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## Exploring medical trainees' experiences of leadership and followership through narratives of the healthcare workplace

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### Contributors

All authors contributed to the study conception and design. LG contributed to data collection and analysis and wrote the first draft of the paper and edited various iterations. CER contributed to the data collection and analysis and edited each iteration of the article. JK and JC contributed to the data analysis and also commented on various iterations of the article.

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### Competing Interests

None.

### Ethical approval

This study was approved by a University Human Research Ethics Committee (not identified here to maintain anonymity of study sites).

For peer review only

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## Abstract

### Objectives:

To explore medical trainees' experiences of leadership and followership in the interprofessional healthcare workplace.

### Design:

A qualitative approach using narrative interviewing techniques in 11 group and 19 individual interviews with UK medical trainees.

### Setting:

Multi-site study across four UK health boards.

### Participants:

Through maximum variation sampling, 67 medical trainees were recruited from a range of specialties and at various stages of training. Participants shared stories about their experiences of leadership and followership in the healthcare workplace.

### Methods:

Data were analysed using thematic and narrative analysis.

### Results:

We identified 171 personal incident narratives about leadership and followership. Participants most often narrated experiences from the position of follower. Their narratives illustrated many factors that facilitate or inhibit developing leadership identities; that traditional medical and interprofessional hierarchies persist within the healthcare workplace; and that wider healthcare systems can act as barriers to distributed leadership practices.

### Conclusion

This paper provides new understandings of the multiple ways in which leadership and followership is experienced in the healthcare workplace and sets out recommendations for future leadership educational practices and research.

## Strengths and Limitations of Study

- This is the first study to explore how medical trainees experience leadership and followership in the healthcare workplace through narrative analysis
- The large number of narratives across multiple UK sites and different specialties, enhances the transferability of our findings
- We had relatively low numbers of male, non-white and Foundation trainee participants so our findings are most relevant to female, white and specialty trainee doctors.

## Introduction

Recently, literature on healthcare leadership has shifted from notions of traditional hierarchical practices to arguing for distributed (or shared) leadership models. Distributed leadership is no longer solely the province of those in formal leadership positions, but is the responsibility of healthcare professionals across all levels of an organisation.<sup>1-5</sup> Modern theoretical discourses assert that leadership is a process involving leaders and followers acting within a fluid context so that people construct leader or follower identities moment-to-moment.<sup>6,7</sup> Suggested benefits of such distributed leadership practices include improved patient experience; reduced errors, infection and mortality; increased staff morale and reduced staff absenteeism and stress.<sup>8</sup> Taking this perspective, those in non-formal positions of healthcare leadership (e.g. medical trainees) are expected to undertake leadership throughout their careers and develop their leader identities.<sup>9</sup>

Whilst the healthcare literature envisages effective distributed leadership practices for improving healthcare workplace cultures, patient safety and quality of care, little is known about how leadership processes are experienced by medical trainees. Within this paper

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2  
3 therefore, we present an analysis of how medical trainees' leader and follower identities are  
4  
5 constructed through their healthcare workplace narratives.  
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7

### 8 Researching distributed leadership processes 9

10 Until recently, the focus of scholarly activity in leadership has been on individuals as  
11  
12 leaders.<sup>10,11</sup> For example, in healthcare, many studies have concentrated on *the role of leaders*  
13  
14 rather than *the processes of leadership*.<sup>e.g. 12,13</sup> However, many leadership theorists criticise  
15  
16 leader-centric research for its emphasis on individuals as leaders, how effective their  
17  
18 activities are and how others (followers) act in response to their influence.<sup>11,14</sup> Rather,  
19  
20 leadership theorists argue that leadership can only be understood through exploring the  
21  
22 underlying social systems in which leadership happens.<sup>6, 15</sup> As a product of co-construction,  
23  
24 leadership is perceived as an on-going negotiation as part of a multi-faceted interaction  
25  
26 between social beings.<sup>16</sup> Each interaction can be seen as socially and historically bound  
27  
28 operating through language, within a socially-constructed context.<sup>16, 17</sup>  
29  
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33 Some studies have opened up opportunities to explore leadership processes and the  
34  
35 link between senior clinicians and the wider organisation. For example, combining interviews  
36  
37 and observation, MacIntosh and colleagues explored the extent to which interactions between  
38  
39 clinicians and managers were two-way discussions, finding that each group presented  
40  
41 themselves as less powerful than the other group and lacking agency.<sup>18</sup> They described the  
42  
43 clinician-manager relationships as having potential to limit the opportunities for distributed  
44  
45 leadership processes. In addition, Martin and colleagues revealed through interview and  
46  
47 observation, that there was the potential for disconnect between the desire for distributed  
48  
49 leadership and actual organisational practices.<sup>5</sup>  
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54 Focus on wider organisational leadership processes within these studies could be to  
55  
56 the exclusion of leadership that occurs day-to-day within the clinical context, where medical  
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2  
3 trainees will have their first experiences of leadership (both as leaders and followers). Our  
4  
5 study seeks to bridge this gap and add to the literature on distributed leadership in healthcare  
6  
7 by focussing on how medical trainees experience leadership.  
8  
9

### 10 Aim and research questions

11 This study aimed to explore how medical trainees experience leadership in the  
12  
13 interprofessional healthcare by asking two research questions. What are medical trainees'  
14  
15 lived experiences of leadership and followership in interprofessional healthcare workplaces?  
16  
17 How do medical trainees construct their identities as leaders and followers within their  
18  
19 narratives of interprofessional healthcare workplaces?  
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22

### 23 Methods

#### 24 Study design

25 We undertook a qualitative study using group and individual interviews to elicit medical  
26  
27 trainees' personal incident narratives (PINs) of their experiences of leadership and  
28  
29 followership. Ascribing to the notion that meanings are constructed by people as they interact  
30  
31 with the world around them, our study draws on social constructionist epistemology.<sup>19</sup>  
32  
33

34 We used narrative enquiry methodology. Narrative accounts of the healthcare workplace  
35  
36 offer abundant resources for research.<sup>20</sup> The narratives referred to in this paper are short,  
37  
38 about discrete events, and recounted in interactions in various contexts as sense-making tools.  
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21, 22 A narrative in this form makes the self the central character (or protagonist), either  
playing an active part within the story or as Chase describes as an: 'interested observer of  
others' actions',<sup>23, p. 657</sup>

A narrative is the shared construction between the narrator and his/her audience.<sup>21, 23, 24</sup>

Bound to this is the context in which the narrative is shared; the specific setting, audience and  
the reason the story is told.<sup>23, 24</sup> Pivotal to our paper is the concept of the narrative turn in that  
narrators construct events through their story, expressing their feelings, beliefs and

1  
2  
3 understandings about leadership processes.<sup>24</sup> As such, the narrative becomes a construction of  
4  
5 who the narrator is, who they wish to be and how they wish to be seen.<sup>25</sup> In other words,  
6  
7 when a story is told, the narrator constructs and presents identities, events and realities in  
8  
9 interaction with others.<sup>23, 24</sup> Thus, paying attention to and asking questions not only about  
10  
11 what participants experience but also how they narrate their leadership experiences can afford  
12  
13 insight into the multiple identities that medical trainees construct as leaders and followers.<sup>23</sup>  
14

### 15 16 17 Sampling and recruitment

18 Upon receiving ethical approval and appropriate institutional consents we utilised maximum-  
19  
20 variation sampling to ensure a diversity of medical trainees in terms of their stage of training,  
21  
22 specialty and location. Following an initial recruitment drive by email, we recruited further  
23  
24 participants using flyers at trainee teaching sessions and snowballing.<sup>26</sup>  
25  
26

### 27 28 Data collection

29 We conducted eleven group and nineteen individual interviews with 67 medical trainees (25  
30  
31 male: 42 female, 53 white: 14 non-white) from both early-stage (34) and higher-stage  
32  
33 (trainees beyond the half-way point: 33) postgraduate medical training. Our sample came  
34  
35 from four UK Health Boards and a range of specialty groups including: General Practitioner  
36  
37 (GP) trainees (23); medical trainees (13); surgical trainees (11); and service-orientated  
38  
39 trainees such as anaesthetists, radiology and pathologists (10). Our sample also included eight  
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41 foundation doctors.  
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44  
45 We devised an interview guide, which ensured some consistency in approach across  
46  
47 interviews. The semi-structured nature of the interviews allowed for flexibility so that ideas  
48  
49 could be pursued and expanded upon. The interviews were broadly split into two sections:  
50  
51 first, we asked participants to articulate their understandings of leadership and followership  
52  
53 (reported elsewhere).<sup>27</sup> Following this, narrative interviewing techniques were used to collect  
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55 narratives of participants' experiences of leadership and followership in the interprofessional  
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3 healthcare workplace. All interviews were audio-recorded (with permission) and  
4  
5 independently transcribed. All interviews were conducted by the primary author bar one (the  
6  
7 second author conducted an early group interview and provided feedback on interview  
8  
9 technique to the primary author thus enhancing research rigour).  
10

### 11 12 Data analysis

13 We began our analysis with thematic framework analysis.<sup>28</sup> This allowed us to identify  
14  
15 patterns across the data. We constantly familiarised ourselves with the data through repeated  
16  
17 reading of transcripts and listening to audio-recordings. A team data analysis session was  
18  
19 held which provided opportunity to discuss and negotiate possible themes to be included in  
20  
21 the thematic coding framework. Prior to the session, a subset of data were analysed separately  
22  
23 by each team member. Through an iterative process of discussion, feedback and agreement  
24  
25 within the team, a coding framework was developed which was then used to index the data.  
26  
27 To identify narratives, we drew on Labov's construction that a narrative is a structured  
28  
29 account of an incident that has become part of the biography of the storyteller.<sup>29</sup> Using Atlas-  
30  
31 ti (Version 7.2), we identified, time-stamped and coded all narratives.  
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36

37 Using the premise that identities are formed through talk and interaction we explored  
38  
39 the interplay between different thematic groupings.<sup>24</sup> To do this, we used a form of structural  
40  
41 narrative analysis which pays attention to the ways in which narratives are organised.<sup>21</sup> Labov  
42  
43 states that a fully formed narrative includes seven elements: (1) abstract; (2) orientation; (3)  
44  
45 complicating action; (4) evaluation; (5) most reportable event; (6) resolution; and (7) a  
46  
47 coda.<sup>29</sup> Not all stories however will contain all elements and often elements occur in different  
48  
49 sequences, with narrators moving back and forth, providing further complicating actions and  
50  
51 evaluations as they make sense of the story.<sup>30</sup> Thus, we were able to explore how participants  
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53 constructed their identities as leaders and followers within their narrative, what parts of the  
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3 story participants constructed as important, and how the narrator used language to illustrate  
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5 how they evaluated the events.<sup>31</sup>  
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## 8 **Results**

9 Across the data, we identified 171 distinct narratives. Initial thematic analysis identified three  
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11 different sets (or groupings) of themes. Contextual themes for the narratives provided  
12  
13 orientation to the timing of the events; where the events took place; how the narrators  
14  
15 positioned themselves in the story (for example, as leader, follower or observer); the type of  
16  
17 activity that was being undertaken when the event occurred; and how the narrator evaluated  
18  
19 their experience (for example, positively, negatively or neutrally) through their commentary  
20  
21 on the events. The second group of themes focussed on the content of the story and  
22  
23 signposted its gist (i.e. the main plotline of the story). Finally, process-orientated themes  
24  
25 focussed on *how* the stories were narrated. This set of themes highlighted, for example,  
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27 linguistic features used by narrators to articulate their stories.  
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32 **What are medical trainees' lived experiences of leadership and followership in**  
33 **interprofessional healthcare workplaces?**  
34

### 35 *Contextual themes*

36  
37 Participants most often constructed themselves as followers within the stories (n=80), with  
38  
39 around half as many constructed from the position of leader (n=41). Of the 171 narratives,  
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41 144 were set in the hospital, with only 12 set in GP practice, despite GP trainees offering the  
42  
43 highest proportion of narratives across the specialties (sharing 53, of which 36 were hospital-  
44  
45 based).  
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49  
50 The activities on which stories centred were wide-ranging: they were most likely to  
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52 come from the clinical environment and be related to clinical leadership activities (n=119).  
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54 This included stories about complex patient scenarios, which participants deemed to be  
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56 extraordinary (n=37). Still related to clinical leadership, were stories about acute emergency  
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3 scenarios (n=32) and routine patient care (n=29). Data also included stories about formal  
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5 ward-based activities such as planned team meetings and ward rounds (n=15). Narratives  
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7 were evenly balanced between positively and negatively evaluated experiences (80 positive;  
8  
9 77 negative).

10  
11  
12 We identified two overarching themes for the content of the narratives (Static  
13 leadership relationships and Emergent leadership relationships) and a series of sub-themes as  
14 defined in Table 1. We also identified three key process-orientated themes: pronominal;  
15 emotional; and metaphoric talk. What follows in this section is an overview of each of these  
16  
17 themes with illustrative data excerpts presented in Table 2.

18  
19  
20  
21  
22 [Insert Table 1 around here]

### 23 24 25 *Static leadership relationships*

26  
27  
28 Static leadership relationships was the dominant content-related theme (n=131). Here, the  
29  
30 identity of the leader and follower/s remained static throughout the story and trainees  
31  
32 typically narrated from the position of follower. These leader-follower relationships were  
33  
34 based on the traditional hierarchies found within the healthcare workplace. From this, we  
35  
36 identified 12 sub-themes, which focussed on leader behaviours within the stories and which  
37  
38 were seen to be facilitative or inhibitive to good leader-follower relationships (see Table 1).

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40  
41 Here, we talk in-depth about the most common three themes only. Excerpt 1 (Table 2)  
42  
43 illustrates a facilitative sub-theme, where the leader is seen to be entering into a supportive  
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45 dialogue or behaving in a supportive way to facilitate leadership processes and leader-  
46  
47 follower relationships. Here, the leader is perceived to have acted in the best interests of the  
48  
49 patient regardless of the outcome. As a follower, this participant describes how she felt  
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51 valued, respected and supported within this relationship, that it was conducive to learning and  
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53 that this type of relationship was something to aspire to.  
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[Insert Table 2 around here]

In contrast, Excerpt 2 (see Table 2) illustrates an inhibitive sub-theme in which the leader is seen to be unsupportive and lack dialogue with the trainee as a follower. The trainee reports that these behaviours led to lost confidence and feelings of non-validity and exclusion. This is reported to be detrimental to training experiences and at times detrimental to patient care.

We also identified abuse narratives (see Excerpt 3, Table 2). This subtheme categorised narratives around direct and indirect experiences of what constituted abuse as perceived by participants (this included undermining and humiliation). As well as being the recipients of abuse, participants witnessed others being abused too. The abuser was most often identified as the consultant but trainees also reported abuse from other more senior trainees and nursing staff. Abuse typically revolved around clinical leadership and during routine patient care (for example, surgical theatre) or formal activities such as the ward rounds or meetings, as illustrated in Excerpt 3 (see Table 2).

Participants often reported negative emotional responses to these experiences: they talked about feeling humiliated and non-human, sometimes getting angry themselves; the need to keep going and “survive” training; and being careful to avoid situations in which abuse was likely to happen/occur.

#### *Emergent leadership relationships*

A smaller proportion of narratives (n=40) were coded to the content-related theme: Emergent leadership relationships. Unlike the previous theme, in which the identities of the leaders and followers were static, here participants recounted how the combination of individuals involved, the context (including the task), the relationships within that context and the wider systems affected who emerged as the leader within the experience. Leadership emergence

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3 was more likely to be categorised in narratives that related directly to patient care scenarios,  
4  
5 namely: complex patient cases; routine patient care; and acute emergency care. Interestingly,  
6  
7 no narratives in which formal clinical activities were being undertaken were coded to this  
8  
9 theme, indicating more static (and possibly traditional) leader-follower relationships within  
10  
11 more formalised clinical settings.  
12

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14  
15 We identified six subthemes within these narratives which described the factors either  
16  
17 facilitative of inhibitive to leadership emergence (see Table 1). Unlike the static leadership  
18  
19 relationship subthemes, medical trainees typically narrated emergent leadership relationship  
20  
21 narratives from the position of leader. Excerpt 4 (see Table 2) illustrates an example in which  
22  
23 emergent leadership relationships were facilitated by individual knowledge or experience.  
24  
25 The trainee describes an incident where, as a junior trainee, her broad-based training  
26  
27 experience made her more ‘expert’ than those with more specialised training.  
28  
29

30  
31 Often stories within this subtheme were interprofessional. Participants narrated  
32  
33 incidents in which more experienced nurses and other members of the interprofessional team  
34  
35 took on leadership. Participants narrated this as emergent because they were working in the  
36  
37 context of traditional interprofessional hierarchies, which meant that they thought doctors  
38  
39 were expected to lead. Perhaps unsurprisingly, participants inevitably saw leadership  
40  
41 emergence occurring in the best interests of the patients, as illustrated in excerpt 5 (see Table  
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43 2).  
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46  
47 In order for leaders to step forward and out of traditional hierarchical boundaries,  
48  
49 participants narrated the process of traditional leaders needing to “step back” (as illustrated  
50  
51 above). This was sometimes perceived to be difficult. At times, participants narrated  
52  
53 experiences in which traditional leaders stepped back through their non-engagement, as  
54  
55 illustrated in Excerpt 6 (see Table 2).  
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### *Process-orientated themes*

From the position of follower, participants often used the pronouns “we” and “us” to describe themselves and their contemporaries, and “them” and “they” to describe a group of leaders within their narratives, indicating a perceived separation (and potentially adversarial relationships) between followers and leaders. This was particularly apparent within the negatively evaluated narratives (See Table 3: Excerpt 1).

