4 DEVELOPING A LEADERSHIP FRAMEWORK FOR THE IMU

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4.1 Background

The 21st century has seen emerging challenges to the healthcare system as a result of epidemiological and demographic transitions, technological innovations, professional differentiations and population demands. These have led to glaring gaps and striking inequities in health both between and within countries[1]. Healthcare systems therefore need to continually and efficiently reform to adapt to these new challenges, and meet the needs and demands of the population.

The strategic objectives of the reforms should include:

- Implementing evidence-based medicine to standardise delivery quality
- Improving organisational flow to increase volumes and revenue
- Designing patient-centred care coordination models to attract new market segments
- Encouraging new customer markets through developing state-of-the-art healthcare service
- Designing and carrying out a plan to dramatically enhance the behavioural competencies of all staff, and
- Improving operations to increase productivity and cut cost, waste, and cycle times[2].

Reforms in the healthcare system will inevitably have implications for health professionals in the system as well as the health professions education system that produces them. They need to be aligned around a common goal: doing what's right for patients[3], and pivotal in achieving this goal is leadership[4].

Leadership is usually understood in relation to the behaviour of an individual and their relationship to their followers, resulting in an emphasis on the behaviour, characteristics and actions of leaders. Leaders are expected to develop a vision that sets the organisation's direction. Vision statements identify the organisation's core capabilities, defines the domain in which it will operate, specifies its customer relationship, and details the strategic direction of the company. They provide explicit directions to the team members but leave enough room for innovation and management initiatives[5], continuity and change management[6,7]. Organisations that do not take the time to develop their visions and missions are often ineffective.

To maintain performance, organisations need to adapt to their changing environments. They have to learn how to adapt to changes in the diversity of their workforce and customers as well as to the changing demands for social responsibility[8]. As organisations adapt, their leadership will also have to change; leaders must become change agents[9].

This Chapter examines leadership practices in both the healthcare system and the health professions education system with particular reference to the International Medical University (IMU) as a provider of health professions education, and proposes a leadership framework for organisational development at the IMU.

4.2. Concepts of Leadership

4.2.1 Transformational and Transactional Leadership

Leaders may broadly be identified as transformational or transactional. Transformational leaders are visionary and enthusiastic, with an inherent ability to motivate subordinates, raise their awareness about what is important and increase their concerns for achievement, self-actualisation and ideals[10]. They move followers to go beyond their own self-interests for the good of their organisation. One learns to be a transformational leader by role modelling. The role model inspires, challenges and motivates team members, who in turn begin to be encouraged to think creatively and to develop

problem solving skills[11]. Transformational leadership and mentoring have quite similar elements[12]. Transformational leadership consists of a relationship between supervisor and supervisee, and mentoring consists of a relationship between mentor and mentee. The supervisor and mentor usually have personality traits, e.g. charisma, influence, skills, knowledge and expertise that allow them to be an effective role model for the supervisee or mentee. The supervisee and mentee, on the other hand, have high regards and respect for their supervisor or mentor, and possesses an attitude of willingness to learn and to take on responsibilities[13]. By encouraging an environment for leaders to develop leaders, teamwork within the organisation will be promoted. No leaders can have followers without a close working relationship. Similarly, no followers will follow a leader who is not engaging in their work.

Transactional leaders are said to be 'instrumental' and frequently focus on exchanging relationships with their subordinates[14] to cater to the self-interests of their constituencies by means of contingent reinforcement, positive in the case of constructive rewards, praise and promises for constituents' success in meeting commitments[15]. The reinforcement may be aversive, such as negative feedback, reproof, or disciplinary action in the case of followers' failure to meet commitments[16].

It has been theorised that transformational leadership is more closely linked to superior organisational performance.

4.2.2 Shared Leadership

However, it is becoming ever more clear that no one person can be an expert on all aspects of the work that need to be done[17], especially in the current context of rapid socio-economic and technological changes that characterise the 21st century. Successful organisations will need to increasingly rely on highly independent, knowledgeable individuals working as part of multi-disciplinary teams. The concept of shared or distributed leadership has been proposed as essential for managing these changes.

