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Thesis title

Exploring collaboration and leadership in postgraduate medical education (PME) in a London teaching hospital: A Self-Study approach.

Thesis submitted by Aine Burns for the award of Education Doctorate at the Institute of Education, University College London, UK.

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I, Aine Burns, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Abstract

There is a dearth of research on leadership experiences in postgraduate medical education (PME).

This work examined the lived experience and performance of a leader (director) in PME in a large London teaching hospital. The objective was to improve training and gain generalizable insights to assist others in PME leadership roles.

Uniquely, the study followed a self-study (SS) paradigm, not used previously in healthcare education. There were three distinct research components. The first a continuous autoethnographic appraisal of the researcher's leadership performance in PME. The second a collaborative action research (CAR) project with two Trust education leads (TELs) and the third a further CAR project that emerged during the first COVID-19 pandemic surge in 2020 and involved a sizeable and diverse group of hospital colleagues and trainees.

In line with SS and CAR methodology, a variety of mainly qualitative tools were employed to generate data for iterative analysis and cyclical action. These included diaries, recorded and transcribed research meetings, action logs, recalled meetings and encounters, e-mails, some artefacts and frequent timed stream of consciousness writings (termed 'free writing' FW) that served to tap into subconscious thoughts related to the DME role.

The findings revealed previously hidden gaps between the author's aspirations and practice and evidenced the effect of changes enacted. Considerable tensions around operational pragmatism, control, relationships, acting as the conduit between education policy makers and those at the coalface, were evidenced and considered. Further, the emotional capital of PME leadership was exposed and critiqued.

When faced with the COVID-19 crisis, lessons from the first CAR study enabled the enactment of a flat, collaborative, compassionate and effective leadership style purposefully harnessing trainee intellectual potential and 'local' knowledge to solve new and complex problems. This leadership strategy proved successful and impacted positively on many areas of hospital function during the crisis. Crucially, placing trust

in younger colleagues was highly effective and valued by the trainees. The model has potential to transfer to other circumstances.

The study identified four key interconnected themes: context, tensions and emotions, complex relationships, and self-actualization as a leader, as important in the evolution of the authors DME journey from dissatisfied struggling leader through to mobilizing collaborative actions to enacting a new leadership style during the COVID pandemic. After-action reflections make the case for reimagining the DME role and how the key themes could be used as a starting framework.

The unique contribution of this study is the use and value of SS in medical education, the novel exploration of the lived experience of a DME and the demonstration that 'collaborative' leadership in PME was effective during crisis and non-crisis times. It exposes the invidious position DMEs, and trainees are placed in and concludes that increased trust and autonomy with decreased bureaucracy will enable better trainee experience and so could impact on retention.

Impact statement
The research has had an impact on several levels.

On a personal level I have deepened my thinking, understanding and knowledge, of leadership and relationships in postgraduate medical education and purposefully changed my style. I have evidenced how I evolved, through this work, into a more collaborative and distributive leader who will continue to engage more actively and more compassionately with trainees and colleagues. I have come to understand that this approach is more effective and satisfying, with a better chance of achieving enhanced trainee experience.

Having experienced the highs and lows of Self-Study (SS) in my situated setting, this EdD has deepened my understanding. In May 2021 I presented SS as a potential toolkit in education research, to a group of young doctors undertaking a 'springboard to leadership' programme at the Royal College of Physicians. Gratifyingly, the talk provoked considerable discussion and interest amongst the attendees. I believe, my study confirms that there is great potential for SS research in this landscape and will continue to promote its benefits as a tool to enhance individual or group practice in healthcare education.

I embarked on this latest thesis work partly to unearth new knowledge regarding leadership in PME. While it could be argued that the key insights, described are not unexpected I wish I was more keenly aware of them when I began my education leadership career. Thus, I am certain that new and veteran DMEs as well as others in leadership positions will benefit from reflecting on the four key themes in small group discussions or workshops, considering whether they are relevant to them and what steps they can take towards "self-actualization" of their own leadership. I anticipate future opportunities to participate in the development of leaders in education and I will share my insights amongst peers when I can and publish them.

While some value to trainee experience in my Trust was evidenced during this work, the complexity of healthcare education conducted in a relentlessly busy and cash strapped service setting meant that it was difficult to define specific benefit. However, the study illustrated how service often trumped training and how this added considerable burden to members of PME faculty. The study also shone a light on the emotional capital I expended on PME issues. Further, the deep concern and

responsibility PMEs faculty feels for trainees was evidenced and needs to be acknowledged so that faculty are prepared for its impact. This emotional expenditure is a previously unstudied area that is deserving of further research to ascertain whether my lived experiences are generalizable and to determine how it could be best used. In recent months I have had discussions with leadership and wellbeing groups both at Royal College of Physicians (RCP) and Health Education England (HEE) to consider how to take this forward.

The IFS portion of this EdD likely impacted on the sustained improvement in the training environment in an adjacent hospital's emergency department.

While the arrival of the COVID-19 pandemic truncated the original plan to conduct and evaluate collaborative action research (CAR) with a group of TELs and while only two had been recruited when the pandemic struck, both TELs certainly enjoyed the experience and have demonstrated renewed energy and commitment to improving their training environment. This work forced me to acknowledge how little support was available to new TELs in my organization. As a result, I have changed how new TELs are induced and supported. I now use CAR whenever possible to help create strong early relationships with the TELs. By role modelling this approach I hope that they too can encourage and disseminate this practice.

The most memorable impact of this work, for me, however, resulted from COVID-19 adversity. The emergent "PME COVID-19 taskforce" proved to be highly influential in delivering the urgent changes needed to cope with the crisis in our hospital. This CAR taskforce was informed by the earlier 'pilot' work and leadership literature. Several manuscripts have already been published from this group (Appendix IX). They describe: the COVID-19 PME taskforce leadership template (BMJ leader http://dx.doi.org/10.1136/leader-2021-000487). The article acknowledges that the blueprint has the potential to be adapted for other crises and in other circumstances. The importance of maintaining formal education events through a crisis (Future healthcare journal 7(3), e67,2020) was the first paper to be accepted. Describing how attention to wellbeing was privileged and its impact was a joint effort with a Welsh hospital (Future healthcare journal 7(3), e71,2020). Two medical students described their ITU volunteering experience (Medical education online 25(1),1784373 2020). The COVID-19 taskforce IT group described the rapid wholesale move to 'Microsoft

Teams’ on-line communication (BMJ health & care informatics 27(3), 2020). Further, the COVID-19 taskforce experience was presented at the National Association of Clinical Tutors meeting in early 2021 and to the RCP “emerging women’s leaders” programme in April 2021.The work of the group was celebrated at a trust board meeting and in the local newspaper (Appendix XI).

The trainees involved in the taskforce reported positive personal experiences of leadership that were both enjoyable and formative. Friendships were forged that I hope will last. Many expressed a desire to continue involvement in healthcare leadership. The future impact of these ambitions is clearly impossible to guess but is likely to be positive.