[Insert Table 3 around here]

When followership experiences were evaluated more positively and the leadership process was seen to go well, pronouns “we” and “us” would be used to describe the whole team, including both leaders and followers together (See Table 3: Excerpt 2). From the position of leader, participants often used the pronoun “I” when describing leadership decisions, which seemed to indicate their agency and autonomy within the situation (See Table 3: Excerpt 3).

Participants typically used positive emotional talk within stories that were evaluated positively (Table 3: Excerpt 4) and negative emotional talk (Table 3: Excerpt 5) within stories evaluated as negative experiences.

Across the narratives, we identified hundreds of metaphoric linguistic expressions (MLEs).<sup>32</sup> Although it is outside the scope of this paper to present a full systematic metaphor analysis, we identified broad groups of metaphors which revealed participants’ understandings of leader-follower relationships.<sup>32-34</sup> We identified eight overarching conceptual metaphors used to describe the leader-follower relationship. These were LEADER-FOLLOWER RELATIONSHIP AS: WAR; HIERARCHY; PARENTALISM; SPORT; CONSTRUCTION; MACHINE; JOURNEY; and TRANSACTION (the convention of cognitive linguistics requires that conceptual metaphors are presented in small capitals: see Table 4).<sup>34</sup>

[Insert Table 4 about here]

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3 How do medical trainees construct their identities as leaders and followers within their  
4 narratives of interprofessional healthcare workplaces?  
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7  
8 Here, we pull together both content and process-related themes to present a more detailed  
9  
10 exploration of one narrative. This narrative from ‘Carol’ (a pseudonym, female early-stage  
11 GP trainee) comes from an event she experienced during her time as a trainee in psychiatry. It  
12 is not explicitly clear what grade of training Carol was at the time of her story but through her  
13 use of language and the events narrated she is clearly junior to the narrative protagonists (see  
14 Table 5). Carol presents a complex patient scenario in which people in contact with a  
15 particular patient needed prophylactic treatment for meningococcal disease. The focus of  
16 Carol’s story is on her personal experience of trying to take leadership as the consultant (a  
17 psychiatrist) states that he does not have the necessary experience to do so. Carol describes  
18 how attitudes, systems and protocols become barriers to fully undertaking leadership in this  
19 scenario. Indeed, the key message of Carol’s narrative is that her ability to take on leadership  
20 is inhibited by the wider systems in which she works. We identified other content-related  
21 themes, which could facilitate and/or inhibit leadership processes. Facilitative aspects  
22 included her emergence as leader due to her own knowledge and expertise, in contrast to the  
23 consultant’s unwillingness to engage in leadership due to his own lack of experience, leading  
24 him to support her leadership emergence. Inhibitive aspects include Carol’s description of  
25 traditional systems, protocols and expectations that the consultant should be leading.  
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46 [Insert Table 5 about here]  
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48 Carol describes different interactions with different sets of actors in her narrative. Firstly,  
49 there is the interaction between herself and her consultant. Secondly, there is the interaction  
50 she has with a group of people (i.e. “the people”, line 21) she repeatedly describes as “they”  
51 or “them”. Throughout the narrative she is not specific about who “they” are. However, in  
52 lines 7 and 8, she lists a group of specialties and we assume that “they” are included within  
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3 this group. In the following paragraphs, we explore how Carol constructs her identities as  
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5 leader and follower in relation to these two interactions.  
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### 8 *Carol as a capable leader, the consultant as supportive follower*

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10 When Carol narrates her interaction with the psychiatry consultant, she constructs herself as a  
11  
12 confident and capable leader. She describes a discussion with her consultant in which  
13  
14 responsibility for dealing with the situation becomes hers (lines 19 and 20). When evaluating  
15  
16 this event, she uses positive language with intensifiers, to construct herself as “really  
17  
18 confident” that she can handle the situation (line 21) and qualifies this with the short  
19  
20 statement that: “I did”. Within this interaction, Carol identifies herself as the leader through  
21  
22 regular use of “I” to indicate her agency and control of the situation (lines 7 and 12). Despite  
23  
24 her describing the consultant as having a part in the process (e.g. writing prescriptions, line  
25  
26 12), she chooses not to use the pronoun “we”, suggesting that she does not see herself and the  
27  
28 consultant as a team. Possibly to reinforce her own identity as a strong leader, she constructs  
29  
30 her consultant as a supportive follower who undertakes tasks “for me” (line 12). This is  
31  
32 emphasised early in the narrative through her use of derogatory language to describe the  
33  
34 consultant as having “no idea what to do” (line 10) and as being “largely useless” (line 14),  
35  
36 constructing him as lacking both clinical knowledge and leadership.  
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### 42 *Carol as child, consultant as ‘daddy’*

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44 The second type of interactions Carol has within this narrative (with other healthcare  
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46 professionals as part of workplace systems and cultures) reveals a contrasting picture relating  
47  
48 to her and her consultant’s identity construction. “Their” express desire is to speak to the  
49  
50 consultant (lines 9), and “they” ask Carol if her consultant knows what is happening (line 15).  
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52 Carol’s pronoun use at this point places distance between her and this wider group and gives  
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54 this part of her narrative a confrontational feel. Carol narrates that she is powerless to change  
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56 systems which expect the consultant to be the leader and thus within this interaction, Carol  
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3 shifts her own position from leader to follower. Carol uses negative emotional language such  
4  
5 as “difficult” (line 18) and “frustrating” (line 23) to express how she finds this and how this  
6  
7 interaction effects her identity construction.  
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10  
11 Key within this narrative is Carol’s use of a metaphoric linguistic expression (MLE),  
12  
13 which reveals how she thinks her and her consultant’s identities, and their relationships, are  
14  
15 ascribed by others as: LEADER-FOLLOWER RELATIONSHIP AS PARENTALISM (line 22).  
16  
17 Through her use of this MLE (‘where’s your daddy?’), she constructs her identity as ascribed  
18  
19 by others as a young child and the consultant as her male parent. This reveals that she thinks  
20  
21 others see her as junior within the wider healthcare system. Indeed, Carol states that the  
22  
23 consultant is required to sign the prescriptions in order for the task to be fulfilled and thus  
24  
25 protocol reinforces this traditional hierarchy (line 12), reinforcing her lowly position within  
26  
27 the hierarchy. She finishes the narrative by expressing that this (childlike) identity imposed  
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29 on her ultimately undermines how she feels as a leader (lines 23).  
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34 In summary, this narrative reveals a complex and at times contrasting interplay  
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36 between individuals, context, relationships and systems, which seem to simultaneously  
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38 facilitate and inhibit Carol’s emerging leader identity. As an individual, Carol feels confident  
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40 that she can cope with the situation and her relationship with the consultant is such that she  
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42 feels able to move away from traditional hierarchies to take control, which within this context  
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44 she feels is appropriate due to her superior knowledge of how to approach the situation.  
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46 However, through this narrative Carol also describes the frustrations of trying to take on  
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48 leadership in a wider healthcare system in which protocols and traditional hierarchical  
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50 attitudes prevent her from fully undertaking the role and ultimately positions her as  
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52 “childlike” and “undermined”.  
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## Discussion and conclusions

Despite the espoused rhetoric of distributed leadership relationships within the healthcare literature, static, our data indicate that hierarchical leadership relationships remain the norm.<sup>4, 8, 9</sup> We argue that a workplace perpetuating leadership processes embedded in static leader-follower relationships has the potential to be prescriptive about the division of labour and may be inflexible to innovation with potential adverse implications for patient care.<sup>6, 8, 11</sup> Within the 'static leadership relationships' theme, the focus of the content-related subthemes was often on evaluation of whether individuals were 'good' or 'bad' leaders. Schyns and Miendl suggest that leaders are evaluated through followers' ideas about leadership that have been formed through previous experiences as part of professional socialisation.<sup>35</sup> Leaders are thus linked to pre-existing prototypes.<sup>11, 36</sup> Included in this were narratives about abusive leader-follower relationships. Experiences of abuse are reflected in findings from both undergraduate and postgraduate studies, in which abuse within the healthcare workplace has been narrated by medical and other healthcare students and trainees.<sup>37-40</sup> It would appear that abuse continues to be experienced in the postgraduate sphere.

Our findings revealed that participants most commonly drew on their experiences of clinical leadership in hospitals. Despite the traditional notion that leadership is focussed on organisational change, 'leadership' within these narratives was about 'influential acts of organising' (IAOs) that happened day-to-day in the healthcare workplace.<sup>41</sup> This difference could perhaps be explained by the recruitment of participants from out with traditional positions of organisational leadership, which meant their focus was on 'everyday' leadership experiences. In previous leadership research, narrative inquiry has been limited to the broader narratives of an organisation or the life story of a leader.<sup>42, 43</sup>

Less than a quarter of the narratives were about 'emergent leadership relationships', most of which involved complex patient scenarios. It can be suggested that these scenarios

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3 could be seen as ‘non-linear’ or ‘wicked’ problems, requiring emergent leadership  
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5 relationships that can happen out with traditional hierarchies.<sup>17,44</sup> Key to these was the  
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7 assumption that actions were in the best interests of the patient (thus, these emergent  
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9 relationships can be seen as patient-centred). However, our findings show that at a local level,  
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11 there is some work to be done on cultural shifts toward what could be described as distributed  
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13 leadership patterns.  
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17 Pronominal, emotional and metaphorical talk gave insight into how participants  
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19 evaluated the leadership relationships they had experienced. To our knowledge, no-one has  
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21 explored previously process-related themes identified within leadership narratives  
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23 specifically. In previous leadership literature, metaphors have been used to describe  
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25 leadership as an overall phenomenon, or to describe particular aspects of leadership.<sup>16, 45</sup>  
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27 Similar process-related themes have been found in narratives that describe the student/doctor-  
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29 patient relationship and the student-doctor feedback relationship at the undergraduate level.<sup>31,</sup>  
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Carol’s narrative revealed an unpredictable situation in which change (and learning)  
was required in response.<sup>46</sup> Through her narrative, Carol constructed her identity as a leader  
out with her formal position, and thus leadership was ‘emergent’.<sup>46</sup> Carol’s narrative also  
revealed the ‘enabling’ identities of her consultant, who had to act as a bridge between the  
administrative structures within the organisation and the adaptive leadership required to solve  
the issue faced.<sup>46</sup> Our narrative analysis also revealed the potential for ‘disconnect’ between  
the emergent leadership expectations of the immediate context and those of traditional  
hierarchies within the wider organisation, which firmly positioned Carol as a follower. These  
barriers could explain why static leader-follower relationships perpetuate as the norm and  
echo the work of Martin and colleagues.<sup>5</sup>

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3 Narrative inquiry is not novel in the field of medical education. It has been utilised to  
4 analyse, for example, professionalism dilemmas; prescribing experiences; and feedback  
5 experiences.<sup>30, 31, 38, 47- 49</sup> Through their narratives, participants had the opportunity to develop  
6 their own voice as they constructed their stories, others' voices and multiple realities.<sup>23</sup> This  
7 approach was particularly valuable when considering that some narratives describing  
8 workplace abuse and other types of experiences were also evaluated negatively. We suggest  
9 that these narratives, at times, became 'acts of resistance', which challenged traditional  
10 hierarchical conceptualisations of leadership.<sup>50</sup> Such 'resistance' was possibly a conscious act  
11 to 'subvert' asymmetrical power relationships that were constructed through traditional  
12 healthcare hierarchies.<sup>50, p. 433</sup> Narrative analysis has also highlighted the potential use of  
13 narratives for educational purposes. Through story-telling, participants repeatedly evaluated  
14 their experiences. Using narratives in this way would provide opportunities for learners to  
15 evaluate and make sense of their leadership experiences and reflect critically on their  
16 developing identities as leaders, followers and doctors, exploring opportunities for on-going  
17 development and building on their understandings of leadership processes.<sup>51</sup>

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37 However, our research is not without its methodological challenges. We acknowledge  
38 the lower proportion of male, non-white and foundation doctors within our sample, meaning  
39 that our findings may be less transferable to these groups. While using interview methods  
40 revealed a complex picture of leadership within the interprofessional healthcare workplace it  
41 also exposed a limitation in our interview study, in that we sought only to interview medical  
42 professionals. Broadening our narrative interviews to take into account the whole  
43 interprofessional team would have enriched this data and should be considered for future  
44 interview research. In addition, although our study was multi-site, it was conducted in the UK  
45 so the findings might not be transferable to other countries with different healthcare and  
46 healthcare education systems. Finally, our cross-sectional data did not allow for exploration  
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3 into how experiences of leadership and the formation of leader identities might change over  
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5 time as doctors move through training and this should be considered in further (longitudinal)  
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7 research.  
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11 In conclusion, this study has led to better understandings about participants' multiple,  
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13 constructed realities of leadership and followership in different healthcare contexts. The  
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15 findings from this study reveal that many factors influence developing leader identities; that  
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17 traditional medical and interprofessional hierarchies persist within the healthcare workplace;  
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19 and that wider healthcare systems can act as barriers to distributed (or shared) leadership  
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21 practices. Collecting and analysing narrative data provided us with new understandings of the  
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23 multiple ways in which leadership and followership is experienced in the healthcare  
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25 workplace. Exploring the interplay between both what the narratives contained and how the  
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27 narratives were told, provided unique insights into how narrators constructed their identities  
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29 as leaders or followers against the backdrop of a complex healthcare workplace.  
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**Table 1: Narrative content themes and subthemes**

<b>Theme: Static leadership relationships (n=131)</b>	<b>Definition</b>
Sub-themes:	
Facilitated by supportive dialogue or behaviours (n=25)	Leaders are perceived to take part in supportive behaviours or dialogue through revealing fallibility, listening, accommodating, being fair, responsive, or showing empathy.
Inhibited by unsupportive behaviours or lack of dialogue (n=21)	Leaders are perceived to be unsupportive and lack dialogue with followers. This is done through them being unfair, not admitting fallibility, not listening, being unresponsive or lacking empathy.
Abusive (n=21)	Abuse was constructed through the actions of leaders including undermining, verbal abuse, physical abuse, humiliation and/or criticism.
Inhibiting team-working (n=14)	Participants described instances of poor team working, often with conflict/disagreement being described or a lack of inclusivity.
Conflictive decision-making (n=12)	Trainees described those perceived to be leaders in conflict/disagreement with each other about patient care.
Fostering constructive team-working (n=8)	Team-working was described that was collaborative and perceived to be conducive to good patient care.
Ineffective due to unclear role definition (n=7)	Described when there was a perceived lack of leadership or when too many people were trying to take on the leadership role.
Effective, based on clearly defined roles (n=6)	Roles here were defined often as a result of having time to prepare for the situation. For example, a multiple trauma coming into Accident and Emergency.
Identified through traditional clinical roles (n=6)	For example, Doctor as leader, nurse as follower.
Collective decision-making (n=5)	Sharing group goals, all team members working towards the same goal, and with an appropriate allocation of tasks.
Identified through traditional hierarchies (n=4)	The most senior person present was seen to automatically take the lead. Assumed through traditional hierarchies.
Effective, based on practiced protocols (n=2)	This often related to cardiac arrest scenarios in which protocols are practiced and the scenario is seen to “run” “smoothly” due to repeated practice of these scenarios.
<b>Theme: Emergent leadership relationships (n=40)</b>	<b>Definition</b>
Sub-themes:	
Facilitated by individual knowledge or experience (n=21)	An individual will “step into” leadership based on previous experience or knowledge. Leadership can sometimes come from unexpected sources and doesn’t necessarily follow traditional hierarchies.

Facilitated by lack of engagement of expected leader (n=9)	Trainees described being “pushed into” a leadership role due to lack of engagement of a perceived leader. Sometimes the perceived leader can “hand leadership back to the junior”. Trainees are not actively seeking to take on leadership but sometimes circumstance requires them to do so.
Facilitated by systems and protocols (n=5)	For example, trainees used protocol to support a change in clinical care and take on leadership.
Facilitated by timing (n=3)	Due to the timing of incidents, trainees take on leadership e.g. at night.
Inhibited by lack of knowledge or experience (n=1)	Trainees describe an individual who “steps into” the leadership role but is unable to take on that role due to lack of experience or knowledge.
Inhibited by systems and protocols (n=1)	Where systems do not allow leadership to emerge (e.g. consultant to consultant referral systems.) Often this was linked to perceptions of traditional medical hierarchies.



