

Moving on to explanations as to why only a few (four) developed a 'corporate-oriented' sense of professionalism, these four certainly did not enter with any such orientation. Further investigation is needed, but it might simply be that the intervention provided greater exposure to financial and performance type issues for these four, although this does not seem particularly likely. Alternatively, career stage may partly explain this, in line with the view of Ibarra, Snook and Guillém Ramo (2008). In this case most Fellows needed to complete their specialist training, which limited their opportunities for immediate involvement in service development or more business type issues. This perhaps led to a greater focus on gaining personal insight and on the relational aspects of leadership, which were of immediate benefit in the new role and likely to be of use on return to the clinical role. Another possible explanation is that experiencing particular conflict with members of one's original role set during the transition process, as three of the four did with their clinical colleagues, may exacerbate separation from the old identity and drive people further towards the new reference group, and the identity associated with that group. Ibarra (2003) notes that loosening ties with old connections may be as important for

identity change as forming new associations. In this case, the new reference group included business managers and mentors (predominantly medical directors) who were more likely to have a strong financial orientation and concern with performance (Degeling, Kennedy and Hill, 2001). This may have led to the group internalising such values (Ely, Ibarra and Kolb, 2011) and developing a more 'corporate-oriented' sense of professionalism. The way in which key events are made sense of and interpreted has been suggested to play an important role in how potential leaders develop their sense of self (Bennis and Thomas, 2002), with Ashforth (2001) suggesting that difficult experiences are likely to promote greater sensemaking. In this case, experiencing conflict potentially led to greater sensemaking and disruption of the existing values and beliefs of those Fellows who developed a 'corporate-oriented' sense of professionalism.

In terms of why participation in the Fellowship did not engender transition to a state where the group were committed to taking on a formal leadership role, one possible explanation is that there appeared to be some ambiguity as to whether this was a particular objective. The director of the CIHM delivering the programme appeared to believe that these were future medical and clinical directors, and many Fellows perceived that their colleagues viewed them as having been selected for these reasons. However, this was not explicitly stated by the commissioners, and one of the educational programme leaders stated that she and her colleague were not preparing the group for a particular role. As such, the Fellows may not have been encouraged down this line of thought. A contingency factor in whether leadership development can engender commitment to assuming a formal role as a leader may be the original motivations of participants on entering an intervention. The majority of Fellows did not enter motivated to become a leader in the formal sense, suggesting that initial motivations and intentions on entry may be less capable of being changed than attitudes towards ways of working within the existing role. Work looking at teachers undergoing leadership development supports this conclusion (Brown-Muth and Ferrigno, 2004).

It also appears that whilst live experience of leading projects may have been core to engendering change, exposure to the likes of medical directors may have had unintentional consequences. This is in terms of exposing the group to the realities of that particular role and the challenges of it, such that they were deterred from wanting to pursue it. Medical directors have suggested that there is an issue with succession planning, as juniors are

more aware of the negatives of the job than the positives (Giordano, 2010). Negative perceptions of the group included the perceived isolation of the role, from clinical work and clinical colleagues, and the time commitment required. Perceived isolation may be important for doctors. Hoff, Winthrop and Nelson (2002) have drawn attention to the social nature of medicine, suggesting that the portrayal of doctors as autonomous, dominating types minimises the importance to them of social relations and having a network of peer support to buffer the challenges they face on a day to day basis. Again, career stage may have had an impact, given that the majority had to finish their specialist training and were aware that they would go through another transition in becoming a consultant. Most were thinking ahead as to what they might do once embedded within this role, but were aware that they had to get there first. The medical culture is hierarchical, with established norms as to what it is appropriate for doctors to concern themselves with at different stages of their career (Sinclair, 1997), and this did appear to exercise some constraint on the thinking of the Fellows with regards to their involvement in leadership. Bagnall (2012) in her review of recent leadership development interventions for junior doctors found similar issues related to hierarchy, with juniors being encouraged not to step out of line.