Finally, the work highlights the huge benefit of trusting trainees in ‘real world’ leadership roles. Further it calls for a reimagining of the DME role to incorporate more trust and autonomy and less bureaucracy. Through my current professional role as elected Vice President for Education and Training at the RCP (London) I will champion a deepening/restoration of trust within the profession. I will also use my position to call for regulatory bodies to encourage similar trusting relationships to extend to all doctors and trainers who, my work suggests, are currently being constrained by excessive scrutiny and tick box assessments of dubious value.

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Dedication and Acknowledgements

This thesis would not have been possible without the forbearance and help of many individuals too numerous to mention here and I thank them.

Chief amongst those whom I must praise is my primary supervisor Dr d'Reen Struthers who has been a critical friend in the true sense and now understands more about my director of postgraduate medical education (DME) role than almost anyone else! She immersed her thinking in my world, challenging me repeatedly to see differently and hence adopt new positionings. I can only hope to emulate her supervisory skills and commitment. My second supervisor Professor Jeff Bezemer, too, has provided much thoughtful comment for which I am most grateful.

My other critical friends and colleagues, Zarina Khan, in particular, has worked alongside me in this journey and been a total star. Professor Faye Gishen has been a cherished 'study buddy' always several steps ahead in our shared EdD goal! I would also like to thank my Royal Free NHS trust education, renal and administrative colleagues. Special thanks go to the 2 TELS who co-investigated some of my research dilemmas and the numerous fantastic trainees whose brilliance and energy never ceases to awe and inspire me and were central to my motivations. The future of our profession is in good hands.

Particular thanks need to go to my grown-up children (Eoin, Brid, Deirdre, John, and Ciara) who have, as always, been my strength and inspiration. They have had to put up with my absence and my occupying the kitchen table through countless evenings and weekends. They have helpfully debated with and challenged me as needed. Finally, I remember my mother Mary and my father Paddy whose quiet supportive ways I look back on with great fondness.

Mike my husband of 38 years has travelled this and many other journeys with me through all their bumps and twists. Lately his Italian is greatly improved! Gratze mile Mike and I dedicate this thesis to you.

Mile buiochas gach dhuine (a million thank yous to each one of you)!

Reflective Statement

I started thinking about embarking on a doctoral journey in education almost 10 year ago in 2012. Having completed an MSc in medical education I felt I had more fuel in this tank and I was excited to see where it would lead me. I qualified as a medical doctor in 1983 having moved away from home to study at the age of 17. I became the first doctor in my family. Over the past almost four decades I have continued to practice medicine and have enjoyed a very rewarding and successful career. As I approach the final stages, this EdD has given me an opportunity to look back on my contributions to medical and healthcare education.

I have been fortunate that my post evolved organically into what is now coveted as a ‘portfolio career’ though the term was not invented then. Accordingly, I spend 50% of my working time practicing medicine and 50% in medical education. That I gravitated to education is not surprising as teaching is very much part of my family history. Looking back, I realize that very early in my medical career I began seeking out teaching opportunities. With seniority, I became more involved and interested in developing qualified doctors as they journeyed towards their specialty practices. I also acquired increasing responsibility and ultimately became the director of PME in my Trust.

Many years ago, when I was appointed as the renal unit training lead, I embarked on a Certificate of Medical Education because I felt I had few convincing credentials to carry out this role. I found the academic aspects of this course and the emphasis on professionalism invigorating. I recognized that my performance as an educator improved and I relished the many mini projects that were part of the programme. Having finished, I was keen to continue in this vein and enrolled for a MSc in Medical Education via distance learning. Having completed this degree in 2008 I began to think of a doctorate. Exactly why puzzles me still but my motivation was likely a combination of academic stimulation and the understanding that I performed my education role better while I was studying and researching in parallel.

In 2012, I approached UCL and filled an application form, but my husband suffered a serious illness and I needed to put my ambitions on hold. At this time, Professor Deborah Gill (currently Pro-Vice-Provost for student affairs at UCL, then head of UCL medical school) introduced me to the less conventional notion of a professional

doctorate. I was not convinced. When my life circumstances changed and, I could once again pursue this ambition I still wanted to research towards a conventional PhD. I spoke to one possible supervisor and again was advised to consider the EdD. Finally, it was agreed that I could join the 2016 EdD cohort for a month and decide, if the EdD was for me, after that experience. The first few Friday sessions were enlightening. I was introduced to a global group of peers whose specialist disciplines were varied: from sign language to autism to religious studies. I was particularly in awe of the NGOs and knew that, individually and collectively, these very impressive people could inspire and teach me. I was hooked.

The first year 'Foundations of Professionalism' (FOP) assignment proved to be a joy. We were tasked with writing a 5,000-word essay on professionalism. I found myself inspecting my soul in search of answers to fundamental questions about my motivation both to practice medicine and nephrology (my specialty) as well as the attraction to teach and lead in PME. I particularly benefited from the days we spent getting to know the EdD group and faculty. I immersed myself in Brian Cunningham's book Exploring Professionalism that exposed me to previously unconsidered ideas that were very relevant to my professional world. I began to consider the importance of relationships in education and how learners are inspired and supported.

My thinking returned repeatedly to how I could improve the training of postgraduate doctors for whom I was responsible. My MOE 1 and 2 projects, modules in year 1, helped convince me that surveys and conventional inquiry would not yield the outcomes I was looking-for. The MOE2 project did, however, identify some unmet needs among senior educators who are called Trust Education Leads (TELs) in my Trust.

In 2018, I was surprised to be seconded to an adjacent hospital with the express task of improving education and training in their emergency department. The department was judged by the general medical council (GMC) to be a very poor training environment and was warned that if rapid improvements were not made their trainees would be removed with significant effects on the local community and hospital viability.

By then, I had encountered self-study (SS) and wondered if an auto-ethnographic study of my role in conducting this task could help me discover the underlying issues and effect positive change. I had read much about the theoretical basis and practice of SS from LaBoskey, Whitehead, Russell, Ritter, Pinnegar and Vanassche and was enthusiastic to give SS a try. I spent one day each week for the following 12 months as an outsider studying this department from the inside where I acted as a training clinician on the 'shop floor'. I set out to use a SS approach in the EdD institutionally focussed study (IFS). I kept field notes and diaries that charted my observations and reflections as well as how the recorded events made me feel. I concluded that although there were many great people working in the department, it was excessively busy, and staff were not treated with compassion. I diarized (witnessed or reported) events that shocked me. It was clear that the emotional impact of caring was not addressed amongst staff. On one occasion some trainees were forced to retreat to the public café because they had no private place to go, to grieve the death of a child who the department could not save. Further, the trainees were left feeling anxious as there was a paucity of instructional support. One senior member of staff frequently left trainees in tears. As an outsider on the inside, aspiring to be "a kindly Trojan horse taking notes" an analogy used in Ybema's book on organizational ethnography, I could see and reflect on what others had either not seen or not acknowledged.

Each day, I wrote up my field notes and diary entries. Reading these back and analysing the themes shocked me to my core. I revisited many of my own training memories to help me understand what it must feel like for these trainees and used every opportunity to engage face to face in training discussions and events with them. I worked real time with the chief executive and the lead for education in the department, trial, and error fashion, to find ways to improve the situation. We reinstated time for teaching, on the floor support for trainees, regular simulated training, drills, and skills sessions and importantly we began to listen to weekly trainee feedback "you said we did". A space in the public café was designated for staff only. The undermining individual was 'performance managed' by the CEO and no longer works in the organization. As the year went on the trainees began to feel cared for and valued. Repeat inspections were more positive and the restrictions were removed.