**Table 2: Excerpts from narratives**

**Excerpt 1:** “...the registrar who was there...who in that situation [cardiac arrest] was leading the team...was very good at...knowing what everyone’s limitations were and...telling you to do things without patronising you or making you feel silly...you could see the medical student was...looking petrified...he [registrar] gave them a job to allow them to feel involved but...not get too involved that they got scared...it was really something to learn from” (Female, foundation trainee)

**Excerpt 2:** “...a consultant who didn’t come up to the ward...when he did come up he was never that fussed if you were with him or not...he would just leave you a list of things to do...it was a bit disheartening...you were never...completely reassured about what you were doing...you never really get to grips with his actual overall plan...so you end up not feeling that important part in a team because it doesn’t matter if you were there or not...you’ve to follow blindly what he wrote...” (Male, early-stage medical trainee)

**Excerpt 3:** “[during ward round] he [the consultant] asked everyone to leave...which was a bit mortifying...a nurse and student and possibly even somebody else in the room at the time and he asked them to leave and told me off for something...I asked him questions about it because I didn’t...understand what he was talking about because it made no sense to me...and so I asked him...but he was extremely emotional and angry about it and stormed out...” (Female, higher-stage surgical trainee)

**Excerpt 4:** “I was there [GP practice] for one day...a patient who come screaming... this patient was in labour and she [the GP] have no experience in doing labour at all... then I came to the room...the GP stepped down and I led the team that I’m doing the examination and assessment and then get each one of them a job... So it doesn’t mean that the most senior who can do it. I was not senior, I was trainee....And they agreed, and accepted it...they stepped back and then they let me just give clear instruction...they doesn’t know what to do...because I was just finished my gynae training” (Female, higher-stage GP trainee)

**Excerpt 5:** “... although everyone was kind of looking at me...I noticed that one of the nurses was managing to get through to the patient and kind of getting him to listen ...and I thought, I think ‘this is when I should be quiet and let this nurse deal with it’ and I just did what the nurse said...” (Female, foundation trainee)

**Excerpt 6:** “...we [junior trainees] were kind of saying, ‘well I don’t think this person needs resuscitating because they got quite unwell’ and he [consultant] just didn’t have a clue what to do. He [consultant] said, ‘well that’s not really my, my area’ and kind of then deposited it back to us and said ‘well if you think they’re not for resuscitation, then you take the decision’...but then he was kind of not really living up to what we’d hoped...” (Female, early-stage GP trainee)



**Table 3: Excerpts illustrating process-orientated themes****Pronoun use:**

**Excerpt 1:** “...*they* [the ward nurses] were really dismissive of all the doctors and *they* really didn't want *us* to be there and *they* all knew each other very well...even though *we* were technically more senior, *they* were more experienced [with resuscitation] and it was a really difficult power struggle” (Female, early-stage GP trainee)

**Excerpt 2:** “...discussion about a decision that had been made...It was like, ‘well *we* should really...this and that and the other’, and he said...‘fair enough’...” (Male, early-stage surgical trainee)

**Excerpt 3:** “...‘bring back information about that [a patient decision] and *I will* have a discussion and *I'll* support you on that, and if there is any change, if there is anything better we can do, then *I can give my views* on it..’” (Male, higher-stage medical trainee)

**Emotional talk:**

**Excerpt 4:** “it was probably the *happiest* professionally *happiest* time” (Male, early-stage medical trainee)

**Excerpt 5:** “it was *difficult*... it was *very awkward* yes” (Female, higher-stage service trainee)

Table 4: Metaphoric talk excerpts

Conceptual metaphors and examples	Identity construction
<p><b>LEADER-FOLLOWER RELATIONSHIP AS WAR:</b>  <i>"...first thing he [clinician-manger] started to do is just to...<b>attack, attack</b> other consultants...and started to just to <b>stab</b>...even in the same team you're supposed to share the same targets and because if the <b>ship sinks, everybody will sink</b>"</i>(Male, early-stage GP trainee)</p>	<p>Leader as aggressor; followers as victims; department as 'ship'</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS HIERACHY:</b>  <i>"I mean there's one person...if it was <b>monkeys in the zoo</b>, there's one person who's very much the <b>dominant personality, and the alpha male</b>...he's very clear at any kind of whole unit meeting that, you know, this is his view, and he'll <b>shout it from the rooftop</b>"</i> (Male, early-stage medical trainee)</p>	<p>Leader as alpha monkey; followers as subordinate lower-ranking monkeys; Leader is also 'higher up' (as in, on the rooftop)</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS PARENTALISM:</b>  <i>"There's no doubt about it, she gave 110 per cent to her patients. And we used to talk about ourselves as students, and <b>we wanted to be like her when we grew up</b>"</i> (Female, early-stage GP trainee)</p>	<p>Leader as adult; followers as children; leader is also role model</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS SPORT:</b>  <i>"And the number of times you felt like a <b>piggy in the middle</b>. You were being <b>batted backwards and forwards</b>. At the end of the day you're just trying to do the best for the patient who is outside your expertise"</i> (Female, early-stage GP trainee)</p>	<p>Leaders as game-players; followers as objects to be played with (i.e. ball)</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS CONSTRUCTION:</b>  <i>"Other ways of optimising influence of people around you, you just kind of like learn gradually through working, through <b>building working relationships</b>..."</i> (Male, higher-stage surgical trainee)</p>	<p>Leader as builder; leader-follower relationship as the object to be built</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS MACHINE:</b>  <i>"...it works really well and <b>very efficiently</b> and suddenly everyone kind of <b>clicks into gear</b>...the senior registrar will be <b>running it</b>..."</i> (Male early-stage GP trainee)</p>	<p>Leader as machine operator; followers as parts of the machine</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS JOURNEY:</b>  <i>"He's been a good enough leader that day, we'll do it, we'll go that <b>extra mile</b> for him."</i> (Male, higher-stage surgical trainee)</p>	<p>Leader as destination; followers as travellers</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS TRANSACTION:</b>  <i>"...good managers are probably <b>effectively good sales people</b> so you have to treat each person individually..."</i> (Male, early-stage surgical trainee)</p>	<p>Leader as seller; followers as consumers</p>

Table 5: “Where’s your daddy?”

Lines	Narrative*
	<u>Evaluation #1</u>
1	Carol: I had an <i>interesting</i> thing
	<u>Orientation #1</u>
2	when I was doing psychiatry and we had a patient who, <b>they</b> phoned me on a Saturday at lunch time
	<u>Complicating Action #1</u>
3	to say that she’d tested positive for meningococcus and it was, eh was in air, in a sputum sample, so it
4	would have aero-cised
	<u>Most Reportable Event</u>
5	So <b>they</b> said everybody who’d been [on] the ward for the last two weeks plus relatives plus staff all
6	had to get, erm, prophylactic treatment for meningococcus
	<u>Resolution #1</u>
7	And <b>I</b> mean <b>I</b> was phoning sort of infectious disease and occupational health and public health and
8	everybody
	<u>Complicating Action #2</u>
9	And a lot of <b>them</b> were saying, well look <b>we</b> want to, <b>we</b> want to speak to <b>your</b> consultant
	<u>Evaluation #1</u>
10	But the consultant hadn’t done anything that wasn’t psychiatry for 40 years and he had no idea what to
11	do
	<u>Complicating Action #3</u>
12	So literally the consultant was sitting in the corner of the office signing prescriptions for <b>me</b> , while <b>I</b>
13	organised everything
	<u>Evaluation #2</u>
14	because he was, he was <i>largely useless</i>
	<u>Complicating Action #4</u>
15	Erm, but <b>they</b> kept sort of saying, ‘well does <b>your</b> consultant know what <b>you’re</b> doing? Can I speak
16	to someone more senior?’
17	Interviewer: And how did you find that then? How did you find that situation?
	<u>Evaluation #3</u>
18	It was <i>difficult</i> because
	<u>Orientation #2</u>
19	I, <b>I mean I’d</b> , <b>I’d</b> phoned the consultant first just to let him know, and he just said, ‘well look I have
20	no idea what to do, can you manage this?’
	<u>Evaluation #5</u>
21	And <b>I</b> was <i>really confident</i> that <b>I</b> could manage it <b>myself</b> , and <b>I did</b> . But it was just sort of, the people
22	looking over your shoulder going, sort of ‘ <u>Where’s your daddy</u> ’ kind of thing. It was just, it’s a bit
23	<i>frustrating</i> . And it sort of <u>undermines</u> <i>how you feel</i> as a leader a wee bit
	* <b>Editing notes:</b> ...=speech edited out for brevity; Metaphors <u>underlined</u> ; Interesting pronoun use in <b>bold</b> ; Emotional talk in <i>italics</i>

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## Leadership and followership in the healthcare workplace: Exploring medical trainees' experiences through narrative inquiry

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# Leadership and followership in the healthcare workplace: Exploring medical trainees' experiences through narrative inquiry

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## Abstract

### Objectives:

To explore medical trainees' experiences of leadership and followership in the interprofessional healthcare workplace.

### Design:

A qualitative approach using narrative interviewing techniques in 11 group and 19 individual interviews with UK medical trainees.

### Setting:

Multi-site study across four UK health boards.

### Participants:

Through maximum variation sampling, 67 medical trainees were recruited from a range of specialties and at various stages of training. Participants shared stories about their experiences of leadership and followership in the healthcare workplace.

### Methods:

Data were analysed using thematic and narrative analysis.

### Results:

We identified 171 personal incident narratives about leadership and followership. Participants most often narrated experiences from the position of follower. Their narratives illustrated many factors that facilitate or inhibit developing leadership identities; that traditional medical and interprofessional hierarchies persist within the healthcare workplace; and that wider healthcare systems can act as barriers to distributed leadership practices.

### Conclusion

This paper provides new understandings of the multiple ways in which leadership and followership is experienced in the healthcare workplace and sets out recommendations for future leadership educational practices and research.

## Strengths and Limitations of Study

- This is the first study to explore how medical trainees experience leadership and followership in the healthcare workplace through narrative analysis
- The large number of narratives across multiple UK sites and different specialties, enhances the transferability of our findings
- We had relatively low numbers of male, non-white and Foundation trainee participants so our findings are most relevant to female, white and specialty trainee doctors.

## Introduction

In recent years, there has been an upsurge in the use of the term ‘leadership’ to describe a range of activities connected to the organisation of patient care.<sup>1</sup> ‘Leadership’ is no longer attributed solely to those in formal leadership positions, but is seen to be the responsibility of healthcare professionals across all levels of healthcare organisations.<sup>1-5</sup> Notions of traditional hierarchical practices have given way to arguments for distributed (or shared) leadership models. Modern theoretical discourses assert that leadership is a process involving leaders and followers acting within a fluid context so that people construct leader or follower identities moment-to-moment.<sup>6,7</sup> Suggested benefits of such distributed leadership practices include improved patient experience; reduced errors, infection and mortality; increased staff morale and reduced staff absenteeism and stress.<sup>8</sup> Using this ‘leadership lens’, those in non-formal positions of healthcare leadership (e.g. medical trainees) are expected to undertake leadership throughout their careers and develop their leader identities.<sup>9</sup>

Whilst the healthcare literature contends that effective distributed leadership practices are necessary to improve healthcare workplace cultures, patient safety and quality of care, little is known about how these leadership processes are experienced by medical trainees.

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3 Within this paper we seek to understand better how the notion of 'leadership' has been  
4 embedded into frontline healthcare practice through narrative analyses of how medical  
5 trainees' leader and follower identities are constructed.  
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8

### 9 10 Researching distributed leadership processes

11  
12 Until recently, the focus of scholarly activity in leadership has been on individuals as  
13 leaders.<sup>10,11</sup> In healthcare, many studies have concentrated on *the role of leaders* rather than  
14 *the processes of leadership*.<sup>e.g. 12,13</sup> However, many leadership theorists criticise leader-centric  
15 research for its emphasis on individuals as leaders, how effective their activities are and how  
16 others (followers) act in response to their influence.<sup>11,14</sup> Rather, leadership theorists argue that  
17 leadership can only be understood through exploring the underlying social systems in which  
18 leadership happens.<sup>6, 15</sup> As a product of co-construction, leadership is perceived as an on-  
19 going negotiation as part of a multi-faceted interaction between social beings.<sup>16</sup> Each  
20 interaction can be seen as socially and historically bound operating through language, within  
21 a socially-constructed context.<sup>16, 17</sup>  
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36 Some studies have explored leadership processes and the link between senior  
37 clinicians and the wider organisation. For example, combining interviews and observation,  
38 MacIntosh and colleagues identified the extent to which interactions between clinicians and  
39 managers were two-way discussions, finding that each group presented themselves as less  
40 powerful than the other group and lacking agency.<sup>18</sup> They described the clinician-manager  
41 relationships as having potential to limit the opportunities for distributed leadership  
42 processes. In addition, Martin and colleagues revealed through interview and observation,  
43 that there was the potential for a disconnect between the desire for distributed leadership  
44 within healthcare and actual organisational practices.<sup>5</sup>  
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3 Whilst these studies have focussed on wider organisational leadership processes our  
4 focus is on leadership that may occur day-to-day within the clinical context, where medical  
5 trainees potentially have their first experiences of leadership. Through this, our study seeks to  
6 add to the literature on distributed leadership in healthcare.  
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### 11 Aim and research questions

12 This study aimed to explore how medical trainees experience leadership and followership by  
13 asking two research questions. What are medical trainees' lived experiences of leadership and  
14 followership in interprofessional healthcare workplaces? How do medical trainees construct  
15 their identities as leaders and followers within their narratives of interprofessional healthcare  
16 workplaces?  
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## 25 **Methods**

### 26 Study design

27 We undertook a qualitative study using group and individual interviews to elicit medical  
28 trainees' personal incident narratives (PINs) of their experiences of leadership and  
29 followership. Ascribing to the notion that meanings are constructed by people as they interact  
30 with the world around them, our study draws on social constructionist epistemology.<sup>19</sup>  
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39 We used narrative inquiry methodology. Narrative accounts of the healthcare workplace offer  
40 abundant resources for research.<sup>20</sup> The narratives referred to in this paper are short, about  
41 discrete events, and recounted in interactions in various contexts as sense-making tools.<sup>21, 22</sup>  
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46 A narrative in this form makes the self the central character (or protagonist), either playing an  
47 active part within the story or as Chase describes as an: 'interested observer of others'  
48 actions'.<sup>23, p. 657</sup>  
49  
50  
51  
52

53 A narrative is the shared construction between the narrator and his/her audience.<sup>21, 23, 24</sup>  
54

55 Bound to this is the context in which the narrative is shared; the specific setting, audience and  
56 the reason the story is told.<sup>23,24</sup> Pivotal to our paper is the concept of the 'narrative turn' in  
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3 that narrators construct events through their story, expressing their feelings, beliefs and  
4  
5 understandings about leadership processes.<sup>24</sup> As such, the narrative becomes a construction of  
6  
7 who the narrator is, who they wish to be and how they wish to be seen.<sup>25</sup> In other words,  
8  
9 when a story is told, the narrator constructs and presents identities, events and realities in  
10  
11 interaction with others.<sup>23, 24</sup> Thus, paying attention to and asking questions not only about  
12  
13 what participants experiences are but also how they narrate their leadership experiences can  
14  
15 afford insight into the multiple identities that medical trainees construct as leaders and  
16  
17 followers.<sup>23</sup>

#### 21 The research team

22 The research team included three members with health professions backgrounds (one  
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24 practicing General Practitioner; one ex-physiotherapist; and one ex-clinical psychologist) and  
25  
26 one social scientist. Team members had various personal experiences of leadership and  
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28 management covering clinical, research and educational leadership, with all team members  
29  
30 teaching leadership in healthcare at undergraduate and postgraduate levels.  
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32

#### 35 Sampling and recruitment

36 Upon receiving ethical approval and appropriate institutional consents we utilised maximum-  
37  
38 variation sampling to ensure a diversity of medical trainees in terms of their stage of training,  
39  
40 specialty and location. Following an initial recruitment drive by email, we recruited further  
41  
42 participants using flyers at trainee teaching sessions and snowballing.<sup>26</sup>  
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#### 46 Data collection

47 We conducted eleven group (with between three and seven participants) and nineteen  
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49 individual interviews with 65 medical trainees (25 male: 40 female, 51 white: 14 non-white)  
50  
51 from both early-stage (34) and higher-stage (trainees beyond the half-way point: 31)  
52  
53 postgraduate medical training. Our initial aim was to have only group interviews as from a  
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55 social constructionist perspective they had the potential for participants to build on each  
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3 other's ideas. However, convenience for participants meant that individual interviews were  
4  
5 also necessary. Our sample came from four UK Health Boards and a range of specialty  
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7 trainee groups including: general practice (GP: 23); medicine (13); surgery (11); and service-  
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9 orientated trainees such as anaesthetists, radiology and pathologists (10). Our sample also  
10  
11 included eight foundation doctors.  
12

13  
14 We devised an interview guide which was developed in line with our research questions,  
15  
16 which provided an aide memoir. The semi-structured nature of the interviews allowed for  
17  
18 flexibility so that ideas could be pursued and expanded upon. The interviews were broadly  
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20 split into two sections: first, we asked participants to articulate their understandings of  
21  
22 leadership and followership (reported elsewhere).<sup>27</sup> Following this, narrative interviewing  
23  
24 techniques were used to collect narratives of participants' experiences of leadership and  
25  
26 followership in the interprofessional healthcare workplace. All interviews were audio-  
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28 recorded (with permission) and independently transcribed. All interviews were conducted by  
29  
30 the primary author bar one (the second author conducted an early group interview and  
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32 listened to several initial interviews with the primary author to reflect on the structure and  
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34 relevance of the interview schedule, (thus enhancing research rigour).  
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#### 40 Data analysis