The term, 'shared leadership' is often used interchangeably with 'distributed leadership', 'collective leadership', 'horizontal leadership', and 'team leadership'. In a review of the literature on shared leadership, Kocolowski (2010)[4] noted that most of the studies retrieved fell in the domains of healthcare and education. The review suggests that shared leadership may be referred to as a "relational, collaborative leadership process or phenomenon involving teams or groups that mutually influence one another and collectively share duties and responsibilities otherwise relegated to a single, central leader". Elsewhere, it has been defined as "a dynamic interactive influencing process among individuals in groups for which the objective is to lead one another to the achievement of group or organisational goals or both"[18]. Shared or distributed leadership is first and foremost about leadership practice rather than leaders or their roles, functions, routines, and structures[19].

The concept that leadership is not restricted to people who hold designated leadership positions[20], and that acts of leadership can come from anyone in the organisation emphasises the responsibility of all staff in demonstrating appropriate behaviours, in seeking to contribute to the leadership process and to develop and empower the leadership capacity of colleagues[21].

Such a concept of leadership has evolved from the recognition that no one individual can save a company from mediocre performance, and no one individual, no matter how gifted a leader, can be right all the time[22]. Enterprises that are dependent on the traditional hierarchical model of one leader at the top run a considerable risk; if that individual retires, leaves (or dies in office), the organisation may well lose its continuing capacity to succeed.

According to Kocolowski's review[4], shared leadership is characterised by:

- Resolution of differences within the team to reach agreement
- Distribution of work to take advantage of members' unique skills
- Sharing of information and strategy about the organisation
- Promotion of teamwork within the team itself
- Working together to identify opportunities to improve productivity and efficiency

In order to empower team leadership, it is proposed that team leaders should delegate enough autonomy and responsibility to all members in their team, involve their team in decision making, and encourage their team to self-manage its performance. Further, emerging leadership teams become effective only when they are characterised by:

- Shared strategic goals
- Extensive networks
- Collaborative relationships
- Effective information processing, and
- Focussed action

Walmsley and Brown[23] defined shared leadership in the context of clinical team working as characterised by:

- A shared vision
- A clear strategy and plans for implementation
- Joint accountability for progress
- A recognised leader, but with shared responsibility for outcomes
- The lack of dependency on one or two key individuals
- Well-identified key stakeholders and means by which they keep in touch

4.3 Leadership in Healthcare

In healthcare organisations leaders are responsible for the strategic and operational planning of the services they provide. This is carried out through alignment and deployment of action plans throughout the delivery system. It requires full participation of physicians along with all other levels of clinical and support operations. The leadership is expected to:

- systematically communicate their values, plans and expectations to all staff at all levels;
- periodically review all aspects of organisational performance (i.e. outcomes, customer experience, financial results, workforce experience, and organisational learning);
- use their findings to define and redefine organisational strategy and set priorities for improvement and innovation based on analysis of the expected return on investment; and
- guide the development and deployment of action plans throughout the organisation and ensure high performance by the entire workforce and all the while maintaining a positive environment for the workforce[2].

With the shift to team-based knowledge working (physicians and other clinical and support staff), more traditional models of leadership are being questioned. Traditionally, leadership has been conceived around the idea that one person is firmly "in charge" while the rest are simply followers—what is termed vertical leadership. However, recent research indicates that leadership can be shared by team leaders and team members—rotating to the person with the key knowledge, skills and abilities for the particular issues facing the team at any given moment. It is suggested that poor-performing teams tend to be dominated by the team leader, while high-performing teams display more dispersed leadership patterns, i.e.,

shared leadership. This is not to suggest that leadership from above is unnecessary. On the contrary, the role of the vertical leader is critical to the on-going success of the shared-leadership approach to knowledge work[17].

Healthcare organisations would seem to be especially open to the introduction of shared leadership[4]. As the workload of the professionals increases, shared leadership is becoming widespread[24]. Many hospitals have responded to the need for new forms of leadership, leading them to adopt shared governance as a means to improve outcomes. Primarily, healthcare leaders have to build a community-based leadership vision with key stakeholders who collectively share a set of assumptions about their environment[25].