Thus, the IFS project taught me how powerful autoethnographic research could be in changing and improving practice relatively quickly. The immediacy of effect certainly appealed to my nature. I consulted Ybema's book again and was alerted to the many pitfalls the insider who researches their own workplace, ethnographically, faces. Yet, I was also aware that with regular health education England (HEE) inspections I frequently needed to demonstrate rapid improvement in areas apparently deficient in training. Further, many previous improvement attempts to improve trainee experience in my own hospital had failed. Basking in what appeared to be IFS 'success' the seeds of the final EdD thesis project germinated.

Throughout my IFS, I had continued to worry that my own trainees had variable experiences in our Trust. I questioned my leadership ability and knew it could be improved. I posited that my troubling would again benefit from a SS approach. I was aware of how popular SS had become in teacher education. Ritter's book "Teaching, Learning and Enacting of Self-Study Methodology" evidenced how varied and instructive SS projects were.

Thus, my IFS project signposted me to SS techniques for the thesis research. On this occasion, the project was to be situated in my own hospital Trust. The aim was to identify how I could improve my role as DME and the relationships I had with my TELs to enhance trainee experience. I became intrigued by the variety of methods that could be applied to address the problem. Most did not sit tidily with convention. This was alien research to some extent as my primary degree and medical doctorate were very much grounded in positivist approaches.

My neat plan to conduct an autoethnographic study of a collaborative action research (CAR) project conducted with volunteer TELs was underway, as was my autoethnographic documentation when COVID-19 struck. In keeping with the emergent philosophy of SS, I determined to continue and, further, to apply the lessons I was beginning to draw from the CAR to the COVID-19 pandemic dilemma. Thus, a COVID-19 PME taskforce CAR project was born. This approach was highly successful in reconfiguring many of the hospital activities, to cope with the unprecedented number of patients. Many other unpredictable problems were identified and solved by the group of mainly trainees many of whom could not be

patient facing. The taskforce's success was heralded both within the hospital and without.

Adopting a trusting and adaptive leadership style and deliberately flattening power hierarchies was transformational. I faced many uncomfortable facts about my leadership style and how I was to some extent unable or reluctant to let go. I examined my relationships with my TELs and senior colleagues and found out truths about myself and my motivations, jealousies, preconceptions, likes and dislikes. I uncovered 'guilty secrets' about the prevalence of hierarchical fear and undermining behaviours in our Trust. Using active reflection and reflexion as well as literature and critical friends I was able to begin to understand and change my approach all the while examining the effects. There was some evidence that the first TEL CAR project, too, led to improvements in the volunteers' areas and engendered a new enthusiasm amongst the two TELs. I began to embed my new leadership style in my everyday practice.

The COVID-19 crisis proved to be the best of times and the worst of times. Throughout, I experienced great highs, but these were equally balanced by frustrations and tired, low ebbs. These oscillations were lived in my personal space but also in my professional and organisational worlds. At times, I did not know which space I occupied: whether I was poacher or gamekeeper, friend, advocate, leader or follower, bully or bullied. The emotional capital I expended was caught up in ever changing yet intersecting circles whose boundaries blurred and misted. Now I see that, as professionals in medical education, we attempt to compartmentalise roles and responsibilities, perhaps, to protect ourselves. This research forced me to recognize how futile this strategy is and to accept boundary crossings and insecurity as normal and necessary. Acknowledging uncertainty, vulnerability, tensions, and emotional outlay should, I hope, help others and me in future complex endeavours. I learnt that compassionate leadership begins with acceptance and compassion for self.

I worry that my private journey exposed by these EdD narratives might seem unimportant or of insufficient scholarly merit. Yet, I contend that it provides a unique new contribution to the PME literature and could advance a wider understanding of PME leadership roles. The four key interlinked themes of context, tensions and emotions, complex relationships and self-actualization as a leader have

generalizability to the PME community and have potential to be used to prepare DMEs and others in PME for their roles. I also concluded that DMEs are placed in invidious positions of liminality and that it is time the role was reimagined and changed substantially. I propose that the four key themes are used as a starting point for this transformation.

The use of SS in healthcare education is novel and I have shown holds great potential for others wishing to better an area of their practice. Furthermore, analysis of my 'lived' experiences, I conclude, demonstrates the importance of DMEs being made aware of, and prepared for, the emotional toll inevitably exacted in PME leadership.

My most important insight, gained largely through analysing the underpinnings of the frustration I documented, is that a restoration/endorsement of trust and autonomy in doctors and their educators is urgently needed to reduce the emotional capital trainees, DMEs and other PME supervisors expend, allow them to flurish and retain them in the profession.

Other lessons I have learned concern the limits of my personal physical and emotional endurance that I argue were reached during the pandemic. The writing up challenge has also been tough for me and I have had to dig deep. This knowledge will allow me to prepare and pace myself better during future crises and to council others considering similar journeys.

Abbreviations

AeI: Aesthetic Inquiry

AEI: Ability Emotional Intelligence

ACP: Advanced care practitioner

AERA: American Education Research Association

AHP: Allied healthcare professional

AI: Appreciative Inquiry

AR: Action research

ARCP: Annual record of clinical practice

CAR: Collaborative action research

CCT: Certificate of completion of training (issued by GMC)

CF: Critical Friend

CKD: Chronic kidney disease

COVID-19: Corona virus identified in 2019

CS: Clinical Supervisor

CT: Clinical Tutor

CoPMeD: Conference of Postgraduate Medical Deans

DGH: District general hospital

DME: Director of Medical Education

DPME: Director of post-graduate medical education

EBM: Evidence based medicine

EI: Emotional intelligence

ES: Education Supervisor

EQ: Emotional quotient

EWTD: European Working Time Directive

FOP: Foundations of professionalism (year 1 module of EdD)

FW: Free Writing (timed 5 minutes)

GMC: General Medical Council

HEE: Health Education England

IFS: Institutionally focussed study (year 2 module of EdD)

IPA: interpretative phenomenological analysis

JCF: Junior Clinical Fellow

JD: Junior Doctor

LDA: Learning and Development Agreement

LEP: Local Education Provider

LFG: Local faculty group

LETB: Local education and training board

MMC: Modernizing Medical Careers

MOE: Methods of Enquiry (1 & 2 research module within the EdD programme)

NACT: National Association of Clinical Tutors

NCHD: Non-Consultant Hospital Doctor

NHS: National Health Service

PA: Physician Associate

PGME: Post Graduate Medical Education

PME: Postgraduate medical education

RCP: Royal college of physicians

RI: Reflective Inquiry

RP: Reflective Practice

SAS: Specialty doctors and Associate Specialists

SASG: Specialty doctors and Associate Specialists Grade

SCF: Senior Clinical Fellow

SHA: Specialty Health Authority (disbanded April 2013)

SIG: Special interest group

SS: Self study

S-STEP: Self-study of teacher education practice

TEL: Trust Education Lead

TEI: Tacit Emotional Intelligence

WTD: Working time directive

Key definitions

Auto ethnography is a form of qualitative research in which an author uses self-reflection and writing to explore anecdotal and personal experiences and connect this autobiographical story to wider cultural political and social meanings and understandings

Clinical Supervisor (CS) is the named clinician responsible for overseeing the clinical performance of an individual trainee within a clinical placement. They are responsible for observing practice, performing work-based assessments, and providing feedback.