41 We began our analysis with thematic framework analysis.<sup>28</sup> This allowed us to identify  
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43 patterns across the data. We constantly familiarised ourselves with the data through repeated  
44  
45 reading of transcripts and listening to audio-recordings. A team data analysis session was  
46  
47 held which provided opportunity to discuss and negotiate possible themes to be included in  
48  
49 the thematic coding framework. Prior to the session, a subset of data were analysed separately  
50  
51 by each team member. Through an iterative process of discussion, feedback and agreement  
52  
53 within the team, a coding framework was developed which was then used to index the data.  
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57 To identify narratives, we drew on Labov's construction that a narrative is a structured  
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3 account of an incident that has become part of the biography of the storyteller.<sup>29</sup> It is  
4 increasingly common within qualitative research to explore patterns across data through the  
5 use of computer assisted qualitative data analysis software (CAQDAS). We used Atlas-ti  
6 (Version 7.2) in our identification, time-stamping and coding of all narratives.<sup>30</sup>  
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13 Using the premise that identities are formed through talk and interaction we explored  
14 the interplay between different thematic groupings.<sup>24</sup> To do this, we used a form of structural  
15 narrative analysis which pays attention to the ways in which narratives are organised.<sup>21</sup> Labov  
16 states that a fully formed narrative includes seven elements: (1) abstract; (2) orientation; (3)  
17 complicating action; (4) evaluation; (5) most reportable event; (6) resolution; and (7) a  
18 coda.<sup>29</sup> Not all stories however will contain all elements and often elements occur in different  
19 sequences, with narrators moving back and forth, providing further complicating actions and  
20 evaluations as they make sense of the story.<sup>30</sup> Thus, we were able to explore how participants  
21 constructed their identities as leaders and followers within their narrative, what parts of the  
22 story participants constructed as important, and how the narrator used language to illustrate  
23 how they evaluated the events.<sup>31</sup>  
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### 38 **Results**

39 Across the dataset, we identified 171 distinct narratives. Initial thematic analysis identified  
40 three different sets (or groupings) of themes. Contextual themes for the narratives provided  
41 orientation to the timing of the events; where the events took place; how the narrators  
42 positioned themselves in the story (for example, as leader, follower or observer); the type of  
43 activity that was being undertaken when the event occurred; and how the narrator evaluated  
44 their experience (for example, positively, negatively or neutrally) through their commentary  
45 on the events. The second group of themes focussed on the content of the story and  
46 signposted its gist (i.e. the main plotline of the story). Finally, process-orientated themes  
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3 focussed on *how* the stories were narrated. This set of themes highlighted, for example,  
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5 linguistic features used by narrators to articulate their stories.  
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8 What are medical trainees' lived experiences of leadership and followership in  
9  
10 interprofessional healthcare workplaces?

### 11 *Contextual themes*

12  
13 Participants most often constructed themselves as followers within the stories (n=80), with  
14  
15 around half as many constructing themselves from the position of leader (n=41). Of the 171  
16  
17 narratives, 144 were set in the hospital, with only 12 set in GP practice. However GP trainees  
18  
19 offered the highest proportion of narratives across the specialties (sharing 53 narratives, of  
20  
21 which 36 were hospital-based).  
22  
23

24  
25 The activities on which stories centred were wide-ranging: they were most likely to  
26  
27 come from the clinical environment and be related to clinical leadership activities (n=119).  
28  
29 This included stories about complex patient scenarios, which participants deemed to be  
30  
31 extraordinary (n=37). Still related to clinical leadership, were stories about acute emergency  
32  
33 scenarios (n=32) and routine patient care (n=29). Data also included stories about formal  
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35 ward-based activities such as planned team meetings and ward rounds (n=15). Narratives  
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37 were evenly balanced between positively and negatively evaluated experiences (80 positive;  
38  
39 77 negative).  
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44 We identified two overarching themes for the content of the narratives (Static  
45  
46 leadership relationships and Emergent leadership relationships) and a series of sub-themes as  
47  
48 defined in Table 1. We also identified three key process-orientated themes: pronominal;  
49  
50 emotional; and metaphoric talk. What follows in this section is an overview of each of these  
51  
52 themes with illustrative data excerpts presented in Table 2.  
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56 [Insert Table 1 around here]  
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### *Static leadership relationships*

Static leadership relationships was the dominant content-related theme (n=131). Here, the identity of the leader and follower/s remained static throughout the story and trainees typically narrated from the position of follower. These leader-follower relationships were based on the traditional hierarchies found within the healthcare workplace. From this, we identified 12 sub-themes, which focussed on leader behaviours within the stories and which were seen to be facilitative or inhibitive to good leader-follower relationships (see Table 1).

Here, we talk in-depth about the most common three themes only. Excerpt 1 (Table 2) illustrates a facilitative sub-theme, where the leader is seen to be entering into a supportive dialogue or behaving in a supportive way to facilitate leadership processes and leader-follower relationships. Here, the leader is perceived to have acted in the best interests of the patient regardless of the outcome. As a follower, this participant describes how she felt valued, respected and supported within this relationship, that it was conducive to learning and that this type of relationship was something to aspire to.

[Insert Table 2 around here]

In contrast, Excerpt 2 (see Table 2) illustrates an inhibitive sub-theme in which the leader is seen to be unsupportive and lack dialogue with the trainee as a follower. The trainee reports that these behaviours led to lost confidence and feelings of non-validity and exclusion. This is reported to be detrimental to training experiences and at times detrimental to patient care.

We also identified abuse narratives (see Excerpt 3, Table 2). This subtheme categorised narratives around direct and indirect experiences of what constituted abuse as perceived by participants (this included undermining and humiliation). As well as being the

1  
2  
3 recipients of abuse, participants witnessed others being abused too. The abuser was most  
4  
5 often identified as the consultant but trainees also reported abuse from other more senior  
6  
7 trainees and nursing staff. Abuse typically revolved around clinical leadership and during  
8  
9 routine patient care (for example, surgical theatre) or formal activities such as the ward  
10  
11 rounds or meetings, as illustrated in Excerpt 3 (see Table 2).  
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15 Participants often reported negative emotional responses to these experiences: they  
16  
17 talked about feeling humiliated and non-human, sometimes getting angry themselves; the  
18  
19 need to keep going and “survive” training; and being careful to avoid situations in which  
20  
21 abuse was likely to happen/occur.  
22

### 23 24 *Emergent leadership relationships*

25  
26 A smaller proportion of narratives (n=40) were coded to the content-related theme: Emergent  
27  
28 leadership relationships. Unlike the previous theme, in which the identities of the leaders and  
29  
30 followers were static, here participants recounted how the combination of individuals  
31  
32 involved, the context (including the task), the relationships within that context and the wider  
33  
34 systems affected who emerged as the leader within the experience. Leadership emergence  
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36 was more likely to be categorised in narratives that related directly to patient care scenarios,  
37  
38 namely: complex patient cases; routine patient care; and acute emergency care. Interestingly,  
39  
40 no narratives in which formal clinical activities were being undertaken were coded to this  
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42 theme, indicating more static (and possibly traditional) leader-follower relationships within  
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44 more formalised clinical settings.  
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50 We identified six subthemes within these narratives which described the factors either  
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52 facilitative or inhibitive to leadership emergence (see Table 1). Unlike the static leadership  
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54 relationship subthemes, medical trainees typically narrated emergent leadership relationship  
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56 narratives from the position of leader. Excerpt 4 (see Table 2) illustrates an example in which  
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3 emergent leadership relationships were facilitated by individual knowledge or experience.  
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5 The trainee describes an incident where, as a junior trainee, her broad-based training  
6  
7 experience made her more ‘expert’ than those with more specialised training.  
8  
9

10 Often stories within this subtheme were interprofessional. Participants narrated  
11 incidents in which more experienced nurses and other members of the interprofessional team  
12 took on leadership. Participants narrated this as emergent because they were working in the  
13 context of traditional interprofessional hierarchies, which meant that they thought doctors  
14 were expected to lead. Perhaps unsurprisingly, participants inevitably saw leadership  
15 emergence occurring in the best interests of the patients, as illustrated in excerpt 5 (see Table  
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17 2).  
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27 In order for leaders to step forward and out of traditional hierarchical boundaries,  
28 participants narrated the process of traditional leaders needing to “step back” (as illustrated in  
29 excerpt 5, above). This was sometimes perceived to be difficult. At times, participants  
30 narrated experiences in which traditional leaders stepped back through their non-engagement,  
31 as illustrated in Excerpt 6 (see Table 2).  
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### 39 ***Process-orientated themes***

40 From the position of follower, participants often used the pronouns “we” and “us” to describe  
41 themselves and their contemporaries, and “them” and “they” to describe a group of leaders  
42 within their narratives, indicating a perceived separation (and potentially adversarial  
43 relationships) between followers and leaders. This was particularly apparent within the  
44 negatively evaluated narratives (See Table 3: Excerpt 1).  
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52 [Insert Table 3 around here]  
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55 When followership experiences were evaluated more positively and the leadership process  
56 was seen to go well, pronouns “we” and “us” would be used to describe the whole team,  
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3 including both leaders and followers together (See Table 3: Excerpt 2). From the position of  
4  
5 leader, participants often used the pronoun “I” when describing leadership decisions, which  
6  
7 seemed to indicate their agency and autonomy within the situation (See Table 3: Excerpt 3).  
8  
9

10  
11 Participants typically used positive emotional talk within stories that were evaluated  
12  
13 positively (Table 3: Excerpt 4) and negative emotional talk (Table 3: Excerpt 5) within stories  
14  
15 evaluated as negative experiences.  
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17  
18 Across the narratives, we identified hundreds of metaphoric linguistic expressions  
19  
20 (MLEs).<sup>32</sup> Although it is outside the scope of this paper to present a full systematic metaphor  
21  
22 analysis, we identified broad groups of conceptual metaphors which revealed participants’  
23  
24 understandings of leader-follower relationships.<sup>32-34</sup> We identified eight overarching  
25  
26 conceptual metaphors used to describe the leader-follower relationship. These were LEADER-  
27  
28 FOLLOWER RELATIONSHIP AS: WAR; HIERARCHY; PARENTALISM; SPORT; CONSTRUCTION;  
29  
30 MACHINE; JOURNEY; and TRANSACTION (the convention of cognitive linguistics requires that  
31  
32 conceptual metaphors are presented in small capitals: see Table 4).<sup>34</sup>  
33  
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35  
36 [Insert Table 4 about here]  
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38  
39 How do medical trainees construct their identities as leaders and followers within their  
40  
41 narratives of interprofessional healthcare workplaces?  
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43  
44 Here, we pull together both content and process-related themes to present a more detailed  
45  
46 exploration of one narrative. This narrative from ‘Carol’ (a pseudonym, female early-stage  
47  
48 GP trainee) comes from an event she experienced during her time as a trainee in psychiatry. It  
49  
50 is not explicitly clear what grade of training Carol was at the time of her story but through her  
51  
52 use of language and the events narrated she is clearly junior to the narrative protagonists (see  
53  
54 Table 5). Carol presents a complex patient scenario in which people in contact with a  
55  
56 particular patient needed prophylactic treatment for meningococcal disease. The focus of  
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3 Carol's story is on her personal experience of trying to take leadership as the consultant (a  
4 psychiatrist) states that he does not have the necessary experience to do so. Carol describes  
5 how attitudes, systems and protocols become barriers to fully undertaking leadership in this  
6 scenario. Indeed, the key message of Carol's narrative is that her ability to take on leadership  
7 is inhibited by the wider systems in which she works. We identified other content-related  
8 themes, which could facilitate and/or inhibit leadership processes. Facilitative aspects  
9 included her emergence as leader due to her own knowledge and expertise, in contrast to the  
10 consultant's unwillingness to engage in leadership due to his own lack of experience, leading  
11 him to support her leadership emergence. Inhibitive aspects include Carol's description of  
12 traditional systems, protocols and expectations that the consultant should be leading.  
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26 [Insert Table 5 about here]  
27

28 Carol describes different interactions with different sets of actors in her narrative. Firstly,  
29 there is the interaction between herself and her consultant. Secondly, there is the interaction  
30 she has with a group of people (i.e. "the people", line 21) she repeatedly describes as "they"  
31 or "them". Throughout the narrative she is not specific about who "they" are. However, in  
32 lines 7 and 8, she lists a group of specialties and we assume that "they" are included within  
33 this group. In the following paragraphs, we explore how Carol constructs her identities as  
34 leader and follower in relation to these two interactions.  
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#### 44 *Carol as a capable leader, the consultant as supportive follower*

45 When Carol narrates her interaction with the psychiatry consultant, she constructs herself as a  
46 confident and capable leader. She describes a discussion with her consultant in which  
47 responsibility for dealing with the situation becomes hers (lines 19 and 20). When evaluating  
48 this event, she uses positive language with intensifiers, to construct herself as "really  
49 confident" that she can handle the situation (line 21) and qualifies this with the short  
50 statement that: "I did". Within this interaction, Carol identifies herself as the leader through  
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3 regular use of “I” to indicate her agency and control of the situation (lines 7 and 12). Despite  
4 her describing the consultant as having a part in the process (e.g. writing prescriptions, line  
5 12), she chooses not to use the pronoun “we”, suggesting that she does not see herself and the  
6 consultant as a team. Possibly to reinforce her own identity as a strong leader, she constructs  
7 her consultant as a supportive follower who undertakes tasks “for me” (line 12). This is  
8 emphasised early in the narrative through her use of derogatory language to describe the  
9 consultant as having “no idea what to do” (line 10) and as being “largely useless” (line 14),  
10 constructing him as lacking both clinical knowledge and leadership.

### 21 *Carol as child, consultant as ‘daddy’*

22  
23 The second type of interactions Carol has within this narrative (with other healthcare  
24 professionals as part of workplace systems and cultures) reveals a contrasting picture relating  
25 to her and her consultant’s identity construction. “Their” express desire is to speak to the  
26 consultant (lines 9), and “they” ask Carol if her consultant knows what is happening (line 15).  
27 Carol’s pronoun use at this point places distance between her and this wider group and gives  
28 this part of her narrative a confrontational feel. Carol narrates that she is powerless to change  
29 systems which expect the consultant to be the leader and thus within this interaction, Carol  
30 shifts her own position from leader to follower. Carol uses negative emotional language such  
31 as “difficult” (line 18) and “frustrating” (line 23) to express how she finds this and how this  
32 interaction effects her identity construction.

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47 Key within this narrative is Carol’s use of a metaphoric linguistic expression (MLE),  
48 which reveals how she thinks her and her consultant’s identities, and their relationships, are  
49 ascribed by others as: LEADER-FOLLOWER RELATIONSHIP AS PARENTALISM (line 22).