Shared leadership is highly practical in the healthcare environment as the quality of patient care often depends on how well a diverse group of medical and administrative experts work together, and how well collective energy is mobilised[26]. In a study of middle-level managers in Finnish social service and healthcare, Konu and Viitanen[27] concluded that shared leadership provides a pathway to creating uniformity in decision-making and defining responsibilities. This too is observed in the nurse-physician relationships where shared leadership is practised. The objectives of shared leadership development should centre on trust, cohesiveness, communication, and conflict resolution with:

- The facilitation of team members learning how to relate to and communicate with each other on an interpersonal basis
- The facilitation of increased levels of trust among group members
- The facilitation of increased group solidarity
- The reduction of misunderstanding among group members
- The facilitation skills necessary for preventing and resolving intra-group conflict

4.4 Leadership in Health Professions Education

The integration of modern science into the health professions education curricula has produced health professionals with the knowledge that contributed to the doubling of life span during the 20th century. By the beginning of the 21st century, health systems worldwide have become more complex and costly, placing additional demands on health workers. Health professions education has to keep pace with these challenges, and reforms of educational programmes are needed in order to produce well-trained graduates to face the challenges of today as well as the future. These reforms should be guided by two proposed outcomes: transformative learning and interdependence in education.

Transformative learning is about developing leadership attributes; its purpose is to produce enlightened change agents. As a valued outcome, transformative learning involves three fundamental shifts:

- from fact memorisation to searching, analysis, and synthesis of information for decision making;
- from seeking professional credentials to achieving core competencies for effective teamwork in health systems; and
- from non-critical adoption of educational models to creative adaptation of global resources to address local priorities.

Interdependence is a key element in a systems approach because it underscores the ways in which various components interact with each other. As a desirable outcome, interdependence in education also involves three fundamental shifts:

- from isolated to harmonised education and health systems;
- from stand alone institutions to networks, alliances, and consortia; and

- from inward-looking institutional preoccupations to harnessing global flows of educational content, teaching resources, and innovations.

Effective leadership is essential for these reforms to take place. The broad engagement of leaders at all levels, local, national, and global, is crucial in achieving the proposed reforms and outcomes. Leadership has to come from within the academic and professional communities, but it must be backed by political leaders in government and society as it also requires a substantial expansion of investments in health professional education from all sources, an effective stewardship mechanism and the provision for shared learning by supporting metrics, evaluation and research[1].

4.5 Student Leadership

Preparing future leaders in the health professions should begin early. Undergraduate education is an ideal setting to lay the foundation for these leadership competencies. The environment in which today's graduates will be practising healthcare will be different to that of their predecessors. Individual professional autonomy has been replaced to some extent by interdisciplinary and inter-professional care, demanding better teamwork and communication[12]. Nevertheless, physicians will continue to function in leadership roles in healthcare teams and are considered to be ultimately responsible for the overall outcomes of patient care. The Institute of Medicine recommends that academic health centres "develop leaders at all levels who can manage the organisational and systems changes necessary to improve health through innovation in health professions education, patient care, and research", and this is echoed by the Academy of Royal Medical Colleges to include undergraduates[18].

For an undergraduate leadership curriculum, emotional intelligence, confidence, humility and creativity have been identified as necessary qualities of leaders; while teamwork, communication, management and quality improvement as necessary knowledge and skills. In the study about leadership curriculum in undergraduate medical education, Varkey et al[28]. reported that students perceived themselves as somewhat or fully competent in communication, conflict resolution and time management, but reported minimal or no knowledge or competence in management and quality improvement, indicating the gaps that need to be filled in the undergraduate medial curriculum in training future healthcare leaders. An explicit leadership curriculum including role play, team training, community experiences, student leadership opportunities, participation in quality improvement projects and mentored leadership development plans are some of the potential methods to enhance leadership training in undergraduate medical education[29]. While experiential training has been perceived as the most effective for teaching leadership skills, the present day students in health professions are armed with a set of additional skills and resources different from their predecessors. Online resources, free or inexpensive web-based tools and meeting platforms permit new and high quality means of communication that can be utilised in their learning and leadership skills development.

4.6 Situational Analysis

This section describes how leadership is perceived at the IMU.

4.6.1 Leadership at the IMU

Staff's perception of leadership at the IMU can best be inferred from the results of the DLOQ survey that was carried out in Sept 2012. The DLOQ assesses the degree to which an organisation perceives it meets the qualities of a learning organisation. Some of the questions in the questionnaire assess the values of a learning organisation that are also consistent with shared leadership. It consists of 43 items, each rated on a 6-point scale, where [1] refers to

a practice which rarely or never occur, and [6] to a practice which is almost always true of your department or work group. The results are summarised in Figure 1. The overall mean score was 3.58.