Collaborative Action Research is a process in which participants systematically work to improve educational and public service. Sometimes the term Collaborative Enquiry is also used.

Compassionate leadership builds connections across boundaries in the process of delivering and improving care. These leaders nurture a culture of compassion and embody inclusion in their leadership.

Director of Postgraduate medical education (DME/DPME) is responsible and accountable for the quality of postgraduate medical training in their trust. The post is interviewed and appointed and is generally occupied by a senior medical clinician.

Educational Supervisor (ES) is the named practitioner overseeing the educational requirements, achievements, and personal & professional development of an individual trainee during that post/placement/programme (to be defined locally and usually for 1 year). They are responsible for performing all appraisals - both educational and the annual NHS appraisal. They require protected time clearly identified in their job plan, usually as SPA time – 0.25 PA per trainee.

Reflective practice is an approach in which the writer examines his/her experience in life. The writer then writes about these and how he or she has changed, developed, or grown from these experiences.

Reflexive practice is a deeper process of systematic refection that involves examining one's own thoughts and feelings and actions and the impact on both the self and others. It has been referred to as reflection in community.

Self-Study (SS) is a genre of research that has become popular in teacher education practice. Under the SS umbrella many usually qualitative methods can be used.

Trust Education Lead (TEL) is an interviewed and appointed lead for supervision and education whose role is to quality assure and enhance learning for typically 30 trainees within their specialty.

Chapter 1 Professional practice problem

This chapter sets out my professional practice problems in leadership and relationships in postgraduate and medical education (PME) in a large London teaching hospital. It describes how leadership responsibilities crept up on me almost unawares. It elucidates aspects of my EdD journey and how I came to acknowledge and accept that feelings of inadequacy and unpreparedness for my directorship role troubled me. I outline how I arrived at my research questions and rationalize the SS methodological framework used to scaffold and tackle the difficulties I faced. It concludes by detailing the aims of the study, the proposed research questions and outlines the thesis construct.

Chapter 2 Background and Context

This chapter sets the scene for the inquiry. It provides an orientation to the research field and the rationale for the study. It is framed purposefully to ensure that readers, unfamiliar with PME, understand the context of the work. It outlines some key perspectives and provides the basis for the theoretical framework as well as the further justification of the research approach and questions.

Chapter 3 Literature review

This chapter focusses on evidence that today's leaders face new and complex challenges and on how traditional leadership models have evolved. It explores what qualities appear to be needed and how to encourage and develop leaders who can rise to the task in healthcare and medical education. There is a strong focus on EI, culture and behaviours because the emotional toll and energy expended in DME leadership emerged prominently in this work. Ultimately, the emergence of collaborative and compassionate leadership practices in healthcare is explored.

Chapter 4 Methods

This chapter builds the case for using autoethnography and collaborative action research as methods within the SS paradigm in this work. It describes the study design, the research tools used and how data was generated, managed, and stored. It charts how participants were selected and recruited and how the study was extended and adapted (within the agreed study framework) as the COVID-19 crisis took hold. It describes and justifies the triple inductive, deductive, and abductive approach used to analyse and interpret the largely qualitative data.

Chapter 5 Data analysis, sense making and insights

This chapter exposes my lived experiences of leadership in PME during the study period. It uses key illustrative examples of the largely qualitative data to show how I made sense of the material in the context of the preceding literature. It shows how 4 key themes: context, emotions and tensions, complex relationships, and self-actualization as a leader, were arrived at using sequential inductive, deductive and abductive analysis. It uses examples from the data and literature to chart how my leadership journey worked its way from a traditional positivist/hierarchical triangular approach to a more collaborative/collective/compassionate/trusting one. It makes the case for and signposts how the DME role could be usefully reimagined.

Chapter 6 Returning to the research questions

This chapter returns to the research questions and explores to what extent this research answered them.

Chapter 7 Discussion, strengths and limitations, future work

This chapter considers again the purpose of the study and the research questions. It showcases the novel value of this work and how the new knowledge fits within the existing body of literature. It discusses strengths and weaknesses in the work and further research directions. The chapter ends on a hopeful note by discussing how trainees were nurtured to become powerful collaborative leaders during an unprecedented global crisis and suggests that increased trust in this group can enhance trainees' feelings of autonomy, belonging and competence and, thus, their overall experience. Finally, it calls for a reimagining of the DME role and proposes what key elements should be included in such a redesign.

Chapter 1 Foreword: Professional practice problem

Chapter Overview

This chapter sets out the professional practice problem of leadership responsibilities in PME in a London teaching hospital. It elucidates aspects of my career and EdD journey and how leadership roles crept up on me almost unawares. It records how I came to acknowledge that feeling of inadequacy and unpreparedness for my directorship role troubled me and how I wanted to better my practice. The chapter ends with the research aims and questions, as well as a methodological framework presented as a diagrammatic construct of the research design.

1.1 Professional practice problem

I was appointed Director of postgraduate medical education (DME)[1] in a large London teaching hospital in 2008 and so became responsible for overseeing the education and training of more than 500 non-consultant hospital doctors. Accordingly, for more than a decade, I have worked solidly to 'succeed' in this role. However, for several years, prompted by assorted inspections and reports, I have worried that the experiences of many of the postgraduate trainee doctors, needed improvement. Over the years, despite numerous strategies and attempts, some training areas became enriched while others, simultaneously, appeared to worsen. Overall, I was aware that the situation fluctuated precariously, and I wanted to find a more consistent way to improve.

My hospital is one of a 'group' of three. One operates as a district general hospital (DGH), one concentrates on elective surgical procedures and I work in a 500 bed, 5,000 staff specialist teaching hospital with patients referred from the sister hospitals as well as local and regional districts. Additionally, the hospital provides some selective highly specialized care[2] for patients who travel from all over England and occasionally other (historically linked) countries. It boasts large kidney and liver units with their allied transplant programmes. As well as my DME role, I practice as a

[1] The DME is responsible for education and training of all non-consultant hospital doctors in a healthcare organisation: see Appendix 1 for more precise roles and responsibilities.
[2] The hospital is the national center for conditions such as Fabry disease, scleroderma, pulmonary hypertension, and amyloidosis.

consultant kidney specialist. My time is divided equally between clinical and postgraduate education duties.

Trainees are placed or choose to come to our institution to gain specialist rather than DGH experiences. Over the years, inspections and surveys have evidenced areas of excellent training. Equally, many trainees have reported unsatisfactory experiences[3]. The trust aspires to be in the top 10% of hospitals for postgraduate training excellence. However, we have failed repeatedly to achieve this goal by standard measures. For example, between 2018 and 2019 the general medical council (GMC) trainee survey, that seeks to examine and rank several thousand aspects of trainee experience (from safe supervision to perceived ease of study leave release) evidenced a modest decrease in red (negative) outliers (112 to 83[4]) and a small increase in green (positive) outliers (31 to 39) with an 'overall satisfaction' rating of 78.34 (from 76.45 in 2018). In general, the results were disappointing and, further, were frustratingly inconsistent in the year-on-year comparisons.