All of this raises the question of whether we can conclude that the Fellowship was worthwhile, such that the strategy of leadership development for doctors might be a successful one and an appropriate use of public money. This is always a difficult question to answer in relation to training and development type interventions and depends on ones point of view and criteria used to judge success. Even where attempts are made to measure return on investment, wider organisational benefits and the longer term effect is difficult to estimate (Kirkpatrick and Kirkpatrick, 2006; Tamkin, Yarnall and Kerrin, 2002). An evaluation was carried out by the deanery which reported that the overall cost of the Fellowship was £3.2million. This amount is not split into the various components, although the educational programme cost just short of £500,000, approximately £12,500 per Fellow. The additional costs are presumed to include the Fellows' salaries (which would have been paid anyway) and money made available for the 'Dragon's Den' initiative, where Fellows could bid for money to fund the training initiatives they had designed for other junior doctors. An investment of around £12,500 per Fellow in terms of education and re-socialisation might be argued to be value for money at this stage in a doctor's career, if the changes in attitude and new ways of working seen here continue to be maintained.

What remains unclear at this stage is whether the transition seen will prove to be sustainable in the longer term. Only when all these Registrars become consultants and GPs might it be possible to make some judgment as to whether the investment was justified, based on how they develop their service and work with others. In order to judge the longer term benefits of such a strategy, much longer term work is needed, to track doctors who go through leadership development during their specialist training from entry, through the programme, through completion of their specialist training and through the transition into the consultant or GP role. While the data collected from four Fellows twelve months post completion of the Fellowship suggests that attitudes and behaviour developed during the year were being maintained and even strengthened, questions still remain as to what will happen when the level of support that the Fellows enjoyed in the fellowship is missing. One Fellow drew attention to the unusual situation they had enjoyed, in terms of the extent of support available. Data from one of the four followed up twelve months later suggests that relationships formed with managers during leadership development interventions may raise expectations about their level of understanding and likely behaviour which are subsequently unfulfilled. As to whether any CEOs and medical directors in particular might emerge from this or other such interventions remains to be seen.

In terms of how likely it is that similar types of transition and identity change would be seen amongst other doctors and other professionals, clearly more work is needed. However, data collected from the comparison group suggests that the Fellows attitudes at the start of the year were similar to those of other doctors at Registrar level. This suggests that attitudes found at the end of the Fellowship year can be attributed to participation in the Fellowship and also that other doctors may make a similar transition. The similar attitude of other Registrars suggests that younger doctors may be more open to gaining management experience and being involved in organisational issues than many established consultants.

The next section looks at the second contribution of the findings. This is with regard to potentially new professional ways of working within public organisations, which may emerge as a result of undergoing leadership development.

8. 4. Contribution 2: The potential for new ways of working within public organisations

Since the 1980s new public management practices have been introduced by successive governments in an attempt to coerce doctors into change, through making them accountable for their decisions and requiring senior doctors to be involved with the management of their organisations. Over time, the focus at policy level has moved from concern with the management of organisations to concern with reforming them and ensuring that leadership capacity exists at the right levels within organisations to achieve this (Brookes, 2011; O'Reilly and Reed, 2010; Lawler, 2007). In medicine and teaching, this latest strategy has been accompanied by normative pressure from the professional academies and associations, which Noordegraaf (2007) suggested may be important if success in this area is to be achieved. However, the new public management literature to date has not addressed the issue of whether intensive leadership and management development during their training might be an effective strategy for engendering a change in doctors' orientation to the management of organisations.