Values such as commitment to truth and enquiry, and trust are indicated as being highly important components of a culture which encourages shared leadership[30]. According to the DLOQ survey results (Figure 4.1), IMU staff perceived less positively the promotion of inquiry and dialogue, such as 'giving open and honest feedback to each other' or 'encouraged to ask why regardless of rank'. It is thought that without inquiry and dialogue, open exchange of ideas is suppressed.

Taking calculated risks in pursuit of organisational goals is considered a desirable value for shared leadership[30], but this is not perceived at the IMU to be supported (Figure 4.1). An overcautious culture leads to conservative behaviour and unwillingness to experiment with new ideas, making it difficult for people to work without going through layers of management for consultation and permission. Work patterns are inflexible and do not encourage employees to design their work in ways that are satisfying and more intrinsically rewarding. People are discouraged from stepping outside the box in the way that they think about and perform their work.

Collaboration and team-working is often cited as the cornerstone of shared leadership[4]. According to the DLOQ survey results, perception of collaboration and team-working, for example, freedom of teams to rethink their mandates or explore ideas that may take them off task, is relatively neutral (Figure 4.2).

The DLOQ's domain on 'Strategic leadership for learning' was perceived positively by staff (Figure 4.2). However, the items have been phrased in such a way as to assume the traditional model of hierarchical leadership. For example, in the IMU, 'leaders' are perceived to 'ensure that the organisation's actions are consistent with its values', suggesting centralised responsibility.

Figure 4.1 Summary results of the DLOQ survey carried out at the IMU in September 2012.