A small amount of evidence suggests that poor GMC survey outcomes can catalyze (at least) short-term improvements (Uthayanan, 2020) or organizational changes to privilege training. Manton (2019) provides a clear summary of why he believes the GMC survey is so important. Yet, some colleagues share my frustration, (Round 2019) and question whether GMC surveys facilitate or hinder improvement goals. However, in truth, I feared that the poor outcomes reflected deficiencies in my DME abilities. There was a clear gap between the Trust's aspirations and the reality of what I was able to achieve. I realised that I approached the GMC survey 'results day' with a sense of dread. The kaleidoscope of outcomes felt like annual, public, ritual humiliation and on several occasions, I considered then dismissed the notion of resigning my DME role. I wondered what else I could/should do to improve/enhance/optimize the postgraduate medical training that doctors experienced in my trust. In the end, I determined to use this Education doctorate (EdD) to research

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[3] Each year the GMC surveys all doctors in training to monitor and report on the quality of postgraduate medical education. More than 75,000 (96%) completed the survey in 2019 https://www.gmc-uk.org>education. In addition the GMC and other designated bodies visit regularly to inspect training sites.

[4] Every component of each question, asked in the GMC survey, is ranked and benchmarked against other institutions. Top ranked components are described as green outliers bottom red (see Uthayanan et al. 2020 for a clear explanation of survey outcomes).

this situated professional practice problem for the benefit of future doctors and the patients they dedicate their lives to caring for.

This thesis followed logically on my earlier EdD assignments[5]. I first encountered self-study of teacher education practices (S-STEP abbreviated to SS for this thesis) as a research paradigm, during a 'foundations of professionalism' (FOP) workshop in year one. It felt like an 'eureka' moment. I pondered its possible value in healthcare education. I consulted the published literature concerning its provenance, history, theoretical underpinnings, and methodology (Bullough, 2001; Hamilton, 1998; Kosnik, 2009; LaBoskey, 2004a, 2004b; Loughran, 2004; Loughran, 2005; Pinnegar, 2009a, 2009b; Ritter, 2018; Russell, 2004; Samaras, 2006; Whitehead, 2009). I listened to the cautions voiced by sceptics (reviewed in Cochran, 2005; Feldman, 2003) as well as (what I interpreted as) the exhausted frustrations of a senior educator who had strived for decades to enact SS in reluctant, traditionalist environments (Russell, 2005). I was minded how far from conventional medical research the SS paradigm, with its interpretivist leanings, strayed. I skirmished briefly with SS in MOE2 keeping a regular timed 'free writing' (FW) narrative[6] and conducting an inductive thematic analysis using the text as research material. However, for submission, I discarded this work in favour of a 'safer' survey project to identify Trust Education Lead (TEL) support needs and the best ways to deliver them.

Later, the institutionally focussed study (IFS) moved away from my positivist beginnings and wholly embraced SS with, its largely qualitative methods and, the intention of improving education and training in a 'failing' NHS emergency department, to which I was seconded for one day per week, throughout 2018. I became the 'researcher and the researched' (Cochran, 2005) purposefully examining my own practice as I tried to uncover and explore ways to enhance the training environment and by implication improve patient safety. I utilized a wide range of

[5] The first years of the EdD comprised 3 modules entitled Foundations of professionalism (FOP), methods of enquiry (MOE) 1 and MOE 2. The MOE modules involved, first designing then conducting a small research project to be written up in 5000-word assignments. The second year of the EdD was spent on a year long institutionally focused research study (IFS) that was required to be submitted as a 20,000-word document. A 45,000-word thesis conducted usually over 3 years completes the requirement.
[6] I use the term 'free writing' (FW) to describe the narratives I created by deliberately recording my stream of consciousness in relation to my postgraduate medical education work. See methods for a fuller description.

approaches in this work including auto-ethnography (immersing myself within the troubled department), diary keeping, recalled interviews, found poetry, written reflections, and inductive thematic analyses. I also built on the 5-minute timed FW method I had invented and discarded in MOE2. I titled this work "My story: A coalition of saints and sinners! An auto-ethnographic study of one medical educator's attempts to improve training and supervision in a London University Hospital's emergency department using a self-study paradigm" (Burns, 2019).

Paying homage to social constructivist ideals, this research was born out of strife (social and political) and nourished by careful attention to SS ideals and methods (Cole, 2005; LaBoskey, 2004b). My IFS (Burns 2019) research took me on a journey that proved both effective and rewarding. I learnt that as a medical educator (very like teacher educators (Beijaard, 2004; Rodgers, 2008) my accrued, professional knowledge and past experiences were intimately woven into my contemporary persona and self-identity. I found that I could not "bracket out" (Pringle, 2011)[7] my bias and beliefs but that this proved to be a useful stance. Recognizing the key role of past experiences in my every thought and action and in creating my unique identity was eye opening. This understanding paved the way for me to initiate and enact constructive changes both in the emergency department and in the way I operated professionally. Since then, I have strived to use these insights at local, regional, and national[8] level. I became more caring recognizing and mitigating the risk to self and trainees of moral injury. I began to delegate and hold individuals accountable and importantly I recognized the power of an ethnographic approach to identify and weed out destructive influences.

Far from a narcissistic jaunt and in keeping with LaBoskey's 'commandments' (referenced in Loughran, 2005, p. 7) my IFS SS was highly discursive and interactive,

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[7] Pringle (2011) professes that in an interpretivist framework bracketing can be conceptualised as raising awareness and making explicit our pre-understandings, values, beliefs, rather than getting rid of them, which would be impossible anyway.

[8] As an elected member of the Royal College of Physicians London council and serving on the education and training board, I contribute to college policy, documents, and debates www.rcplondon.ac.uk. In July 2020, I was elected as RCP London senior censor and vice president for education and training (VPET).

channelling the 'voices' of an array of protagonists in the fraught environment I was researching (Guilfoyle, 2002; Loughran, 2004, pp. 247-271).

Armed with the IFS experience and an appreciation of SS's growth and application in teacher education, I proposed that SS research had substantial potential in medical education. Excited by this notion, I flirted with the idea of introducing SS to the senior education faculty in my own hospital. After some deliberation, I realized that I was not, yet sufficiently experienced in SS to do this. I realized that my EdD thesis research could give me an opportunity to address my 'at home' professional practice problem and determine how I could, perhaps, later, select and sow seeds of SS amongst my peers.

I was also minded how Maxwell (2012, pp. 32-38) and Samaras (2006, p. 84) exhort qualitative researchers to choose topics they are passionate about and to reflect carefully and honestly on their personal practical and scholarly goals before embarking on a new project. In this thesis, I have made very strong claim to both my excitement about SS as a methodological paradigm and my passion for post-graduate medical education. My scholarly goal in submitting this work, as part of an EdD award is clear and, pragmatically, I reckoned that this project could be conducted alongside and as part of my DME work.