50  
51 Through her use of this MLE (‘where’s your daddy?’), she constructs her identity as ascribed  
52 by others as a young child and the consultant as her male parent. This reveals that she thinks  
53 others see her as junior within the wider healthcare system. Indeed, Carol states that the  
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3 consultant is required to sign the prescriptions in order for the task to be fulfilled and thus  
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5 protocol reinforces this traditional hierarchy (line 12), reinforcing her lowly position within  
6  
7 the hierarchy. She finishes the narrative by expressing that this (childlike) identity imposed  
8  
9 on her ultimately undermines how she feels as a leader (lines 23).  
10

11  
12 In summary, this narrative reveals a complex and at times contrasting interplay  
13  
14 between individuals, context, relationships and systems, which seem to simultaneously  
15  
16 facilitate and inhibit Carol's emerging leader identity. As an individual, Carol feels confident  
17  
18 that she can cope with the situation and her relationship with the consultant is such that she  
19  
20 feels able to move away from traditional hierarchies to take control, which within this context  
21  
22 she feels is appropriate due to her superior knowledge of how to approach the situation.  
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24 However, through this narrative Carol also describes the frustrations of trying to take on  
25  
26 leadership in a wider healthcare system in which protocols and traditional hierarchical  
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28 attitudes prevent her from fully undertaking the role and ultimately positions her as  
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30 "childlike" and "undermined".  
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### 36 **Discussion and Conclusions**

37 Despite the espoused rhetoric of distributed leadership relationships within the healthcare  
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39 literature, our data indicate that static and hierarchical leadership relationships remain the  
40  
41 norm.<sup>4, 8, 9</sup> We argue that a workplace perpetuating leadership processes embedded in static  
42  
43 leader-follower relationships has the potential to be prescriptive about the division of labour  
44  
45 and may be inflexible to innovation with potential adverse implications for patient care.<sup>6, 8, 11</sup>  
46  
47 Within the 'static leadership relationships' theme, the focus of the content-related subthemes  
48  
49 was often on evaluation of whether individuals were 'good' or 'bad' leaders. Schyns and  
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51 Miendl suggest that leaders are evaluated through followers' ideas about leadership that have  
52  
53 been formed through previous experiences as part of professional socialisation.<sup>35</sup> Leaders are  
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55 thus linked to pre-existing prototypes.<sup>11, 36</sup> Included in this were narratives about abusive  
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3 leader-follower relationships. Experiences of abuse are reflected in findings from both  
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5 undergraduate and postgraduate studies, in which abuse within the healthcare workplace has  
6  
7 been narrated by medical and other healthcare students and trainees.<sup>37-40</sup> It would appear that  
8  
9 abuse continues to be experienced in the postgraduate sphere.  
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12 Our findings revealed that participants most commonly drew on their experiences of  
13  
14 clinical leadership in hospitals. Despite the traditional notion that leadership is focussed on  
15  
16 organisational change, 'leadership' within these narratives was about 'influential acts of  
17  
18 organising' (IAOs) that happened day-to-day in the healthcare workplace.<sup>41</sup> This difference  
19  
20 could perhaps be explained by the recruitment of participants from out with traditional  
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22 positions of organisational leadership, which meant their focus was on 'everyday' leadership  
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24 experiences. In previous leadership research, narrative inquiry has been limited to the broader  
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26 narratives of an organisation or the life story of a leader.<sup>42, 43</sup>  
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32 Less than a quarter of the narratives were about 'emergent leadership relationships',  
33  
34 most of which involved complex patient scenarios. It can be suggested that these scenarios  
35  
36 could be seen as 'non-linear' or 'wicked' problems, requiring emergent leadership  
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38 relationships that can happen out with traditional hierarchies.<sup>17,44</sup> Key to this was the  
39  
40 assumption that actions were in the best interests of the patient (thus, these emergent  
41  
42 relationships can be seen as patient-centred). However, our findings show that at a local level,  
43  
44 there is some work to be done on cultural shifts toward what could be described as distributed  
45  
46 leadership patterns.  
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51 In the leadership literature there is a lively debate around the broad metaphors of  
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53 'leadership' as an overall phenomenon.<sup>16,45</sup> However, our analysis was concerned more with  
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55 the conceptual metaphors used as part of language-in-interaction and what this revealed about  
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57 leader-follower relationships. This, along with pronominal and emotional talk, gave insight  
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3 into how participants evaluated these relationships. To our knowledge, no-one has explored  
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5 previously metaphoric talk identified within leadership narratives specifically, although  
6  
7 similar talk has been found describing the student/doctor-patient relationship and the student-  
8  
9 doctor feedback relationship at the undergraduate level.<sup>31, 33, 34</sup>

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12 Carol's narrative revealed an unpredictable situation in which change (and learning)  
13  
14 was required in response.<sup>46</sup> Through her narrative, Carol constructed her identity as a leader  
15  
16 out with her formal position, and thus leadership was 'emergent'.<sup>46</sup> Carol's narrative also  
17  
18 revealed the 'enabling' identities of her consultant, who had to act as a bridge between the  
19  
20 administrative structures within the organisation and the adaptive leadership required to solve  
21  
22 the issue faced.<sup>46</sup> Our narrative analysis also revealed the potential for 'disconnect' between  
23  
24 the emergent leadership expectations of the immediate context and those of traditional  
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26 hierarchies within the wider organisation, which firmly positioned Carol as a follower. These  
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28 barriers could explain why static leader-follower relationships perpetuate as the norm and  
29  
30 echo the work of Martin and colleagues.<sup>5</sup>

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36 Narrative inquiry is not novel in the field of medical education. It has been utilised to  
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38 analyse, for example, professionalism dilemmas; prescribing experiences; and feedback  
39  
40 experiences.<sup>30, 31, 38, 47- 49</sup> Through narratives, in the current study, participants had the  
41  
42 opportunity to develop their own voice as they constructed their stories, others' voices and  
43  
44 multiple realities.<sup>23</sup> This approach was particularly valuable when considering that some  
45  
46 narratives including those describing workplace abuse were also evaluated negatively.  
47  
48 Indeed, participants may not have had the opportunity to discuss such distressing matters  
49  
50 before the study and had this study not been conducted. In fact, we suggest that these  
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52 narratives, at times, became 'acts of resistance', which challenged traditional hierarchical  
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54 conceptualisations of leadership.<sup>50</sup> Such 'resistance' was possibly a conscious act to 'subvert'  
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56 asymmetrical power relationships that were constructed through traditional healthcare  
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3 hierarchies.<sup>50, p. 433</sup> Narrative analysis has also highlighted the potential use of narratives for  
4 educational purposes. Through story-telling, participants repeatedly evaluated their  
5 experiences. Using narratives in this way would provide opportunities for learners to evaluate  
6 and make sense of their leadership experiences and reflect critically on their developing  
7 identities as leaders, followers and doctors, exploring opportunities for on-going development  
8 and building on their understandings of leadership processes.<sup>51</sup>

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17 Our research is not without its methodological challenges. We acknowledge that we  
18 chose 'leadership' as a specific lens for our study. Recent critical leadership literature argues  
19 that the rise of 'leaderism' in healthcare discourse has meant that many things that were more  
20 traditionally aligned to, for example, 'interprofessional relationships' or 'clinical decision  
21 making' are now being branded as 'leadership'.<sup>1, 52</sup> Asking participants specifically about  
22 their leadership experiences may have perpetuated this leaderism discourse in our findings,  
23 although it is noteworthy that our participants shared with us more followership than  
24 leadership stories.

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36 As a research team, although we had diversity in terms of our professional  
37 backgrounds (see methods), we were not diverse in terms of other identities such as gender  
38 and ethnicity (we are all female and white). Our interpretation of the data will be influenced  
39 by own understandings and experiences of leadership, and these will inevitably be coloured  
40 by things like our gender. We also acknowledge the lower proportion of male, non-white and  
41 foundation doctors within our sample, meaning that our findings may be less transferable to  
42 these groups. While interview methods helped to reveal a complex picture of the  
43 interprofessional healthcare workplace it also exposed a limitation in our study, in that we  
44 sought only to interview medical professionals. Broadening our narrative interviews to take  
45 into account the whole interprofessional team would have enriched these data and should be  
46 considered for future interview research. In addition, although our study was multi-site, it was

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2  
3 conducted in the UK so the findings might be less transferable to other countries with  
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5 different healthcare and healthcare education systems.  
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8 We used a qualitative, process-orientated approach to our research. We acknowledge  
9  
10 that the use of numbers within the presentation of our data has the potential to draw criticism.  
11  
12 However, it is not unusual for some qualitative researchers to draw on numbers to look at  
13  
14 patterns in large qualitative datasets.<sup>30</sup> We used numbers in our study to elucidate patterns  
15  
16 (similarities and differences) that would not have been apparent with text alone.  
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20 The large number of hospital-based narratives in comparison to community-based  
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22 narratives in our study did not allow us the opportunity to explore whether clinical settings  
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24 made a difference to participants' experiences, something that should be considered for  
25  
26 further study. Indeed, although GPs were a large proportion of our participant group, in the  
27  
28 UK they spend 18 months of their three-year training in hospitals, following a 2-year  
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30 (largely) hospital-based foundation programme. This time spent in hospitals will have  
31  
32 undoubtedly influenced the setting of their stories.  
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36 In addition, although narratives were identified in the same way for individual and  
37  
38 group interviews, we did not note, nor formally explore any differences in data between  
39  
40 group and individual interviews (as this was not relevant to our research questions).  
41  
42 However, this could warrant exploration in further research. Finally, our cross-sectional data  
43  
44 did not allow for exploration into how experiences of leadership and the formation of leader  
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46 identities might change over time as doctors move through training and this should be  
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48 considered in further (longitudinal) research.  
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52 In conclusion, this study has led to better understandings about participants' multiple,  
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54 constructed realities of leadership and followership in different healthcare contexts. The  
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56 findings from this study reveal that many factors influence developing leader identities; that  
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3 traditional medical and interprofessional hierarchies persist within the healthcare workplace;  
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5 and that wider healthcare systems can act as barriers to distributed (or shared) leadership  
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7 practices. Collecting and analysing narrative data provided us with new understandings of the  
8  
9 multiple ways in which leadership and followership is experienced in the healthcare  
10  
11 workplace. Exploring the interplay between both what the narratives contained and how the  
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13 narratives were told, provided unique insights into how narrators constructed their identities  
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15 as leaders or followers against the backdrop of a complex healthcare workplace.  
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**Table 1: Narrative content themes and subthemes**

<b>Theme: Static leadership relationships (n=131)</b>	<b>Definition</b>
Sub-themes:	
Facilitated by supportive dialogue or behaviours (n=25)	Leaders are perceived to take part in supportive behaviours or dialogue through revealing fallibility, listening, accommodating, being fair, responsive, or showing empathy.
Inhibited by unsupportive behaviours or lack of dialogue (n=21)	Leaders are perceived to be unsupportive and lack dialogue with followers. This is done through them being unfair, not admitting fallibility, not listening, being unresponsive or lacking empathy.
Abusive (n=21)	Abuse was constructed through the actions of leaders including undermining, verbal abuse, physical abuse, humiliation and/or criticism.
Inhibiting team-working (n=14)	Participants described instances of poor team working, often with conflict/disagreement being described or a lack of inclusivity.
Conflictive decision-making (n=12)	Trainees described those perceived to be leaders in conflict/disagreement with each other about patient care.
Fostering constructive team-working (n=8)	Team-working was described that was collaborative and perceived to be conducive to good patient care.
Ineffective due to unclear role definition (n=7)	Described when there was a perceived lack of leadership or when too many people were trying to take on the leadership role.
Effective, based on clearly defined roles (n=6)	Roles here were defined often as a result of having time to prepare for the situation. For example, a multiple trauma coming into Accident and Emergency.
Identified through traditional clinical roles (n=6)	For example, Doctor as leader, nurse as follower.
Collective decision-making (n=5)	Sharing group goals, all team members working towards the same goal, and with an appropriate allocation of tasks.
Identified through traditional hierarchies (n=4)	The most senior person present was seen to automatically take the lead. Assumed through traditional hierarchies.
Effective, based on practiced protocols (n=2)	This often related to cardiac arrest scenarios in which protocols are practiced and the scenario is seen to “run” “smoothly” due to repeated practice of these scenarios.
<b>Theme: Emergent leadership relationships (n=40)</b>	<b>Definition</b>
Sub-themes:	
Facilitated by individual knowledge or experience (n=21)	An individual will “step into” leadership based on previous experience or knowledge. Leadership can sometimes come from unexpected sources and doesn’t necessarily follow traditional hierarchies.

Facilitated by lack of engagement of expected leader (n=9)	Trainees described being “pushed into” a leadership role due to lack of engagement of a perceived leader. Sometimes the perceived leader can “hand leadership back to the junior”. Trainees are not actively seeking to take on leadership but sometimes circumstance requires them to do so.
Facilitated by systems and protocols (n=5)	For example, trainees used protocol to support a change in clinical care and take on leadership.
Facilitated by timing (n=3)	Due to the timing of incidents, trainees take on leadership e.g. at night.
Inhibited by lack of knowledge or experience (n=1)	Trainees describe an individual who “steps into” the leadership role but is unable to take on that role due to lack of experience or knowledge.
Inhibited by systems and protocols (n=1)	Where systems do not allow leadership to emerge (e.g. consultant to consultant referral systems.) Often this was linked to perceptions of traditional medical hierarchies.

**Table 2: Excerpts from narratives**

**Excerpt 1:** “...the registrar who was there...who in that situation [cardiac arrest] was leading the team...was very good at...knowing what everyone’s limitations were and...telling you to do things without patronising you or making you feel silly...you could see the medical student was...looking petrified...he [registrar] gave them a job to allow them to feel involved but...not get too involved that they got scared...it was really something to learn from” (Female, foundation trainee)

**Excerpt 2:** “...a consultant who didn’t come up to the ward...when he did come up he was never that fussed if you were with him or not...he would just leave you a list of things to do...it was a bit disheartening...you were never...completely reassured about what you were doing...you never really get to grips with his actual overall plan...so you end up not feeling that important part in a team because it doesn’t matter if you were there or not...you’ve to follow blindly what he wrote...” (Male, early-stage medical trainee)

**Excerpt 3:** “[during ward round] he [the consultant] asked everyone to leave...which was a bit mortifying...a nurse and student and possibly even somebody else in the room at the time and he asked them to leave and told me off for something...I asked him questions about it because I didn’t...understand what he was talking about because it made no sense to me...and so I asked him...but he was extremely emotional and angry about it and stormed out...” (Female, higher-stage surgical trainee)

**Excerpt 4:** “I was there [GP practice] for one day...a patient who come screaming... this patient was in labour and she [the GP] have no experience in doing labour at all... then I came to the room...the GP stepped down and I led the team that I’m doing the examination and assessment and then get each one of them a job... So it doesn’t mean that the most senior who can do it. I was not senior, I was trainee....And they agreed, and accepted it...they stepped back and then they let me just give clear instruction...they doesn’t know what to do...because I was just finished my gynae training” (Female, higher-stage GP trainee)

**Excerpt 5:** “... although everyone was kind of looking at me...I noticed that one of the nurses was managing to get through to the patient and kind of getting him to listen ...and I thought, I think ‘this is when I should be quiet and let this nurse deal with it’ and I just did what the nurse said...” (Female, foundation trainee)

**Excerpt 6:** “...we [junior trainees] were kind of saying, ‘well I don’t think this person needs resuscitating because they got quite unwell’ and he [consultant] just didn’t have a clue what to do. He [consultant] said, ‘well that’s not really my, my area’ and kind of then deposited it back to us and said ‘well if you think they’re not for resuscitation, then you take the decision’...but then he was kind of not really living up to what we’d hoped...” (Female, early-stage GP trainee)

**Table 3: Excerpts illustrating process-orientated themes****Pronoun use:**

**Excerpt 1:** “...*they* [the ward nurses] were really dismissive of all the doctors and *they* really didn't want *us* to be there and *they* all knew each other very well...even though *we* were technically more senior, *they* were more experienced [with resuscitation] and it was a really difficult power struggle” (Female, early-stage GP trainee)

**Excerpt 2:** “...discussion about a decision that had been made...It was like, ‘well *we* should really...this and that and the other’, and he said... ‘fair enough’...” (Male, early-stage surgical trainee)

**Excerpt 3:** “... ‘bring back information about that [a patient decision] and *I will* have a discussion and *I'll* support you on that, and if there is any change, if there is anything better we can do, then *I can give my views* on it..’” (Male, higher-stage medical trainee)

**Emotional talk:**

**Excerpt 4:** “it was probably the *happiest* professionally *happiest* time” (Male, early-stage medical trainee)

**Excerpt 5:** “it was *difficult*... it was *very awkward* yes” (Female, higher-stage service trainee)

Table 4: Metaphoric talk excerpts

Conceptual metaphors and examples	Identity construction
<p><b>LEADER-FOLLOWER RELATIONSHIP AS WAR:</b>  <i>"...first thing he [clinician-manger] started to do is just to...<b>attack, attack</b> other consultants...and started to just to <b>stab</b>...even in the same team you're supposed to share the same targets and because if the <b>ship sinks, everybody will sink</b>"</i>(Male, early-stage GP trainee)</p>	<p>Leader as aggressor; followers as victims; department as 'ship'</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS HIERACHY:</b>  <i>"I mean there's one person...if <b>it was monkeys in the zoo</b>, there's one person who's very much the <b>dominant personality, and the alpha male</b>...he's very clear at any kind of whole unit meeting that, you know, <b>this is his view, and he'll shout it from the rooftop</b>"</i> (Male, early-stage medical trainee)</p>	<p>Leader as alpha monkey; followers as subordinate lower-ranking monkeys; Leader is also 'higher up' (as in, on the rooftop)</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS PARENTALISM:</b>  <i>"There's no doubt about it, she gave 110 per cent to her patients. And we used to talk about ourselves as students, and <b>we wanted to be like her when we grew up</b>"</i> (Female, early-stage GP trainee)</p>	<p>Leader as adult; followers as children; leader is also role model</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS SPORT:</b>  <i>"And the number of times you felt like a <b>piggy in the middle</b>. You were being <b>batted backwards and forwards</b>. At the end of the day you're just trying to do the best for the patient who is outside your expertise"</i> (Female, early-stage GP trainee)</p>	<p>Leaders as game-players; followers as objects to be played with (i.e. ball)</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS CONSTRUCTION:</b>  <i>"Other ways of optimising influence of people around you, you just kind of like learn gradually through working, through <b>building working relationships</b>..."</i> (Male, higher-stage surgical trainee)</p>	<p>Leader as builder; leader-follower relationship as the object to be built</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS MACHINE:</b>  <i>"...it works really well and <b>very efficiently</b> and suddenly everyone kind of <b>clicks into gear</b>...the senior registrar will be <b>running it</b>..."</i> (Male early-stage GP trainee)</p>	<p>Leader as machine operator; followers as parts of the machine</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS JOURNEY:</b>  <i>"He's been a good enough leader that day, we'll do it, we'll go that <b>extra mile</b> for him."</i> (Male, higher-stage surgical trainee)</p>	<p>Leader as destination; followers as travellers</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS TRANSACTION:</b>  <i>"...good managers are probably <b>effectively good sales people</b> so you have to treat each person individually..."</i> (Male, early-stage surgical trainee)</p>	<p>Leader as seller; followers as consumers</p>

Table 5: “Where’s your daddy?”