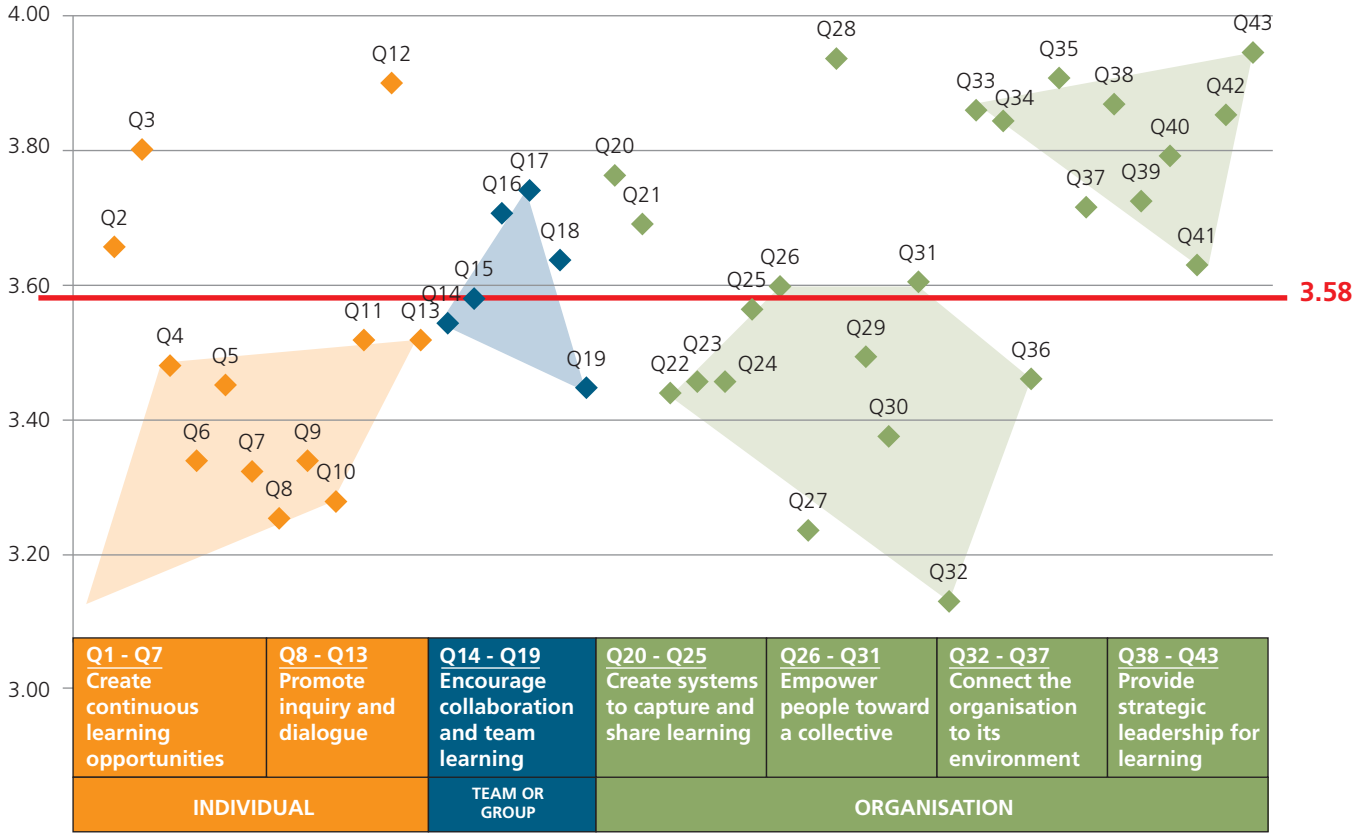


Figure 4.2 Summary results of the DLOQ survey (by questions) of IMU staff carried out in September 2012.

4.6.2 Student Leadership at the IMU

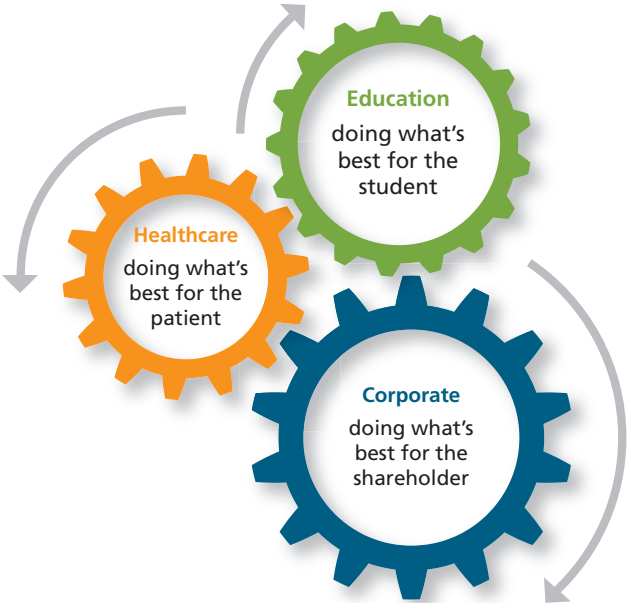
Presently, the student leadership curriculum in the IMU remains a hidden curriculum. Nevertheless, many of the potential methods to enhance the leadership qualities in undergraduate health professional education as proposed by Varkey et al. (2009)[28] are being held in the IMU on a regular basis. Notable mentions include:

- Student engagement in matters related to their training. In the IMU, students are empowered to express their views on matters which affect student life at the University, including academic, student welfare and co-curriculum activities. The student engagement in the matters of their training has been recognised by the AMEE where recently the IMU has been awarded the AMEE - ASPIRE for EXCELLENCE award in the area of Student Engagement.
- Involvement in community projects in leadership roles is an essential part of their training. These projects enable the students to serve the community, experience team-working and nurture their leadership qualities. Again, one of the community projects by the IMU has won the First Place in the MacJannet Prize for Global Citizenship for the Community Service provided to the Orang Asli community in Negeri Sembilan.

The IMU supports an atmosphere where students can openly share ideas, interests, and concerns. Through involvement with co-curricular activities and attendance in programmes organised by student groups, students can develop their skills, knowledge, attitudes, and behaviours in regards to leadership qualities, ethics and professionalism, and other soft skills. Involvement in these activities plays an important and complementary role to learning in the classroom and the IMU strongly supports student creation of and involvement in organisations.