Firstly, the fact that a group of doctors who were motivated to acquire leadership and management skills did not emerge from a costly intervention committed to becoming a future CEO, medical or clinical director might be perceived as a sign that this latest strategy to engage professionals in management is doomed to the same limited level of success as previous attempts (Kings Fund, 2011; Ham and Dickinson, 2008). However, as discussed in chapter one, it is a concept of shared leadership, in which leaders from emerge as and when needed across all levels of NHS organisations which is being promoted by the medical academy and, formally at least, by policymakers, with regards to the NHS and other areas of the public sector. From that perspective, this intervention did produce a cadre of future consultants willing and capable of introducing service reform, in that it helped them understand how they might go about implementing change, developed a greater appreciation of the difficulties involved and fostered ideas about the different types of approaches that might be taken. This raises interesting questions as to what they, and other professionals undergoing such development, might play in the development of public sector organisations in the future. One might speculate that if investment in leadership development based around 'live' service development work continues, then reform may in time become easier. There might be less resistance to the idea of change and policy ideas may become more workable if more professionals gain the skills to implement reform and

develop an expectation that they should be involved. Reforms may also become more client-focused, if professional insight is more routinely integrated into the process.

On this basis, policymakers may gain the indirect control of professionals which some feel is the intent of the new public leadership initiative (Wallace, Tomlinson and O'Reilly, 2011; O'Reilly and Reed, 2010). However, another interpretation is that by demonstrating the ability and willingness to co-operate with reform professionals may gain additional public support, enabling them to challenge the ideas they do not support more robustly. As such, leadership and management competency may strengthen the position of professionals in the way evidence based medicine for example, arguably allows the medical profession to maintain some control and clinical autonomy (Kuhlmann and Burau, 2009; Dent, 2003). Given that none of the Fellows left committed to taking on a formal leadership role, if they continue to be involved in organisational issues from within their professional role, then they may be able to choose when they get involved and thereby maintain some control over what happens, and how it happens. There is some support for this being a likely outcome. Wallace, Tomlinson and O'Reilly (2011) found that whilst head teachers undergoing leadership development bought into the idea of being transformational leaders of their service, they also saw their role as enabling them to decide how, and in some cases whether, reforms are introduced. As Ackroyd (1996) has argued, professionals have proved remarkably adept at adapting to changing circumstances and maintaining their influence over the years.

Secondly, the fact that a 'reform-oriented' sense of professionalism emerged amongst some Fellows, involving enthusiasm and commitment to collaborating more widely with other professionals and even patients, provides support for the idea put forward by Adler, Kwon and Heckscher (2008), that new, more inclusive forms of professional community might be possible. These authors have suggested that professional and organisational modes of control are not mutually exclusive, in the way much of the literature has assumed (Hinings, 2005). They argue that professional communities which work on trust remain important, even though the market and managers play an increasing role in the organisation of professional work, but that these communities are slowly evolving into more collaborative, inter-professional forms, based on shared values, in order to meet the need for greater knowledge sharing and innovation. Such a shift challenges the traditional type of boundary work which professions have engaged in, in a bid to defend their interests

and areas of jurisdiction from being encroached on by other professions and occupations (Fournier, 2000; Abbott, 1988).

The change in attitudes found amongst the 'reform-oriented' group, suggests that leadership development may be able to assist in the emergence of such collaborative, inter-professional, cross-boundary forms of community even amongst health professionals who have so far proved to be remarkably insular in their ways of working (Powell and Davies, 2012; Ferlie et al, 2005; Fitzgerald and Teale, 2004; Degeling, Kennedy and Hill, 2001). McDonald (2004) suggested that inter-professional communities need to emerge in a more organic way, for inter-professional collaboration to be a success. The fact that this type of leadership development intervention was able to generate such a sense of professionalism amongst even a proportion of the group potentially has implications for the way in which professionals more generally might be encouraged to work within bureaucratic organisations, particularly if this kind of intervention and outcome were to be repeated more widely. A shift in favour of greater collaboration with patients also has implications for the individual doctor-patient relationship, such an important aspect of medical professionalism (Degeling, Kennedy and Hill, 2001; Freidson, 1970, 1989). It suggests that less paternal, more equal partner type relationships may emerge. However, as Adler, Kwon and Heckscher (2008) cautioned, any such change is likely to be slow, and the findings here support this, as the Fellows found that resistance to change remains, particularly amongst established members of the profession.