Finally, I rejected formal leadership courses as I was impatient to change and better my practice. I understood that studying leadership theory and likely examples from business and industry would not help me in my quest to improve trainee experience within what I viewed as an acceptable timeframe.

Having chosen to follow a SS research paradigm, I reasoned that two frequently used SS methodologies: autoethnography and collaborative action research (CAR) would be particularly useful (explained in Chapter 4).

1.2 Research questions and thesis construct

In this next section, I outline my research questions and present a diagrammatic representation of the study construct to orient the reader.

Posing any research questions, at the outset of SS research, does not fit comfortably with its professed exploratory values. However, given time constraints and the likely breath of this work, I argued that it was necessary to narrow the focus using research

questions, but that I would actively seek emergent questions as the research progressed.

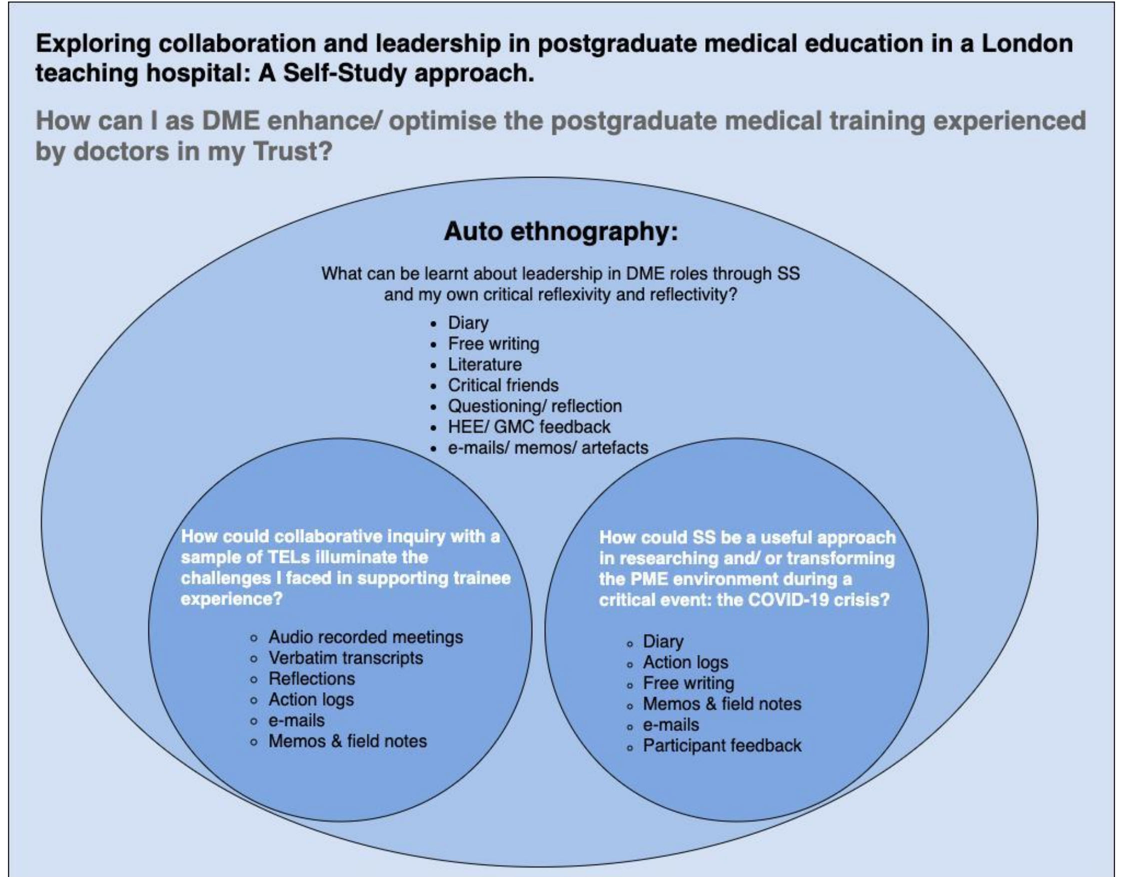
I settled on the first questions before the research began. The COVID pandemic prompted the first of two 'emergent' questions (listed in italics below). The second of these arose later as I analysed data and began to recognise the importance of emotional capital and how I had as a result changed my leadership style from hierarchical to favour a more compassionate and collaborative approach. Addressing this last question arguable exposes, the unique value and legacy of this work for PME.

- How can I as DME enhance/optimise the postgraduate medical training experienced by doctors in my Trust?
- What can be learnt about leadership in DME roles through SS and my own critical reflexivity and reflectivity?[9]
- How could collaborative inquiry with a sample of TEL[10]s illuminate the challenges I faced in supporting trainee experience?
- *How could SS be a useful approach in researching and/or transforming the PME environment during a critical event: the COVID-19 crisis?*
- *How does an understanding of compassionate leadership shape/change the DME role?*

Figure 1 provides an overview of the study construct and outlines which methodology addressed each research question and how data was collected.

[9] There is an important distinction in the terms reflexivity and reflectivity. In this thesis, I use the term critical reflexivity to be a vital precondition for critical reflection.

[10] Trust Education Leads, (appointed to oversee the quality of training in their specialty area).



How does an understanding of compassionate leadership shape/change the DME role?

Figure 1.1. Overview of thesis construct: Key questions and methods employed to address each one.

Thus far, I have outlined the professional practice problem, my research questions and how they arose and were addressed. In the next section I take a step back so that the reader can understand the context of postgraduate medical education in the UK.

Chapter 2 Background and Context

This chapter is framed purposefully to ensure that readers, unfamiliar with PME, understand the context of the work.

2.1 Rationale and motivation for the study

As a senior hospital consultant physician and DME in a London university teaching hospital contributing to the ideal of a well-trained and motivated medical workforce is central to my purpose.

In the UK, an aging multi-morbid population, public expectation, diagnostic and treatment complexity as well as austere National Health Service (NHS) funding and working time directives, are challenging healthcare education, and consequently, delivery of care (Kilty, 2017; Swanwick, 2013; Grant, 2007; Patel, 2016). Compared to previous generations, current post-graduate training doctors[11] experience much fewer apprenticeship-type relationships with their seniors and more arms' length, arguably impersonal, instruction to the detriment, many believe, of medical training.

These latter factors may have contributed to a growing and vexed manpower crisis in UK healthcare (Abbasi, 2019; Iliffe, 2019; Slop, 2018) and underlines the importance of this work. Further, there is evidence of increasing dissatisfaction with medical professional careers, early burnout and worrying numbers leaving the profession (Iacobucci, 2014; Lemaire, 2017; Rimmer, 2018b; Smith, 2018).