4.7 Conclusions and Recommendations

As an organisation, the IMU is a body of three closely knitted primary structures, each with a clear primary goal:



A progressive leadership framework is pivotal for IMU's success in the corporate, healthcare and education arenas. Current thinking would suggest that embracing shared leadership is the way forward. For this to take place, certain key guiding principles[30, 31], must be observed:

- Humility – no one individual can perform all aspects of work that need to be done
- Equity – each individual has his/her unique knowledge and skills, and there must be mutual recognition of the unique contribution of each individual
- Partnership – all individuals therefore need to work together with mutual respect and trust
- Ownership – within the team they must be capable of making personal commitment to the outcomes of their work and to the mission of the team
- Accountability – all individuals must own the consequences for actions that are inherent in their role

Underpinning these principles should be an organisational culture based on[30]:

- **Mutual respect** – We respect that each individual has unique skills to lead this mission
- **Trust** – We trust that each of us will fulfil our role
- **Unity** – We remain united in our mission in the face of conflict
- **Commitment to truth and enquiry** – We are committed to the truth and will enquire to seek it
- **Openness** – We are open to each other's ideas, thoughts and feelings
- **Risk-taking** – We support taking calculated risks in pursuit of organisational goals

As these values permeate the whole organisation, leadership can be developed so that it is evident and recognised at all levels. Developing leadership at all levels promotes the ability to respond to the rapid, even

disruptive changes that are the reality of today's operating environment. It is also the case that the larger, more complex and global an organisation is, the more it needs to embrace the principle of leadership at all levels. This is a challenge to the idea that leadership and management are hierarchical; typically that leaders are more 'senior' in an organisation than managers. This principle, therefore, can be contentious in that it challenges many assumptions about authority, guardianship of knowledge and expertise.

Leadership at all levels is more relevant to today's matrixed, complex and fast moving organisations. It increases the leadership capacity in an organisation to execute complex and stretching strategies. The concept of leadership at all levels opens up many more opportunities for engagement, innovation, talent management and in overall terms, operating effectively in the reality of today.

We propose a leadership framework based on the concept of shared or distributed leadership. The central aim of the framework is to support the achievement of IMU's primary goals of doing what is right for the patient, doing what is right for the student, and doing what is right for the shareholder. We propose devolution of responsibility and assumption of ownership and accountability in acknowledgement of the unique skills and expertise individuals bring. We further propose that shared leadership is developed by equitable distribution of responsibility based on knowledge and skills, with individuals working in partnerships to achieve the common goals.

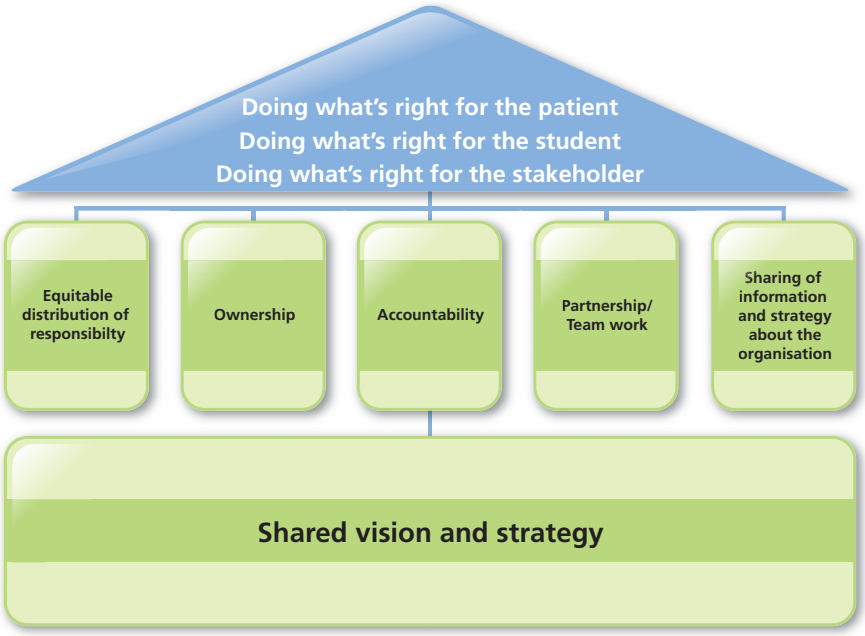


Figure 4.3 Leadership Framework

We make the following recommendations to support the development of shared or distributed leadership:

- Development of organisational and management structures that empower staff to assume responsibility with ownership and accountability
- Within formal forums / committees as well as spontaneous or improvised groupings, individuals or teams should have responsibility for certain aspects of the agenda
- Multi-disciplinary and inter-professional working in order to take advantage of the unique skills and talents of all staff
- Development of communication and inter-personal skills to support effective teamwork and working in partnership
- Development of emotional intelligence and conflict resolution skills to enable effective working in partnerships and teams

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