Thirdly, these findings suggest that new way of considering restratification within professions may need to be considered. Freidson (1984, 1994) suggested that a restratification was occurring which involved the emergence of new elites, who either direct and control the work of the rank and file, or develop the knowledge and design the guidelines and rules which the rank and file must follow. Previous work has suggested that new structural arrangements and accompanying new roles within primary and secondary care, are leading to restratification amongst the medical profession both in the US (Hafferty and Light, 1995) and here in the UK (Calnan and Gabe, 2009; Martin, Currie and Finn, 2009; McDonald et al, 2009; Pickard, 2009; Locock, Regan and Goodwin, 2004).

These Fellows undoubtedly sought stratification for instrumental reasons, in that they wanted to mark themselves out from their peers in order to have an advantage when it came to applying for a consultant role. However, they did not seek an elite role or to gain influence and power, as some doctors have been found to do both here and in the US (Llewellyn, 2001; Montgomery, 2001; Hoff, 1999), either on entry to or exit from the Fellowship. Nor, having sought such stratification, in terms of wanting to mark themselves out from their peers, were the group keen to exclude their peers from gaining leadership skills, in order to maintain some form of closure (Parkin, 1979) and improve their position in the labour market (Murphy, 1988; Larson, 1977). In contrast, they were keen to create and embed opportunities for their peers to acquire leadership and management skills. One way of looking at this is that, as the first cohort on a prestigious, high profile intervention the group have already marked themselves out and acquired an elite status, beyond any which might be acquired through participating in later interventions. As the deanery website noted, “due to the high status of the programme Fellows are in high demand for a variety of clinical conferences, forums and knowledge-sharing events.”

All of this suggests that restratification, and indeed elite status, may occur through means beyond professionals moving into formal administrative and research elite positions (Hafferty and Light, 1995; Freidson, 1984). These ‘Darzi elites’ marked themselves out whilst remaining, currently at least, within the rank and file. Waring and Bishop (2010) found a similar situation occurring within an operating department, when some members of the team were selected to be part of a project group introducing lean procedures. If more professionals across all levels of organisations gain leadership and management skills then the ‘rank and file’ (Freidson, 1984, 1994) may become increasingly stratified. To a certain extent, the Fellows were similar to some of the GP elites, noted by McDonald et al (2009) who remained largely grounded in clinical work despite having assumed positions within the PCT. The next section looks at the third contribution of the thesis in terms of recommendations for policy and practice.

8.5. Contribution 3: Recommendations for policy and practice

With regard to leadership development interventions there are some specific recommendations for practice that have emerged. Firstly, if the objective of development is to develop a cohort of future leaders in the formal sense then a careful selection process, one which includes examination of potential recruits' interests and motivations, is recommended.

Secondly, there appears to be a need for training and guidance for those taking on mentoring roles in this situation has been highlighted. The fact that sponsors/mentors were asking *after* the projects had been designed and submitted exactly what was expected of the Fellows suggests that they needed greater clarity regarding the role. Sponsors need to be able communicate the objectives and expectation behind any novel role to other supervisors and stakeholders, in order to reduce some of the role ambiguity noted. Mentors need to consider and reflect on the nature of the advice they give. For example, in one case a Fellow was being told by his mentor, this is what needs to happen and how it needs to happen, which placed him in a difficult position such that he ended up slipping into an approach which failed to engage his colleagues.