Lines	Narrative*
	<u>Evaluation #1</u>
1	Carol: I had an <i>interesting</i> thing
	<u>Orientation #1</u>
2	when I was doing psychiatry and we had a patient who, <b>they</b> phoned me on a Saturday at lunch time
	<u>Complicating Action #1</u>
3	to say that she’d tested positive for meningococcus and it was, eh was in air, in a sputum sample, so it
4	would have aero-cised
	<u>Most Reportable Event</u>
5	So <b>they</b> said everybody who’d been [on] the ward for the last two weeks plus relatives plus staff all
6	had to get, erm, prophylactic treatment for meningococcus
	<u>Resolution #1</u>
7	And <b>I</b> mean <b>I</b> was phoning sort of infectious disease and occupational health and public health and
8	everybody
	<u>Complicating Action #2</u>
9	And a lot of <b>them</b> were saying, well look <b>we</b> want to, <b>we</b> want to speak to <b>your</b> consultant
	<u>Evaluation #1</u>
10	But the consultant hadn’t done anything that wasn’t psychiatry for 40 years and he had no idea what to
11	do
	<u>Complicating Action #3</u>
12	So literally the consultant was sitting in the corner of the office signing prescriptions for <b>me</b> , while <b>I</b>
13	organised everything
	<u>Evaluation #2</u>
14	because he was, he was <i>largely useless</i>
	<u>Complicating Action #4</u>
15	Erm, but <b>they</b> kept sort of saying, ‘well does <b>your</b> consultant know what <b>you’re</b> doing? Can I speak
16	to someone more senior?’
17	Interviewer: And how did you find that then? How did you find that situation?
	<u>Evaluation #3</u>
18	It was <i>difficult</i> because
	<u>Orientation #2</u>
19	I, <b>I mean I’d</b> , <b>I’d</b> phoned the consultant first just to let him know, and he just said, ‘well look I have
20	no idea what to do, can you manage this?’
	<u>Evaluation #5</u>
21	And <b>I</b> was <i>really confident</i> that <b>I</b> could manage it <b>myself</b> , and <b>I did</b> . But it was just sort of, the people
22	looking over your shoulder going, sort of ‘ <u>Where’s your daddy</u> ’ kind of thing. It was just, it’s a bit
23	<i>frustrating</i> . And it sort of <u>undermines</u> <i>how you feel</i> as a leader a wee bit
	* <b>Editing notes:</b> ...=speech edited out for brevity; Metaphors <u>underlined</u> ; Interesting pronoun use in <b>bold</b> ; Emotional talk in <i>italics</i>

### Contributors

All authors contributed to the study conception and design. LJG contributed to data collection and analysis and wrote the first draft of the paper and edited various iterations. CER contributed to the data collection and analysis and edited each iteration of the article. JSK and JC contributed to the data analysis and also commented on various iterations of the article.

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### Competing Interests

No, there are no competing interests.

### Ethical approval

This study was approved by a University Human Research Ethics Committee (not identified here to maintain anonymity of study sites).

### Data sharing

No additional data is available from this study.



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## Leadership and followership in the healthcare workplace: Exploring medical trainees' experiences through narrative inquiry

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# Leadership and followership in the healthcare workplace: Exploring medical trainees' experiences through narrative inquiry

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## Abstract

### Objectives:

To explore medical trainees' experiences of leadership and followership in the interprofessional healthcare workplace.



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3 Design:

4 A qualitative approach using narrative interviewing techniques in 11 group and 19 individual  
5 interviews with UK medical trainees.  
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10 Setting:

11 Multi-site study across four UK health boards.  
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14 Participants:

15 Through maximum variation sampling, 65 medical trainees were recruited from a range of specialties  
16 and at various stages of training. Participants shared stories about their experiences of leadership and  
17 followership in the healthcare workplace.  
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23 Methods:

24 Data were analysed using thematic and narrative analysis.  
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29 Results:

30 We identified 171 personal incident narratives about leadership and followership. Participants most  
31 often narrated experiences from the position of follower. Their narratives illustrated many factors that  
32 facilitate or inhibit developing leadership identities; that traditional medical and interprofessional  
33 hierarchies persist within the healthcare workplace; and that wider healthcare systems can act as  
34 barriers to distributed leadership practices.  
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41 Conclusion

42 This paper provides new understandings of the multiple ways in which leadership and followership is  
43 experienced in the healthcare workplace and sets out recommendations for future leadership  
44 educational practices and research.  
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## Strengths and Limitations of Study

- This is the first study to explore how medical trainees experience leadership and followership in the healthcare workplace through narrative analysis
- The large number of narratives across multiple UK sites and different specialties, enhances the transferability of our findings
- We acknowledge that our construction of the leader-follower dyad in this study may have influenced our study findings (e.g. encouraging further co-construction of leader-follower dualism by participants)
- We had relatively low numbers of male, non-white and Foundation trainee participants so our findings are most relevant to female, white and specialty trainee doctors

## Introduction

In recent years, there has been an upsurge in the use of the term ‘leadership’ to describe a range of activities connected to the organisation of patient care.<sup>1</sup> ‘Leadership’ is no longer attributed solely to those in formal leadership positions, but is seen to be the responsibility of healthcare professionals across all levels of healthcare organisations.<sup>1-5</sup> Notions of traditional hierarchical practices have given way to arguments for distributed (or shared) leadership models. Modern theoretical discourses assert that leadership is a process involving leaders and followers acting within a fluid context so that people construct leader or follower identities moment-to-moment.<sup>6,7</sup> Suggested benefits of such distributed leadership practices include improved patient experience; reduced errors, infection and mortality; increased staff morale and reduced staff absenteeism and stress.<sup>8</sup> Using this ‘leadership lens’, those in non-formal positions of healthcare leadership (e.g. medical trainees) are expected to undertake leadership throughout their careers and develop their leader identities.<sup>9</sup>

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3 Whilst the healthcare literature contends that effective distributed leadership practices  
4 are necessary to improve healthcare workplace cultures, patient safety and quality of care,  
5  
6 little is known about how these leadership processes are experienced by medical trainees.  
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8 Within this paper we seek to understand better how the notion of 'leadership' has been  
9  
10 embedded into frontline healthcare practice through narrative analyses of how medical  
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12 trainees' leader and follower identities are constructed.  
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### 15 16 17 Researching distributed leadership processes

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19 Until recently, the focus of scholarly activity in leadership has been on individuals as  
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21 leaders.<sup>10,11</sup> In healthcare, many studies have concentrated on *the role of leaders* rather than  
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23 *the processes of leadership*.<sup>e.g. 12,13</sup> However, many leadership theorists criticise leader-centric  
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25 research for its emphasis on individuals as leaders, how effective their activities are and how  
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27 others (followers) act in response to their influence.<sup>11,14</sup> Rather, leadership theorists argue that  
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29 leadership can only be understood through exploring the underlying social systems in which  
30  
31 leadership happens.<sup>6, 15</sup> As a product of co-construction, leadership is perceived as an on-  
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33 going negotiation as part of a multi-faceted interaction between social beings.<sup>16</sup> Each  
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35 interaction can be seen as socially and historically bound operating through language, within  
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37 a socially-constructed context.<sup>16, 17</sup>  
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43 Some studies have explored leadership processes and the link between senior  
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45 clinicians and the wider organisation. For example, combining interviews and observation,  
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47 MacIntosh and colleagues identified the extent to which interactions between clinicians and  
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49 managers were two-way discussions, finding that each group presented themselves as less  
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51 powerful than the other group and lacking agency.<sup>18</sup> They described the clinician-manager  
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53 relationships as having potential to limit the opportunities for distributed leadership  
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55 processes. In addition, Martin and colleagues revealed through interview and observation,  
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3 that there was the potential for a disconnect between the desire for distributed leadership  
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5 within healthcare and actual organisational practices.<sup>5</sup>  
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9 Whilst these studies have focussed on wider organisational leadership processes our  
10 focus is on leadership that may occur day-to-day within the clinical context, where medical  
11 trainees potentially have their first experiences of leadership. Through this, our study seeks to  
12 add to the literature on distributed leadership in healthcare.  
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### 15 16 17 18 Aim and research questions

19 This study aimed to explore how medical trainees experience leadership and followership by  
20 asking two research questions. What are medical trainees' lived experiences of leadership and  
21 followership in interprofessional healthcare workplaces? How do medical trainees construct  
22 their identities as leaders and followers within their narratives of interprofessional healthcare  
23 workplaces?  
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### 30 31 Methods

#### 32 33 Study design

34 We undertook a qualitative study using group and individual interviews to elicit medical  
35 trainees' personal incident narratives (PINs) of their experiences of leadership and  
36 followership. Ascribing to the notion that meanings are constructed by people as they interact  
37 with the world around them, our study draws on social constructionist epistemology.<sup>19</sup>  
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40 We used narrative inquiry methodology. Narrative accounts of the healthcare workplace offer  
41 abundant resources for research.<sup>20</sup> The narratives referred to in this paper are short, about  
42 discrete events, and recounted in interactions in various contexts as sense-making tools.<sup>21, 22</sup>  
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45 A narrative in this form makes the self the central character (or protagonist), either playing an  
46 active part within the story or as Chase describes as an: 'interested observer of others'  
47 actions'.<sup>23, p. 657</sup>  
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3 A narrative is the shared construction between the narrator and his/her audience.<sup>21, 23, 24</sup>  
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5 Bound to this is the context in which the narrative is shared; the specific setting, audience and  
6  
7 the reason the story is told.<sup>23,24</sup> Pivotal to our paper is the concept of the 'narrative turn' in  
8  
9 that narrators construct events through their story, expressing their feelings, beliefs and  
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11 understandings about leadership processes.<sup>24</sup> As such, the narrative becomes a construction of  
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13 who the narrator is, who they wish to be and how they wish to be seen.<sup>25</sup> In other words,  
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15 when a story is told, the narrator constructs and presents identities, events and realities in  
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17 interaction with others.<sup>23, 24</sup> Thus, paying attention to and asking questions not only about  
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19 what participants experiences are but also how they narrate their leadership experiences can  
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21 afford insight into the multiple identities that medical trainees construct as leaders and  
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23 followers.<sup>23</sup>  
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28 The research team

29 The research team included three members with health professions backgrounds (one  
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31 practicing General Practitioner; one ex-physiotherapist; and one ex-clinical psychologist) and  
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33 one social scientist. Team members had various personal experiences of leadership and  
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35 management covering clinical, research and educational leadership, with all team members  
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37 teaching leadership in healthcare at undergraduate and postgraduate levels.  
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41 Sampling and recruitment

42 Upon receiving ethical approval and appropriate institutional consents we utilised maximum-  
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44 variation sampling to ensure a diversity of medical trainees in terms of their stage of training,  
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46 specialty and location. Following an initial recruitment drive by email, we recruited further  
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48 participants using flyers at trainee teaching sessions and snowballing.<sup>26</sup>  
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52 Data collection

53 We conducted eleven group (with between three and seven participants) and nineteen  
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55 individual interviews with 65 medical trainees (25 male: 40 female, 51 white: 14 non-white)  
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3 from both early-stage (34) and higher-stage (trainees beyond the half-way point: 31)  
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5 postgraduate medical training. Our initial aim was to have only group interviews as from a  
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7 social constructionist perspective they had the potential for participants to build on each  
8  
9 other's ideas. However, convenience for participants meant that individual interviews were  
10  
11 also necessary. Our sample came from four UK Health Boards and a range of specialty  
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13 trainee groups including: general practice (GP: 23); medicine (13); surgery (11); and service-  
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15 orientated trainees such as anaesthetists, radiology and pathologists (10). Our sample also  
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17 included eight foundation doctors.  
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21 We devised an interview guide which was developed in line with our research questions,  
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23 which provided an aide memoir. The semi-structured nature of the interviews allowed for  
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25 flexibility so that ideas could be pursued and expanded upon. The interviews were broadly  
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27 split into two sections: first, we asked participants to articulate their understandings of  
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29 leadership and followership (reported elsewhere).<sup>27</sup> Following this, narrative interviewing  
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31 techniques were used to collect narratives of participants' experiences of leadership and  
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33 followership in the interprofessional healthcare workplace. All interviews were audio-  
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35 recorded (with permission) and independently transcribed. All interviews were conducted by  
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37 the primary author bar one (the second author conducted an early group interview and  
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39 listened to several initial interviews with the primary author to reflect on the structure and  
40  
41 relevance of the interview schedule, (thus enhancing research rigour).  
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#### 46 Data analysis

47 We began our analysis with thematic framework analysis.<sup>28</sup> This allowed us to identify  
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49 patterns across the data. We constantly familiarised ourselves with the data through repeated  
50  
51 reading of transcripts and listening to audio-recordings. A team data analysis session was  
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53 held which provided opportunity to discuss and negotiate possible themes to be included in  
54  
55 the thematic coding framework. Prior to the session, a subset of data were analysed separately  
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3 by each team member. Through an iterative process of discussion, feedback and agreement  
4 within the team, a coding framework was developed which was then used to index the data.  
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6 To identify narratives, we drew on Labov's construction that a narrative is a structured  
7 account of an incident that has become part of the biography of the storyteller.<sup>29</sup> It is  
8 increasingly common within qualitative research to explore patterns across data through the  
9 use of computer assisted qualitative data analysis software (CAQDAS). We used Atlas-ti  
10 (Version 7.2) in our identification, time-stamping and coding of all narratives.<sup>30</sup>  
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19 Using the premise that identities are formed through talk and interaction we explored  
20 the interplay between different thematic groupings.<sup>24</sup> To do this, we used a form of structural  
21 narrative analysis which pays attention to the ways in which narratives are organised.<sup>21</sup> Labov  
22 states that a fully formed narrative includes seven elements: (1) abstract; (2) orientation; (3)  
23 complicating action; (4) evaluation; (5) most reportable event; (6) resolution; and (7) a  
24 coda.<sup>29</sup> Not all stories however will contain all elements and often elements occur in different  
25 sequences, with narrators moving back and forth, providing further complicating actions and  
26 evaluations as they make sense of the story.<sup>30</sup> Thus, we were able to explore how participants  
27 constructed their identities as leaders and followers within their narrative, what parts of the  
28 story participants constructed as important, and how the narrator used language to illustrate  
29 how they evaluated the events.<sup>31</sup>  
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## 45 Results

46 Across the dataset, we identified 171 distinct narratives. Initial thematic analysis identified  
47 three different sets (or groupings) of themes. Contextual themes for the narratives provided  
48 orientation to the timing of the events; where the events took place; how the narrators  
49 positioned themselves in the story (for example, as leader, follower or observer); the type of  
50 activity that was being undertaken when the event occurred; and how the narrator evaluated  
51 their experience (for example, positively, negatively or neutrally) through their commentary  
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3 on the events. The second group of themes focussed on the content of the story and  
4  
5 signposted its gist (i.e. the main plotline of the story). Finally, process-orientated themes  
6  
7 focussed on *how* the stories were narrated. This set of themes highlighted, for example,  
8  
9 linguistic features used by narrators to articulate their stories.  
10

11  
12 What are medical trainees' lived experiences of leadership and followership in  
13  
14 interprofessional healthcare workplaces?

### 15 16 *Contextual themes*

17  
18 Participants most often constructed themselves as followers within the stories (n=80), with  
19  
20 around half as many constructing themselves from the position of leader (n=41). Of the 171  
21  
22 narratives, 144 were set in the hospital, with only 12 set in GP practice. However GP trainees  
23  
24 offered the highest proportion of narratives across the specialties (sharing 53 narratives, of  
25  
26 which 36 were hospital-based).  
27

28  
29  
30 The activities on which stories centred were wide-ranging: they were most likely to  
31  
32 come from the clinical environment and be related to clinical leadership activities (n=119).  
33  
34 This included stories about complex patient scenarios, which participants deemed to be  
35  
36 extraordinary (n=37). Still related to clinical leadership, were stories about acute emergency  
37  
38 scenarios (n=32) and routine patient care (n=29). Data also included stories about formal  
39  
40 ward-based activities such as planned team meetings and ward rounds (n=15). Narratives  
41  
42 were evenly balanced between positively and negatively evaluated experiences (80 positive;  
43  
44 77 negative).  
45  
46  
47

48  
49 We identified two overarching themes for the content of the narratives (Static  
50  
51 leadership relationships and Emergent leadership relationships) and a series of sub-themes as  
52  
53 defined in Table 1. We also identified three key process-orientated themes: pronominal;  
54  
55 emotional; and metaphoric talk. What follows in this section is an overview of each of these  
56  
57 themes with illustrative data excerpts presented in Table 2.  
58  
59  
60

[Insert Table 1 around here]

### *Static leadership relationships*

Static leadership relationships was the dominant content-related theme (n=131). Here, the identity of the leader and follower/s remained static throughout the story and trainees typically narrated from the position of follower. These leader-follower relationships were based on the traditional hierarchies found within the healthcare workplace. From this, we identified 12 sub-themes, which focussed on leader behaviours within the stories and which were seen to be facilitative or inhibitive to good leader-follower relationships (see Table 1).