2.2 Postgraduate medical education in the UK

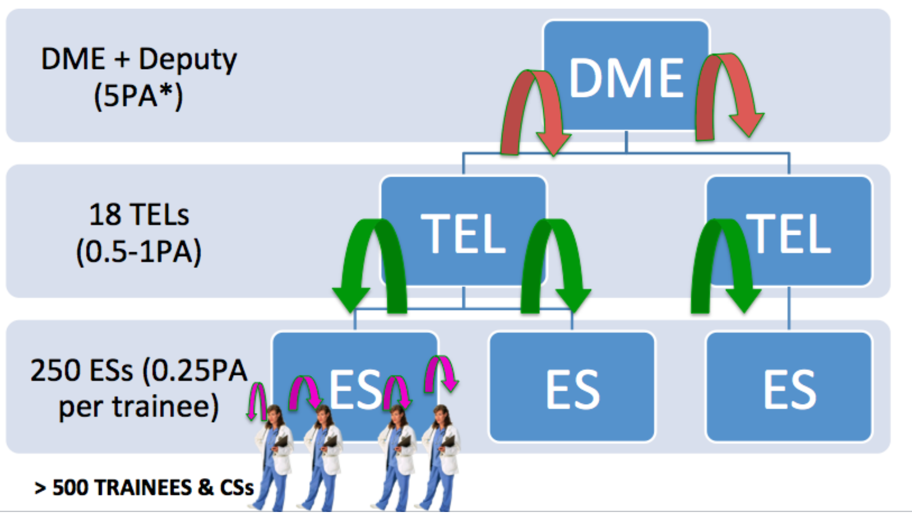
For word count reasons and to assist those unfamiliar with PME in the UK I have placed this section in Appendix 1.

2.3 Local training pathways and governance

By accepting the DME role in 2008, I became responsible for assuring PME and training in my organization. To accomplish this, I designed and implemented a governance hierarchy (Figure 2.2) whereby initially 18 and subsequently 22 consultant doctors were either interviewed or appointed to remunerated roles (1PA =

[11] Often referred to as junior doctors. However, I have reservations about this term as I find it softly demeaning and so generally refer to all non-consultant hospital doctors as trainees in this thesis.

4 hours per week in job plans) as Trust Education Leads (TELs). Some were already established in very similar but non-remunerated college (clinical/ college tutor) roles (responsible primarily to their individual colleges but also to me as DME). Hereafter, I have used the term TEL to designate both. I was full of the zeal and envisioned success if I applied myself sufficiently well to the task. With no formal leadership training and little experience, my governance hierarchy mirrored what I have experienced before and the grander structure I was a part of.



* PA = programmed activity in job planning = 4hours per week, ES = education supervisor, CS = Clinical supervisor

Figure 2.2 Postgraduate medical education (PME) governance structure I established on my appointment as DME.

Each TEL has the task of overseeing education and training for, typically 30, trainees in their specialty area. Every trainee is also supported by a designated, trained education supervisor[12] (ES) who they meet (as a minimum) every other month. A variety of clinical supervisors (CS) oversee their day-to-day patient facing activity and should 'feed up' information about a trainee's performance to the ES. A deputy and a small administrative team support the DME role. Together the DME, deputies, TELs and senior administrators (N=2) make up the senior PME faculty. In summary, this faculty is responsible and accountable for formal, participatory, and psychological professional development and performance of the trainee doctors.

[12] The PME department has more than 250 registered ESs.

My governance hierarchy reflected a pyramid of power and authority that I later came to realise neither suited my style nor delivered the results I aspired to. I have depicted this as a triangle in Figure 2.3 and will return to this concept later.

Figure 2.3. Diagrammatic representation of my early leadership style.

Gill, (2013) (in her EdD thesis) cites Eraut's empirical work with beginning professionals and makes a convincing argument that the success of a workplace learner depends both on available opportunities and the quality of relationships in the workplace (p. 27). Therefore, it follows that our PME faculty mission should be to privilege learning opportunities and relationships that engender medical professionalism and optimise patient care. It seemed reasonable that the TELs, particularly, should be able to assist in ensuring positive learning cultures (opportunity and relationships) and be at the forefront of any improvement endeavours. Yet, in truth, I was at a loss to know how best to maximize their involvement and to motivate and energize them in this task.

The TELs are a diverse and interesting group. Some are passionate about education while others appear to have taken on the role reluctantly out of departmental necessity or political expediency. Most had been interviewed (by me and a senior administrator) and appointed formally to this clearly specified role[13]. As mentioned previously, a small number were already established in a very similar but non-remunerated clinical/ college tutor role: responsible primarily to their individual Royal Colleges but also operationally to me as DME.

Full TEL roles are assigned 4 hours per week (1 programmed activity or PA) in job plans conducted flexibly alongside other, usually direct patientcare, activities. Occasional TELs 'job-share' with colleagues and then generally divide the role pragmatically, each taking responsibility for a group of trainees identified mostly by seniority[14].

[13] Job description available on request

[14] Job sharing TELs might divide responsibility one taking 'ownership' of the more junior and the other the more senior trainees.

2.4 Evidence of lack of engagement

Throughout my tenure as DME, I have felt uneasy about this governance structure and have harboured concerns that TEL and indeed ES skills, energy and expertise were not used optimally. I trialled various strategies to engage them more fully with little sustained success. I organised, for example, numerous peer learning and faculty development events, on different days of the week and at assorted times with circa 30% final turnout, even when refreshments were provided! (see Appendix II for examples). Yet, those who attended did report value and enjoyment and as I hoped for voluntary engagement, I did not mandate attendance.

Some TELs needed to be reminded to review their GMC trainee survey results and the PME administrative team were often forced to ask repeatedly for (GMC/HEE mandated) action plans to address the issues raised. A few TELs had been openly and publicly dismissive of GMC survey and HEE visit findings and made no apparent attempt to enhance their trainee experience or survey results. They regularly declared the processes not fit for purpose. Some refused to engage with the inspectors during quality visits and did not attend even when specifically requested. Some complained to me that 'modern trainees' were not as resilient as previous generations who worked longer hours with less supervision.

In a module (MOE2) of the EdD taken in Year 2, I conducted a survey to identify TEL support needs and the best ways to deliver them. Based on the findings, I organized alternate month 'community of learning' (COL) events in the hope of adopting a more collaborative approach, but these, too, were poorly attended and on one occasion despite eleven TELs having registered a mere three turned up. Thus, I believed, it was time for a fresh approach to my leadership.

2.5 Grounding a fresh approach in earlier EdD experiences

I skirmished, briefly, with SS in MOE2 keeping a timed free writing (FW) diary and conducting a thematic analysis, using the FW narrative as research material. However, for submission, I discarded this work in favour of a 'safer' survey project. Later, my IFS moved away from my 'deep-rooted', positivist beginnings in bench research and clinical medicine (two examples cited here: Alston, 2015; Burns, 1995) and wholly embraced qualitative SS methodologies. This later research dealt with a

significant training 'problem' in another institution to which I was seconded for one day each week from a 12-month period (December 2017 to 2018). I found this initial experience of SS highly formative and effective. My seeing, understanding, and doing as an individual, clinician, teacher, professional educator, and leader began to change. Some improvements occurred during my secondment and there is evidence that the progress made has been sustained[15] and GMC restrictions have since been removed from the department.