Thirdly, while leadership development involving live service development work appears to be beneficial, in terms of developing the skills and enhancing the confidence of participants, both the individual learner and the organisation are likely to benefit more where projects have the support of the executive team. It may also be advisable for those commissioning interventions to seek guidance from practitioners with organisational and management development expertise as to the feasibility of a project for learning and development purposes. Wicked problems which involve multiple perspectives and cross organisational boundaries appear to be useful for promoting learning and exposing participants to the type of issues are likely to face in the future, as they progress their career. In fact, utilising wicked problems which expose doctors to multiple perspectives and conflict may be invaluable for engendering recognition of the need for greater

collaboration. However, those sponsoring interventions which include such problems need to be realistic about the outcomes that can be achieved.

Fourthly, interventions for doctors may wish to consider whether they are completely removed from a clinical role. Given that the majority of doctors are likely to exercise leadership from within a working clinical role, leadership and management experience which allows them to draw on their credibility and rapport with their colleagues may be beneficial. A balance may need to be found between creating a feeling of tension, by placing doctors in a new role in order to precipitate a change in orientation and attitude, and allowing them to play to their strengths and to draw on their existing networks.

Fifthly, the positive views formed of senior management teams suggests that many executive teams have taken on board suggestions that they need to be open to feedback and to foster a culture of participation and empowerment (Kirkpatrick et al, 2008; Yukl, 2009). However, those at the top of organisations may now need to concentrate on developing new avenues for communication between middle managers and doctors on the frontline. Where such opportunities were introduced or observed as part of the Fellowship they were found to be beneficial. Finally, it may be that the training of non-clinical managers needs to be considered, in terms of how far it includes opportunities to understand the way in which doctors are trained and to study and observe clinical practice.

In terms of recommendations for policy, while the Kings Fund (2011) have stated that continued investment in development is needed if policymakers are to develop doctors as leaders, issues were raised by these findings in relation to when and how these interventions might occur, in order to maximise benefit for all concerned. Klaber and Bridle (2010) have noted there is no easy answer to this. They suggest that undergoing development in advance of the consultant stage can help doctors think about what they might do and give them the chance to build skills, whereas waiting until consultant stage means they are more likely to be able to put things into practice straight away.

Given that two Fellows followed in this research developed and led new, within-Trust programmes running over a six months period and reported similar attitudinal changes

amongst Registrars participating, this suggests that wider attitudinal change, exposure to non-clinical managers and experience in change management may be achieved through use of shorter, less expensive interventions. Given this, and the fact that the many short courses available are suggested to be inadequate to develop doctors as leaders and managers (Edwards, 2005) policymakers and commissioners might wish to consider reducing the number of short courses and increasing the number of such within-Trust interventions. Longer, more intensive interventions of the kind studied here could perhaps be then targeted at junior doctors who show a particular interest in becoming future leaders and at consultants in the early stages of their careers. The latter is the level of doctor many Fellows felt need input if more junior doctors are to get involved in leading and managing within the NHS. Consideration might also be given to routinely offering a module of leadership development based around service development and quality improvement work at the end of specialist training, in order to ease the transition into the consultant role, given that many of the senior Registrars studied here felt more confident about taking the next step based on their experiences in the Fellowship. The chapter now moves on to look at limitations and opportunities for future research.

8.6. Limitations and opportunities for future research

The findings uncovered in this research are obviously the result of a single case study, and so carry the usual caveats associated with such a research design, in terms of their ability to generalise beyond the case itself. However, Yin (1984) distinguished between statistical generalisation and analytical generalisation, suggesting that in the latter, findings from a current case can be compared against pre-existing theory, as the findings here were, against the theory of role transition (Nicholson, 1984). Other steps were taken to enhance generalisability, in terms of studying a case that was not only of intrinsic interest but also of instrumental interest (Stake, 2005), given the move towards developing more doctors and indeed professionals across the public sector as leaders. The findings were also compared with what is known about the wider population of doctors and other professionals within existing literature (Gomm, Hammersley and Foster, 2000). In addition, the views and experiences of a comparison group of doctors, at the same level of specialist training as those participating in the intervention were sought, in a bid to determine how representative the group was of the wider population and to corroborate certain findings.