Here, we talk in-depth about the most common three themes only. Excerpt 1 (Table 2) illustrates a facilitative sub-theme, where the leader is seen to be entering into a supportive dialogue or behaving in a supportive way to facilitate leadership processes and leader-follower relationships. Here, the leader is perceived to have acted in the best interests of the patient regardless of the outcome. As a follower, this participant describes how she felt valued, respected and supported within this relationship, that it was conducive to learning and that this type of relationship was something to aspire to.

[Insert Table 2 around here]

In contrast, Excerpt 2 (see Table 2) illustrates an inhibitive sub-theme in which the leader is seen to be unsupportive and lack dialogue with the trainee as a follower. The trainee reports that these behaviours led to lost confidence and feelings of non-validity and exclusion. This is reported to be detrimental to training experiences and at times detrimental to patient care.

We also identified abuse narratives (see Excerpt 3, Table 2). This subtheme categorised narratives around direct and indirect experiences of what constituted abuse as

1  
2  
3 perceived by participants (this included undermining and humiliation). As well as being the  
4  
5 recipients of abuse, participants witnessed others being abused too. The abuser was most  
6  
7 often identified as the consultant but trainees also reported abuse from other more senior  
8  
9 trainees and nursing staff. Abuse typically revolved around clinical leadership and during  
10  
11 routine patient care (for example, surgical theatre) or formal activities such as the ward  
12  
13 rounds or meetings, as illustrated in Excerpt 3 (see Table 2).  
14  
15

16  
17 Participants often reported negative emotional responses to these experiences: they  
18  
19 talked about feeling humiliated and non-human, sometimes getting angry themselves; the  
20  
21 need to keep going and “survive” training; and being careful to avoid situations in which  
22  
23 abuse was likely to happen/occur.  
24  
25

### 26 27 *Emergent leadership relationships*

28  
29 A smaller proportion of narratives (n=40) were coded to the content-related theme: Emergent  
30  
31 leadership relationships. Unlike the previous theme, in which the identities of the leaders and  
32  
33 followers were static, here participants recounted how the combination of individuals  
34  
35 involved, the context (including the task), the relationships within that context and the wider  
36  
37 systems affected who emerged as the leader within the experience. Leadership emergence  
38  
39 was more likely to be categorised in narratives that related directly to patient care scenarios,  
40  
41 namely: complex patient cases; routine patient care; and acute emergency care. Interestingly,  
42  
43 no narratives in which formal clinical activities were being undertaken were coded to this  
44  
45 theme, indicating more static (and possibly traditional) leader-follower relationships within  
46  
47 more formalised clinical settings.  
48  
49

50  
51 We identified six subthemes within these narratives which described the factors either  
52  
53 facilitative or inhibitive to leadership emergence (see Table 1). Unlike the static leadership  
54  
55 relationship subthemes, medical trainees typically narrated emergent leadership relationship  
56  
57  
58  
59  
60

narratives from the position of leader. Excerpt 4 (see Table 2) illustrates an example in which emergent leadership relationships were facilitated by individual knowledge or experience.

The trainee describes an incident where, as a junior trainee, her broad-based training experience made her more ‘expert’ than those with more specialised training.

Often stories within this subtheme were interprofessional. Participants narrated incidents in which more experienced nurses and other members of the interprofessional team took on leadership. Participants narrated this as emergent because they were working in the context of traditional interprofessional hierarchies, which meant that they thought doctors were expected to lead. Perhaps unsurprisingly, participants inevitably saw leadership emergence occurring in the best interests of the patients, as illustrated in excerpt 5 (see Table 2).

In order for leaders to step forward and out of traditional hierarchical boundaries, participants narrated the process of traditional leaders needing to “step back” (as illustrated in excerpt 5, above). This was sometimes perceived to be difficult. At times, participants narrated experiences in which traditional leaders stepped back through their non-engagement, as illustrated in Excerpt 6 (see Table 2).

### ***Process-orientated themes***

From the position of follower, participants often used the pronouns “we” and “us” to describe themselves and their contemporaries, and “them” and “they” to describe a group of leaders within their narratives, indicating a perceived separation (and potentially adversarial relationships) between followers and leaders. This was particularly apparent within the negatively evaluated narratives (See Table 3: Excerpt 1).

[Insert Table 3 around here]

1  
2  
3 When followership experiences were evaluated more positively and the leadership process  
4 was seen to go well, pronouns “we” and “us” would be used to describe the whole team,  
5 including both leaders and followers together (See Table 3: Excerpt 2). From the position of  
6 leader, participants often used the pronoun “I” when describing leadership decisions, which  
7 seemed to indicate their agency and autonomy within the situation (See Table 3: Excerpt 3).  
8  
9

10  
11  
12  
13  
14  
15 Participants typically used positive emotional talk within stories that were evaluated  
16 positively (Table 3: Excerpt 4) and negative emotional talk (Table 3: Excerpt 5) within stories  
17 evaluated as negative experiences.  
18  
19

20  
21  
22  
23  
24 Across the narratives, we identified hundreds of metaphoric linguistic expressions  
25 (MLEs).<sup>32</sup> Although it is outside the scope of this paper to present a full systematic metaphor  
26 analysis, we identified broad groups of conceptual metaphors which revealed participants’  
27 understandings of leader-follower relationships.<sup>32-34</sup> We identified eight overarching  
28 conceptual metaphors used to describe the leader-follower relationship. These were LEADER-  
29 FOLLOWER RELATIONSHIP AS: WAR; HIERARCHY; PARENTALISM; SPORT; CONSTRUCTION;  
30 MACHINE; JOURNEY; and TRANSACTION (the convention of cognitive linguistics requires that  
31 conceptual metaphors are presented in small capitals: see Table 4).<sup>34</sup>  
32  
33  
34  
35  
36  
37  
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39

40  
41 [Insert Table 4 about here]  
42

43 How do medical trainees construct their identities as leaders and followers within their  
44 narratives of interprofessional healthcare workplaces?  
45  
46

47 Here, we pull together both content and process-related themes to present a more detailed  
48 exploration of one narrative. This narrative from ‘Carol’ (a pseudonym, female early-stage  
49 GP trainee) comes from an event she experienced during her time as a trainee in psychiatry. It  
50 is not explicitly clear what grade of training Carol was at the time of her story but through her  
51 use of language and the events narrated she is clearly junior to the narrative protagonists (see  
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60

1  
2  
3 Table 5). Carol presents a complex patient scenario in which people in contact with a  
4  
5 particular patient needed prophylactic treatment for meningococcal disease. The focus of  
6  
7 Carol's story is on her personal experience of trying to take leadership as the consultant (a  
8  
9 psychiatrist) states that he does not have the necessary experience to do so. Carol describes  
10  
11 how attitudes, systems and protocols become barriers to fully undertaking leadership in this  
12  
13 scenario. Indeed, the key message of Carol's narrative is that her ability to take on leadership  
14  
15 is inhibited by the wider systems in which she works. We identified other content-related  
16  
17 themes, which could facilitate and/or inhibit leadership processes. Facilitative aspects  
18  
19 included her emergence as leader due to her own knowledge and expertise, in contrast to the  
20  
21 consultant's unwillingness to engage in leadership due to his own lack of experience, leading  
22  
23 him to support her leadership emergence. Inhibitive aspects include Carol's description of  
24  
25 traditional systems, protocols and expectations that the consultant should be leading.  
26  
27  
28  
29

30 [Insert Table 5 about here]  
31

32 Carol describes different interactions with different sets of actors in her narrative. Firstly,  
33  
34 there is the interaction between herself and her consultant. Secondly, there is the interaction  
35  
36 she has with a group of people (i.e. "the people", line 21) she repeatedly describes as "they"  
37  
38 or "them". Throughout the narrative she is not specific about who "they" are. However, in  
39  
40 lines 7 and 8, she lists a group of specialties and we assume that "they" are included within  
41  
42 this group. In the following paragraphs, we explore how Carol constructs her identities as  
43  
44 leader and follower in relation to these two interactions.  
45  
46  
47  
48

#### 49 *Carol as a capable leader, the consultant as supportive follower*

50 When Carol narrates her interaction with the psychiatry consultant, she constructs herself as a  
51  
52 confident and capable leader. She describes a discussion with her consultant in which  
53  
54 responsibility for dealing with the situation becomes hers (lines 19 and 20). When evaluating  
55  
56 this event, she uses positive language with intensifiers, to construct herself as "really  
57  
58  
59  
60

1  
2  
3 confident” that she can handle the situation (line 21) and qualifies this with the short  
4  
5 statement that: “I did”. Within this interaction, Carol identifies herself as the leader through  
6  
7 regular use of “I” to indicate her agency and control of the situation (lines 7 and 12). Despite  
8  
9 her describing the consultant as having a part in the process (e.g. writing prescriptions, line  
10  
11 12), she chooses not to use the pronoun “we”, suggesting that she does not see herself and the  
12  
13 consultant as a team. Possibly to reinforce her own identity as a strong leader, she constructs  
14  
15 her consultant as a supportive follower who undertakes tasks “for me” (line 12). This is  
16  
17 emphasised early in the narrative through her use of derogatory language to describe the  
18  
19 consultant as having “no idea what to do” (line 10) and as being “largely useless” (line 14),  
20  
21 constructing him as lacking both clinical knowledge and leadership.  
22  
23  
24

### 25 26 *Carol as child, consultant as ‘daddy’*

27  
28 The second type of interactions Carol has within this narrative (with other healthcare  
29  
30 professionals as part of workplace systems and cultures) reveals a contrasting picture relating  
31  
32 to her and her consultant’s identity construction. “Their” express desire is to speak to the  
33  
34 consultant (lines 9), and “they” ask Carol if her consultant knows what is happening (line 15).  
35  
36 Carol’s pronoun use at this point places distance between her and this wider group and gives  
37  
38 this part of her narrative a confrontational feel. Carol narrates that she is powerless to change  
39  
40 systems which expect the consultant to be the leader and thus within this interaction, Carol  
41  
42 shifts her own position from leader to follower. Carol uses negative emotional language such  
43  
44 as “difficult” (line 18) and “frustrating” (line 23) to express how she finds this and how this  
45  
46 interaction effects her identity construction.  
47  
48  
49  
50

51  
52 Key within this narrative is Carol’s use of a metaphoric linguistic expression (MLE),  
53  
54 which reveals how she thinks her and her consultant’s identities, and their relationships, are  
55  
56 ascribed by others as: LEADER-FOLLOWER RELATIONSHIP AS PARENTALISM (line 22).

57  
58 Through her use of this MLE (‘where’s your daddy?’), she constructs her identity as ascribed  
59  
60



1  
2  
3 by others as a young child and the consultant as her male parent. This reveals that she thinks  
4  
5 others see her as junior within the wider healthcare system. Indeed, Carol states that the  
6  
7 consultant is required to sign the prescriptions in order for the task to be fulfilled and thus  
8  
9 protocol reinforces this traditional hierarchy (line 12), reinforcing her lowly position within  
10  
11 the hierarchy. She finishes the narrative by expressing that this (childlike) identity imposed  
12  
13 on her ultimately undermines how she feels as a leader (lines 23).  
14  
15

16  
17 In summary, this narrative reveals a complex and at times contrasting interplay  
18  
19 between individuals, context, relationships and systems, which seem to simultaneously  
20  
21 facilitate and inhibit Carol's emerging leader identity. As an individual, Carol feels confident  
22  
23 that she can cope with the situation and her relationship with the consultant is such that she  
24  
25 feels able to move away from traditional hierarchies to take control, which within this context  
26  
27 she feels is appropriate due to her superior knowledge of how to approach the situation.  
28  
29 However, through this narrative Carol also describes the frustrations of trying to take on  
30  
31 leadership in a wider healthcare system in which protocols and traditional hierarchical  
32  
33 attitudes prevent her from fully undertaking the role and ultimately positions her as  
34  
35 "childlike" and "undermined".  
36  
37  
38  
39

## 40 **Discussion and Conclusions**

41 Despite the espoused rhetoric of distributed leadership relationships within the healthcare  
42  
43 literature, our data indicate that static and hierarchical leadership relationships remain the  
44  
45 norm.<sup>4, 8, 9</sup> We argue that a workplace perpetuating leadership processes embedded in static  
46  
47 leader-follower relationships has the potential to be prescriptive about the division of labour  
48  
49 and may be inflexible to innovation with potential adverse implications for patient care.<sup>6, 8, 11</sup>  
50  
51 Within the 'static leadership relationships' theme, the focus of the content-related subthemes  
52  
53 was often on evaluation of whether individuals were 'good' or 'bad' leaders. Schyns and  
54  
55 Miendl suggest that leaders are evaluated through followers' ideas about leadership that have  
56  
57  
58  
59  
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1  
2  
3 been formed through previous experiences as part of professional socialisation.<sup>35</sup> Leaders are  
4  
5 thus linked to pre-existing prototypes.<sup>11,36</sup> Included in this were narratives about abusive  
6  
7 leader-follower relationships. Experiences of abuse are reflected in findings from both  
8  
9 undergraduate and postgraduate studies, in which abuse within the healthcare workplace has  
10  
11 been narrated by medical and other healthcare students and trainees.<sup>37-40</sup> It would appear that  
12  
13 abuse continues to be experienced in the postgraduate sphere.  
14

15  
16  
17 Our findings revealed that participants most commonly drew on their experiences of  
18  
19 clinical leadership in hospitals. Despite the traditional notion that leadership is focussed on  
20  
21 organisational change, 'leadership' within these narratives was about 'influential acts of  
22  
23 organising' (IAOs) that happened day-to-day in the healthcare workplace.<sup>41</sup> This difference  
24  
25 could perhaps be explained by the recruitment of participants from out with traditional  
26  
27 positions of organisational leadership, which meant their focus was on 'everyday' leadership  
28  
29 experiences. In previous leadership research, narrative inquiry has been limited to the broader  
30  
31 narratives of an organisation or the life story of a leader.<sup>42, 43</sup>  
32  
33  
34

35  
36 Less than a quarter of the narratives were about 'emergent leadership relationships',  
37  
38 most of which involved complex patient scenarios. It can be suggested that these scenarios  
39  
40 could be seen as 'non-linear' or 'wicked' problems, requiring emergent leadership  
41  
42 relationships that can happen out with traditional hierarchies.<sup>17,44</sup> Key to this was the  
43  
44 assumption that actions were in the best interests of the patient (thus, these emergent  
45  
46 relationships can be seen as patient-centred). However, our findings show that at a local level,  
47  
48 there is some work to be done on cultural shifts toward what could be described as distributed  
49  
50 leadership patterns.  
51  
52  
53

54  
55 In the leadership literature there is a lively debate around the broad metaphors of  
56  
57 'leadership' as an overall phenomenon.<sup>16, 45</sup> However, our analysis was concerned more with  
58  
59  
60

1  
2  
3 the conceptual metaphors used as part of language-in-interaction and what this revealed about  
4  
5 leader-follower relationships. This, along with pronominal and emotional talk, gave insight  
6  
7 into how participants evaluated these relationships. To our knowledge, no-one has explored  
8  
9 previously metaphoric talk identified within leadership narratives specifically, although  
10  
11 similar talk has been found describing the student/doctor-patient relationship and the student-  
12  
13 doctor feedback relationship at the undergraduate level.<sup>31, 33, 34</sup>

14  
15  
16  
17 Carol's narrative revealed an unpredictable situation in which change (and learning)  
18  
19 was required in response.<sup>46</sup> Through her narrative, Carol constructed her identity as a leader  
20  
21 out with her formal position, and thus leadership was 'emergent'.<sup>46</sup> Carol's narrative also  
22  
23 revealed the 'enabling' identities of her consultant, who had to act as a bridge between the  
24  
25 administrative structures within the organisation and the adaptive leadership required to solve  
26  
27 the issue faced.<sup>46</sup> Our narrative analysis also revealed the potential for 'disconnect' between  
28  
29 the emergent leadership expectations of the immediate context and those of traditional  
30  
31 hierarchies within the wider organisation, which firmly positioned Carol as a follower. These  
32  
33 barriers could explain why static leader-follower relationships perpetuate as the norm and  
34  
35 echo the work of Martin and colleagues.<sup>5</sup>

36  
37  
38  
39  
40 Narrative inquiry is not novel in the field of medical education. It has been utilised to  
41  
42 analyse, for example, professionalism dilemmas; prescribing experiences; and feedback  
43  
44 experiences.<sup>30, 31, 38, 47- 49</sup> Through narratives, in the current study, participants had the  
45  
46 opportunity to develop their own voice as they constructed their stories, others' voices and  
47  
48 multiple realities.<sup>23</sup> This approach was particularly valuable when considering that some  
49  
50 narratives including those describing workplace abuse were also evaluated negatively.  
51  
52 Indeed, participants may not have had the opportunity to discuss such distressing matters  
53  
54 before the study and had this study not been conducted. In fact, we suggest that these  
55  
56 narratives, at times, became 'acts of resistance', which challenged traditional hierarchical  
57  
58  
59  
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1  
2  
3 conceptualisations of leadership.<sup>50</sup> Such ‘resistance’ was possibly a conscious act to ‘subvert’  
4  
5 asymmetrical power relationships that were constructed through traditional healthcare  
6  
7 hierarchies.<sup>50, p. 433</sup> Narrative analysis has also highlighted the potential use of narratives for  
8  
9 educational purposes. Through story-telling, participants repeatedly evaluated their  
10  
11 experiences. Using narratives in this way would provide opportunities for learners to evaluate  
12  
13 and make sense of their leadership experiences and reflect critically on their developing  
14  
15 identities as leaders, followers and doctors, exploring opportunities for on-going development  
16  
17 and building on their understandings of leadership processes.<sup>51</sup>  
18  
19

20  
21 Our research is not without its methodological challenges. We acknowledge that we  
22  
23 chose ‘leadership’ as a specific lens for our study. Recent critical leadership literature argues  
24  
25 that the rise of ‘leaderism’ in healthcare discourse has meant that many things that were more  
26  
27 traditionally aligned to, for example, ‘interprofessional relationships’ or ‘clinical decision  
28  
29 making’ are now being branded as ‘leadership’.<sup>1, 52</sup> Asking participants specifically about  
30  
31 their leadership experiences may have perpetuated this leaderism discourse in our findings.  
32  
33 We acknowledge that prior to eliciting narratives from participants, we drew participants’  
34  
35 attention to leader-follower dualism as a concept through the pre-interview participant  
36  
37 information sheet and questioning them about their understandings of ‘leadership’ and  
38  
39 ‘followership’. We therefore potentially influenced participants through our socially  
40  
41 constructed conceptualisations of leadership and followership. In particular, the notion of  
42  
43 ‘followership’, an uncommonly used or understood term in healthcare is something we  
44  
45 sensitised participants to and they often struggled to define (reported elsewhere<sup>27</sup>).  
46  
47  
48  
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51 As a research team, although we had diversity in terms of our professional  
52  
53 backgrounds (see methods), we were not diverse in terms of other identities such as gender  
54  
55 and ethnicity (we are all female and white). Our interpretation of the data will be influenced  
56  
57 by own understandings and experiences of leadership, and these will inevitably be coloured  
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59  
60

1  
2  
3 by things like our gender. We also acknowledge the lower proportion of male, non-white and  
4  
5 foundation doctors within our sample, meaning that our findings may be less transferable to  
6  
7 these groups. While interview methods helped to reveal a complex picture of the  
8  
9 interprofessional healthcare workplace it also exposed a limitation in our study, in that we  
10  
11 sought only to interview medical professionals. Broadening our narrative interviews to take  
12  
13 into account the whole interprofessional team would have enriched these data and should be  
14  
15 considered for future interview research. In addition, although our study was multi-site, it was  
16  
17 conducted in the UK so the findings might be less transferable to other countries with  
18  
19 different healthcare and healthcare education systems.  
20  
21

22  
23  
24 We used a qualitative, process-orientated approach to our research. We acknowledge  
25  
26 that the use of numbers within the presentation of our data has the potential to draw criticism.  
27  
28 However, it is not unusual for some qualitative researchers to draw on numbers to look at  
29  
30 patterns in large qualitative datasets.<sup>30</sup> We used numbers in our study to elucidate patterns  
31  
32 (similarities and differences) that would not have been apparent with text alone.  
33  
34

35  
36 The large number of hospital-based narratives in comparison to community-based  
37  
38 narratives in our study did not allow us the opportunity to explore whether clinical settings  
39  
40 made a difference to participants' experiences, something that should be considered for  
41  
42 further study. Indeed, although GPs were a large proportion of our participant group, in the  
43  
44 UK they spend 18 months of their three-year training in hospitals, following a 2-year  
45  
46 (largely) hospital-based foundation programme. This time spent in hospitals will have  
47  
48 undoubtedly influenced the setting of their stories.  
49  
50

51  
52 In addition, although narratives were identified in the same way for individual and  
53  
54 group interviews, we did not note, nor formally explore any differences in data between  
55  
56 group and individual interviews (as this was not relevant to our research questions).  
57  
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2  
3 However, this could warrant exploration in further research. Finally, our cross-sectional data  
4 did not allow for exploration into how experiences of leadership and the formation of leader  
5 identities might change over time as doctors move through training and this should be  
6  
7  
8 considered in further (longitudinal) research.  
9  
10

11  
12 In conclusion, this study has led to better understandings about participants' multiple,  
13 constructed realities of leadership and followership in different healthcare contexts. The  
14 findings from this study reveal that many factors influence developing leader identities; that  
15 traditional medical and interprofessional hierarchies persist within the healthcare workplace;  
16 and that wider healthcare systems can act as barriers to distributed (or shared) leadership  
17 practices. Collecting and analysing narrative data provided us with new understandings of the  
18 multiple ways in which leadership and followership is experienced in the healthcare  
19 workplace. Exploring the interplay between both what the narratives contained and how the  
20 narratives were told, provided unique insights into how narrators constructed their identities  
21 as leaders or followers against the backdrop of a complex healthcare workplace.  
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### 35 Contributors

36 All authors contributed to the study conception and design. LJG contributed to data collection and  
37 analysis and wrote the first draft of the paper and edited various iterations. CER contributed to the  
38 data collection and analysis and edited each iteration of the article. JSK and JC contributed to the data  
39 analysis and also commented on various iterations of the article.  
40  
41  
42  
43  
44

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49 SMERC.  
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## Competing Interests

No, there are no competing interests.

## Ethical approval

This study was approved by a University Human Research Ethics Committee (not identified here to maintain anonymity of study sites).

## Data sharing

No additional data is available from this study.



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**Table 1: Narrative content themes and subthemes**

<b>Theme: Static leadership relationships (n=131)</b>	<b>Definition</b>
Sub-themes:	
Facilitated by supportive dialogue or behaviours (n=25)	Leaders are perceived to take part in supportive behaviours or dialogue through revealing fallibility, listening, accommodating, being fair, responsive, or showing empathy.
Inhibited by unsupportive behaviours or lack of dialogue (n=21)	Leaders are perceived to be unsupportive and lack dialogue with followers. This is done through them being unfair, not admitting fallibility, not listening, being unresponsive or lacking empathy.
Abusive (n=21)	Abuse was constructed through the actions of leaders including undermining, verbal abuse, physical abuse, humiliation and/or criticism.
Inhibiting team-working (n=14)	Participants described instances of poor team working, often with conflict/disagreement being described or a lack of inclusivity.
Conflictive decision-making (n=12)	Trainees described those perceived to be leaders in conflict/disagreement with each other about patient care.
Fostering constructive team-working (n=8)	Team-working was described that was collaborative and perceived to be conducive to good patient care.
Ineffective due to unclear role definition (n=7)	Described when there was a perceived lack of leadership or when too many people were trying to take on the leadership role.
Effective, based on clearly defined roles (n=6)	Roles here were defined often as a result of having time to prepare for the situation. For example, a multiple trauma coming into Accident and Emergency.
Identified through traditional clinical roles (n=6)	For example, Doctor as leader, nurse as follower.
Collective decision-making (n=5)	Sharing group goals, all team members working towards the same goal, and with an appropriate allocation of tasks.
Identified through traditional hierarchies (n=4)	The most senior person present was seen to automatically take the lead. Assumed through traditional hierarchies.
Effective, based on practiced protocols (n=2)	This often related to cardiac arrest scenarios in which protocols are practiced and the scenario is seen to “run” “smoothly” due to repeated practice of these scenarios.
<b>Theme: Emergent leadership relationships (n=40)</b>	<b>Definition</b>
Sub-themes:	
Facilitated by individual knowledge or experience (n=21)	An individual will “step into” leadership based on previous experience or knowledge. Leadership can sometimes come from unexpected sources and doesn’t necessarily follow traditional hierarchies.

Facilitated by lack of engagement of expected leader (n=9)	Trainees described being “pushed into” a leadership role due to lack of engagement of a perceived leader. Sometimes the perceived leader can “hand leadership back to the junior”. Trainees are not actively seeking to take on leadership but sometimes circumstance requires them to do so.
Facilitated by systems and protocols (n=5)	For example, trainees used protocol to support a change in clinical care and take on leadership.
Facilitated by timing (n=3)	Due to the timing of incidents, trainees take on leadership e.g. at night.
Inhibited by lack of knowledge or experience (n=1)	Trainees describe an individual who “steps into” the leadership role but is unable to take on that role due to lack of experience or knowledge.
Inhibited by systems and protocols (n=1)	Where systems do not allow leadership to emerge (e.g. consultant to consultant referral systems.) Often this was linked to perceptions of traditional medical hierarchies.

**Table 2: Excerpts from narratives**

**Excerpt 1:** “...the registrar who was there...who in that situation [cardiac arrest] was leading the team...was very good at...knowing what everyone’s limitations were and...telling you to do things without patronising you or making you feel silly...you could see the medical student was...looking petrified...he [registrar] gave them a job to allow them to feel involved but...not get too involved that they got scared...it was really something to learn from” (Female, foundation trainee)

**Excerpt 2:** “...a consultant who didn’t come up to the ward...when he did come up he was never that fussed if you were with him or not...he would just leave you a list of things to do...it was a bit disheartening...you were never...completely reassured about what you were doing...you never really get to grips with his actual overall plan...so you end up not feeling that important part in a team because it doesn’t matter if you were there or not...you’ve to follow blindly what he wrote...” (Male, early-stage medical trainee)

**Excerpt 3:** “[during ward round] he [the consultant] asked everyone to leave...which was a bit mortifying...a nurse and student and possibly even somebody else in the room at the time and he asked them to leave and told me off for something...I asked him questions about it because I didn’t...understand what he was talking about because it made no sense to me...and so I asked him...but he was extremely emotional and angry about it and stormed out...” (Female, higher-stage surgical trainee)

**Excerpt 4:** “I was there [GP practice] for one day...a patient who come screaming... this patient was in labour and she [the GP] have no experience in doing labour at all... then I came to the room...the GP stepped down and I led the team that I’m doing the examination and assessment and then get each one of them a job... So it doesn’t mean that the most senior who can do it. I was not senior, I was trainee....And they agreed, and accepted it...they stepped back and then they let me just give clear instruction...they doesn’t know what to do...because I was just finished my gynae training” (Female, higher-stage GP trainee)

**Excerpt 5:** “... although everyone was kind of looking at me...I noticed that one of the nurses was managing to get through to the patient and kind of getting him to listen ...and I thought, I think ‘this is when I should be quiet and let this nurse deal with it’ and I just did what the nurse said...” (Female, foundation trainee)

**Excerpt 6:** “...we [junior trainees] were kind of saying, ‘well I don’t think this person needs resuscitating because they got quite unwell’ and he [consultant] just didn’t have a clue what to do. He [consultant] said, ‘well that’s not really my, my area’ and kind of then deposited it back to us and said ‘well if you think they’re not for resuscitation, then you take the decision’ ...but then he was kind of not really living up to what we’d hoped...” (Female, early-stage GP trainee)

**Table 3: Excerpts illustrating process-orientated themes****Pronoun use:**

**Excerpt 1:** “...*they* [the ward nurses] were really dismissive of all the doctors and *they* really didn't want *us* to be there and *they* all knew each other very well...even though *we* were technically more senior, *they* were more experienced [with resuscitation] and it was a really difficult power struggle” (Female, early-stage GP trainee)

**Excerpt 2:** “...discussion about a decision that had been made...It was like, ‘well *we* should really...this and that and the other’, and he said... ‘fair enough’...” (Male, early-stage surgical trainee)

**Excerpt 3:** “... ‘bring back information about that [a patient decision] and *I will* have a discussion and *I'll* support you on that, and if there is any change, if there is anything better we can do, then *I can give my views* on it..’” (Male, higher-stage medical trainee)

**Emotional talk:**

**Excerpt 4:** “it was probably the *happiest* professionally *happiest* time” (Male, early-stage medical trainee)

**Excerpt 5:** “it was *difficult*... it was *very awkward* yes” (Female, higher-stage service trainee)

Table 4: Metaphoric talk excerpts

Conceptual metaphors and examples	Identity construction
<p><b>LEADER-FOLLOWER RELATIONSHIP AS WAR:</b>  <i>"...first thing he [clinician-manger] started to do is just to...<b>attack</b>, <b>attack</b> other consultants...and started to just to <b>stab</b>...even in the same team you're supposed to share the same targets and because if the <b>ship sinks</b>, everybody will sink"</i>(Male, early-stage GP trainee)</p>	<p>Leader as aggressor; followers as victims; department as 'ship'</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS HIERACHY:</b>  <i>"I mean there's one person...if it was <b>monkeys in the zoo</b>, there's one person who's very much the <b>dominant personality, and the alpha male</b>...he's very clear at any kind of whole unit meeting that, you know, this is his view, and he'll <b>shout it from the rooftop</b>"</i> (Male, early-stage medical trainee)</p>	<p>Leader as alpha monkey; followers as subordinate lower-ranking monkeys; Leader is also 'higher up' (as in, on the rooftop)</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS PARENTALISM:</b>  <i>"There's no doubt about it, she gave 110 per cent to her patients. And we used to talk about ourselves as students, and <b>we wanted to be like her when we grew up</b>"</i> (Female, early-stage GP trainee)</p>	<p>Leader as adult; followers as children; leader is also role model</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS SPORT:</b>  <i>"And the number of times you felt like a <b>piggy in the middle</b>. You were being <b>batted backwards and forwards</b>. At the end of the day you're just trying to do the best for the patient who is outside your expertise"</i> (Female, early-stage GP trainee)</p>	<p>Leaders as game-players; followers as objects to be played with (i.e. ball)</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS CONSTRUCTION:</b>  <i>"Other ways of optimising influence of people around you, you just kind of like learn gradually through working, through <b>building working relationships</b>..."</i> (Male, higher-stage surgical trainee)</p>	<p>Leader as builder; leader-follower relationship as the object to be built</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS MACHINE:</b>  <i>"...it works really well and <b>very efficiently</b> and suddenly everyone kind of <b>clicks into gear</b>...the senior registrar will be <b>running it</b>..."</i> (Male early-stage GP trainee)</p>	<p>Leader as machine operator; followers as parts of the machine</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS JOURNEY:</b>  <i>"He's been a good enough leader that day, we'll do it, we'll go that <b>extra mile</b> for him."</i> (Male, higher-stage surgical trainee)</p>	<p>Leader as destination; followers as travellers</p>
<p><b>LEADER-FOLLOWER RELATIONSHIP AS TRANSACTION:</b>  <i>"...good managers are probably <b>effectively good sales people</b> so you have to treat each person individually..."</i> (Male, early-stage surgical trainee)</p>	<p>Leader as seller; followers as consumers</p>

Table 5: “Where’s your daddy?”

Lines	Narrative*
	<u>Evaluation #1</u>
1	Carol: I had an <i>interesting</i> thing
	<u>Orientation #1</u>
2	when I was doing psychiatry and we had a patient who, <b>they</b> phoned me on a Saturday at lunch time
	<u>Complicating Action #1</u>
3	to say that she’d tested positive for meningococcus and it was, eh was in air, in a sputum sample, so it
4	would have aero-cised
	<u>Most Reportable Event</u>
5	So <b>they</b> said everybody who’d been [on] the ward for the last two weeks plus relatives plus staff all
6	had to get, erm, prophylactic treatment for meningococcus
	<u>Resolution #1</u>
7	And <b>I</b> mean <b>I</b> was phoning sort of infectious disease and occupational health and public health and
8	everybody
	<u>Complicating Action #2</u>
9	And a lot of <b>them</b> were saying, well look <b>we</b> want to, <b>we</b> want to speak to <b>your</b> consultant
	<u>Evaluation #1</u>
10	But the consultant hadn’t done anything that wasn’t psychiatry for 40 years and he had no idea what to
11	do
	<u>Complicating Action #3</u>
12	So literally the consultant was sitting in the corner of the office signing prescriptions for <b>me</b> , while <b>I</b>
13	organised everything
	<u>Evaluation #2</u>
14	because he was, he was <i>largely useless</i>
	<u>Complicating Action #4</u>
15	Erm, but <b>they</b> kept sort of saying, ‘well does <b>your</b> consultant know what <b>you’re</b> doing? Can I speak
16	to someone more senior?’
17	Interviewer: And how did you find that then? How did you find that situation?
	<u>Evaluation #3</u>
18	It was <i>difficult</i> because
	<u>Orientation #2</u>
19	I, <b>I mean I’d</b> , <b>I’d</b> phoned the consultant first just to let him know, and he just said, ‘well look I have
20	no idea what to do, can you manage this?’
	<u>Evaluation #5</u>
21	And <b>I</b> was <i>really confident</i> that <b>I</b> could manage it <b>myself</b> , and <b>I did</b> . But it was just sort of, the people
22	looking over your shoulder going, sort of ‘ <u>Where’s your daddy</u> ’ kind of thing. It was just, it’s a bit
23	<i>frustrating</i> . And it sort of <u>undermines</u> <i>how you feel</i> as a leader a wee bit
	* <b>Editing notes:</b> ...=speech edited out for brevity; Metaphors <u>underlined</u> ; Interesting pronoun use in <b>bold</b> ; Emotional talk in <i>italics</i>



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