This study has taken the first steps in showing how doctors undergo role transition during leadership development, and the way in which attitudes and orientations are maintained in the short to medium term. Next steps would be to study other trainee doctors, and indeed other professionals, to explore whether the types of transition and identity change found here are observed in other groups and other leadership development interventions. Longer term observation is also needed, which might include entry to an intervention, the experiences and processes undergone during the intervention and the transition back into the clinical role and beyond into the consultant role. This is especially important given that many Fellows were waiting to become a consultant in order to put their full range of new skills and attitudes into practice.

Future research would also benefit from incorporating two particular factors which this study was unable to pursue. Firstly, a wider set of perspectives, particularly those of sponsors and mentors, in order to gain a more rounded assessment of the degree and type of personal change undergone by participants. Secondly, observation of educational sessions would have added to the overall understanding, in terms of how the group influenced each other's sensemaking (Weick, 1995), and attitudinal change. Access issues, seemingly associated with the fact that this was the first Darzi Fellowship and the commissioners were sensitive as to what the outcomes might be, prevented this. In future interventions it might be useful to formally seek the insights that peers offer with regard to change amongst members of a group undergoing a collective transition. This would potentially offer insights for both the researcher and the learners.

Opportunities to compare longitudinal leadership interventions for doctors not in formal leadership roles were limited at the time this intervention took place. As such, there would obviously be a benefit in comparing outcomes across multiple interventions (Yin, 1994; Glaser and Strauss, 1967), and this seems likely to be possible, given that investment in clinical leadership appears set to continue (Spurgeon, Clark and Ham, 2011). Given that a number of other countries, such as Australia and Denmark, are involved in training junior doctors in leadership and management, an international comparison of the design, process and outcomes of medical leadership development interventions would be valuable in helping to develop these further for all concerned. It would also be beneficial to explore whether taking on such project management roles for learning purposes, as the Fellows here did, is better undertaken alongside the clinical role, in order to utilise established

relationships and facilitate ability to influence peers, or, better undertaken whilst removed from the usual clinical role, as was largely the case in this research.

Future research might also wish to look at the impact of speciality differences in terms of attitudes of doctors towards engaging with management and also individual differences such as personality and gender, and the way in which these impact on role transition and attitude change amongst a professional group. This would appear to be particularly beneficial, given that these findings revealed that it was largely women who related some inability to make progress which they attributed to their own level of competence.

8.7 Summary

Despite the highlighted limitations and need for more research, this thesis has addressed a gap in the literature and moved the debate forward as to *whether* and *how* professionalism might be changed amongst professionals not yet in any formal leadership role. Evidence has been provided to support the proposition that leadership development be considered a process of role transition and identity transformation (Ibarra, Snook and Guillém Ramo, 2008), resulting in a potential new model of role transition and identity transformation. The findings suggest possible new ways of professional working and community, supporting the idea put forward by Adler, Kwon and Heckscher (2008). Recommendations for policy and practice, as to how professional leadership development may be taken forward, are made. As such the thesis contributes to academic knowledge and practice.

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APPENDICES

APPENDIX A

Item A1: Interview Guide, Fellows Stage 1

1. How did you come to hear about and be involved in the programme?

-selection process, how much knew about role

2. Anything that influenced your decision to take part

3. What were your main reasons for participating?

4. What experience of leading service development type projects do you have?

-any prior involvement

5. Any other management/leadership experience?

6. What do you hope to gain from participating?

- career prospects
- any thoughts on a leadership/mgt role at this stage
- what will count as a successful year
-

(Later added in what are you most looking forward to?)

7. What concerns, if any, do you have about participating?

- career, project, other

8. What experience do you have of working with managers?

-clinical and non-clinical

9. What views have you formed about managers so far?

-and management process

10. What is your experience of organisational change?

- positive or negative experiences
- views on what makes the difference between a positive change initiative and one which has a negative impact
- role of leadership
-

(* For those already working on projects)

11. How are you approaching your projects

- Anything that is helping or getting in the way?

12. Is there anything that has surprised you at this stage?

13. Are there any learnings at this stage?

Item A2: Interview Guide, Fellows Stage 2

A: How would you describe experience to others?

- Experiences of day to day working life (who work with, how)

B: Approach to projects

- Follow guidance programme leaders or mentors
- Any factors that enabled progress
- Any factors that hampered progress

C: Any things that surprised you during year?

- Reactions (own and others)
- Progress
- Challenges

D: How did you deal with these and what did you think about the experiences?

E: Key things learnt, and aspects plan to take forward

- Most beneficial aspects of year
- Any impact on future career plans

F: Any change in own self and plans for future

- Insights into own self
- Future career plans

G: Changes in attitudes

- Non-clinical managers
- Doctors involvement in organisational/management issues
- Working with other stakeholders

Appendix B

Item B1: 'A Priori Themes' developed prior to coding

Context
Political
Background to Fellowship
Design of Fellowship
Preparation
Recruitment into Fellowship
Motivations
Goals
Concerns
Attitudes
Managers
Clinical Leaders
Prior Experience
Leading and managing
Organisational Change
Encounter
Surprises
Adjustment
Personal Change
Attitudes to managers
Attitudes to leadership
Role Innovation
Stabilization
Future Career Plans

Item B2: Initial Free Nodes Created

Type	Name
Free Node	Challenges
Free Node	Colleagues reactions
Free Node	Concerns
Free Node	Views on educational input
Free Node	Effective leadership
Free Node	Goals
Free Node	Influencers on participation
Free Node	Initial approach to project
Free Node	Insights emerging
Free Node	Local Trust
Free Node	Medical Culture
Free Node	Motivations for participating
Free Node	Objectives of programme
Free Node	Experience and views of managers on entry
Free Node	Political context
Free Node	Experience and views of clinical leaders on entry
Free Node	Prior experience of change
Free Node	Experience of leadership on entry
Free Node	Project measures
Free Node	Projects
Free Node	Promotion of programme
Free Node	Fellows reactions
Free Node	Recruitment and selection
Free Node	Reference group reactions
Free Node	Relating with managers
Free Node	Relations amongst Fellows
Free Node	Sponsors
Free Node	Supporters
Free Node	Views clinicians in management
Free Node	Views of management
Free Node	Views of self
Free Node	Views on making change
Free Node	Views on NHS
Free Node	Views on policy

Item B3: Themes emerging at 1st and 2nd refinement post first interviews

Major theme in tree node	Sub-theme at stage 1 refinement	Further sub-themes (at stage 1 refinement)	Sub-theme (post 2 nd refinement)
Preparation	Recruitment		Recruitment
Preparation	Selection		Selection
Preparation	Motivations for participating	Improve job prospects; Personal development	Motivations for participation 1. Career development 2. Personal development
Preparation	Concerns	Collegial relations; Failing on projects,	Concerns 1. Collegial relations 2. Failing on projects
Preparation	Experience and initial views managers	Split into experience of managers and views of NHS managers	Prior experience of working with other professionals 1. Managers
Preparation	Leadership and mgt experience on entry	Leading change; Professional leadership	Prior experience organisational change 1. Leading change 2. On receiving end change
Preparation	Views of management	Prior experience change/on receiving end change Some content merged with views managers	Attitudes on entry 1. Managers

			Attitudes on entry 2. Medical Leadership
Encounter	Challenges	Project challenges; Personal challenges	Leave in free nodes, refine stage 2 interviews
Encounter	Approach to project		Leave in free nodes, refine stage 2 interviews
Preparation	Goals		Fellows' Goals 1. Make mark 2. Achieve project goals and objectives 3. Develop leadership skills 4. New perspective on career
Preparation	Objectives of programme		Objectives of Fellowship
Preparation	Views clinical leaders		Prior experience of working with other professionals 2. Clinical leaders
Encounter	Colleagues reactions	split into (a) clinical reactions to role and (b) working with others (i) Fellows, (ii) senior medics, (iii) peers	Experience of working with others 1. Managers

Adjustment	Insights emerging	Some of content moved to evolving views change. Renamed learnings	Experience of working with others 1. Managers 2. Clinical leaders
Adjustment	Views of effective leadership	Re-named evolving views effective l'ship	Emerging views/attitudes Effective leadership
Adjustment	Views on educational input		
Preparation	Influencers on participation		
Encounter	Clinical colleagues reactions to Fellow Relating with managers	Moved some content to clinical reactions to role	Experience of role; Clinical colleagues reactions -positive; negative
Encounter Preparation	Views of self		Attitudes on entry to self
Encounter	Projects	Guidance on managing projects, Fellows; Approach to projects, Reactions to leading projects	
Preparation	Experience and initial views clinical leaders		1. Prior experience of working with other professionals 2. Clinical leaders
Encounter	Relations amongst Fellows		Leave in free nodes for now –refine after 2 nd interviews
Encounter/ Adjustment Preparation	Sponsors		Leave in free nodes for now -refine after 2nd interviews
Preparation	Views on NHS		
Encounter	Initial reactions to the experience	Isolation; Discomfort; Working with others	Own reactions to new role Out of comfort zone -liminality; uncertainty

Encounter	Supporters		Leave in free nodes for now -refine after 2nd interviews
Preparation	Medical Culture		Clinical colleagues reactions to role
Context	Local Trust and sponsor response		
Adjustment	Evolving views of managers		Emerging views Managers
Encounter/ Adjustment	Initial clinical working		
Stabilisation	Future plans		Leave in free nodes for now -refine after 2nd interviews
Adjustment	Personal changes		Leave in free nodes for now -refine after 2nd interviews
Preparation	Ethos of educators		
Preparation	Assumptions and expectations of educators		Fellowship design Ethos and guidance of educational leaders Underpinning principles (whole system working)
Preparation	Modules		Fellowship design Structure and content
Context	SHA and Deanery strategy & Objectives		Objectives of Fellowship

Item B4: The Final Template

Level 1	Level 2	Level 3	Level 4	Level 5
Preparation				
	Factors influencing participation			
		Job status		
		Educational programme		
		Site		
		Nature of projects		
		Key associates		
		Supervisor		
	Incoming views			
		Ability to lead and make successful change		
		NHS managers		
		Medical involvement in management		
	Incoming experiences			
		Leading and managing		
			Leading organisational change	

Level 1	Level 2	Level 3	Level 4	Level 5
Preparation contd	Incoming experiences contd	Interacting with managers		
		Interacting with clinical leaders		
Encounter				
	Surprises/Challenges			
		Establishing oneself		
			Defining the role	
			Others confusion	
		Educational inputs and support		
			Taught modules	
			Individual coaching	
			Programme leaders	
		Balancing the workload		
			Nature and evolution of projects	
			Personal abilities and commitments	
		Working with others		
			Engaging stakeholders	
			Dealing with conflict	

Level 1	Level 2	Level 3	Level 4	Level 5
Encounter contd.		Factors influencing progress		
			Support of key individuals	
				Mentors
				Managers
			Nature of Trust	
			Own abilities	
			Other stakeholders	Specialities
Adjustment				
	Personal change and development			
		Insights developed		
			Leading organisational change	
			Structures, roles and processes	
			Self	
		Attitudes emerging		
			NHS Managers	
			Medical involvement in management	Structural and cultural influences on engagement
			Other professionals	
			Being a leader	

Level 1	Level 2	Level 3	Level 4	Level 5
Stabilization				
	Self assessment of change on exit			
	Future career plans			
	Longer term attitudes			
		Involvement with organisational issues		
		Working with others		
		Career		