Thus, for the current thesis, I aimed to broaden my experience and understanding of SS research. This time, I set out to deliberately examine and research my own role as DME and the collaborations that defined it. In doing so from within my own institution, I positioned myself as a 'true' insider conducting autoethnographic inquiry. I determined to capture, unpack, and portray my relationships (as DME) with others involved in creating trainee experiences in my institution. I sought to pay particular attention to the TELs, in the earnest hope of realising fuller engagement from this group and ultimately benefiting trainees and patients. Further, I set out to examine whether a collaborative action research (CAR) approach with a few TELs would shed light on ways to better my practice.

I understood the challenges and risks of conducting insider research (Ybema, 2009b) and considered and rejected other approaches e.g., further surveys, qualitative interviews, or individual in-depth departmental case studies. I finally, settled on two overarching (autoethnography and CAR) study approaches as I believed, that on balance and given the circumstances and my journey to this point, they offered the best approach as both would help me to understand my current praxis and develop blueprints for immediate and/or future action.

In summary, and in line with SS principles, I set out to examine my own leadership identity in enacting my DME role. I sought to place particular emphasis on the gap between my beliefs and practices and how I interacted with trainees, other staff, colleagues and particularly TELs, in the hope of bettering my performance and improving outcomes, within a large and complex healthcare organization.

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[15]In the 2019 GMC trainee survey, there were no 'outlier' results for this emergency department: a vast improvement on previous years. Further, GMC sanctions were lifted in late 2019 because of sustained improvements. I believe, my IFS contributed in some measure to these achievements.

Having given an overview of my professional practice problem and the PME context, the next chapter set out initially to explore literature on leadership in medical education. However, as emotion emerged as a major and recurrent theme in this work, I switched the emphasis to pay heed to literature on emotional leadership and the challenges facing contemporary medical education. I then examined literature on collaborative practice in other areas of medicine to set the scene for the CAR work.

Chapter 3 Literature review

Chapter Overview

3.1 Challenges facing contemporary medical education

3.1.1 Background

3.1.2 Generational and workforce issues

3.1.3 Changing medical and professional practices

3.1.4 Changing organizational expectations and structures

3.1.4a Historical perspectives (style and attributes)

3.1.4b Realizing the need for leaders in clinical care and healthcare education

3.1.4c Leading or managing

3.2 Emotional leadership

3.2.1 Emotional intelligence

3.2.2 EI, burnout and recovery from stress

3.2.3 Compassionate leadership

3.2.4 Emotional labour

3.2.5 Bullying and incivility

3.2.6 Organisational culture

3.2.6a Organisational educational culture

3.3 Ways of working collaboratively in healthcare

Chapter Overview

This chapter focusses on evidence that today's leaders face new and complex challenges and on how traditional leadership models have in turn evolved. It explores what qualities appear to be needed and how to encourage and develop leaders who can rise to the task in healthcare and medical education. There is a strong focus on EI, culture and behaviours because the emotional toll and energy expended in my DME leadership endeavours emerged prominently in this work. Finally, the emergence of collaborative practice in healthcare is explored.

3.1 Challenges facing contemporary medical education

3.1.1 Background

Leadership challenges in today's healthcare environment are numerous.

In the last three decades there have been several "seismic" upheavals (summarised by Browne, 2014) in the way that medical education is organised, regulated, and structured both at undergraduate and postgraduate level in the UK. Medical knowledge and the way healthcare is delivered have undergone similar revolution. The pace of change and complexity look set to continue. The current state of healthcare education and PME in the UK, reflects this turmoil. Meantime, PME faculty are required to keep up with these changes while at the same time remaining expert in their own clinical fields.

Although healthcare systems are organized very differently across first world countries, many of the underlying issues are shared and there is concern that patients are suffering as we struggle to meet these challenges. The American Institute of Medicine have declared a "*Quality Chasm*" to describe deficiencies in care that have arisen there http://www.ncbi.nlm.nih.gov/books/NBK221522. Their warning that '*as patients arrive with better and more information from the internet and increasingly insist that their desires, needs, and values be met, health care professionals will be called upon to modify their roles to include those of counsellor, coach, and partner'* (accessed 8/3/22) further emphasises the many challenges.

Although, I have already rehearsed some of my motivational challenges in Chapters 1 & 2, in the following section, I have organized discussion of the key DME challenges into relational categories. The first pertains to generational and workforce changes, the second to changing medical and professional practices and the third to local and national organizational expectations and structure.

3.1.2 Generational and workforce issues

Student, trainee, and employee expectations of their leaders have transformed in parallel with societal changes over past decades. Van Wart (2013) demystifies many of the contemporary challenges leaders face. In general, modern leaders are expected to engage in consultation with employees and involve students, but at the same time they can anticipate criticism for not enough stakeholder input or for not conveying a clear enough vision or purpose. The modern employee or trainee demands autonomy and freedom but also expects that their leaders take responsibility when things go wrong. They demand an opportunity for growth, challenge, and glory but at the same time want their leaders to be on hand to coach and mentor them so that everyone can

reach their potential in a timely fashion. Similarly, everyone wants to feel included and enjoy the warmth of belonging and team spirit whilst, simultaneously, they want to experience individual recognition and acknowledgement. Such pressures were unknown and even unimagined in past times. Further, it is well recognised that medicine is a tough job and there is evidence, that many doctors including those in training are unhappy with increasing numbers are leaving the profession.

Even before the pandemic, in the UK, there was an NHS workforce crisis with one in eleven of all NHS posts vacant (Beech, 2019). On wards and in GP practices rota gaps abound adding to working environment pressures and overseas doctors are widely used to fill the service need (Rimmer, 2017; 2018a; Oliver, 2018) and much scepticism about how this issue can be solved (Cowper, 2019).

These and other complexities have led to a renewed focus on leadership in healthcare (reviewed in West, 2015). To improve job satisfaction and retain staff, in any business, the three Ms of meaning, membership and mastery are acknowledged as important (Kanter, 2013 referenced in Friend, 2021). West (2019) echoes these sentiments under the healthcare banner as ABC, autonomy, belonging and competence. However, the ambition to deliver autonomy and flexibility to trainees and their supervisors must be viewed against the workforce backdrop and the demands of increased medical complexity, multiple stakeholders, continued financial constraints as well as ever-growing service and accountability loads. Added to this, the modern medical workforce privileges lifestyle and doctors in post-graduate training are increasingly choosing to train flexibly (Atkins, 2021; Allen, 2005; Harries, 2015) or have 'out of programme' (OOP) experiences. This adds further complexity to workforce scheduling and puts additional strain on those who choose to train fulltime (Graham-Brown, 2021).

Responses to the workforce crisis to date have focused on improving recruitment of staff, but less attention has been paid to optimising training to ensure retention (Andah, 2021). A recent joint HEE/RCP exploration into the so called "F3 phenomenon "of why foundation doctors are increasingly choosing not to progress to traditional training posts is referenced here as an example of how pressured even the most junior trainees feel and how research into retention enablers is important https://www.hee.nhs.uk/sites/default/files/docuents/F3_Phenomenon.

By enhancing trainee experiences and by increasing the focus on wellbeing of doctors DMEs have an opportunity to help alleviate this manpower crisis and slow or reverse the tide of trainee attrition (West, 2019; Gordon, 2021).

The laudable aims of improving trainee experience are also the focus of GMC trainee surveys but when found to be wanting the issues are difficult to resolve in the current healthcare milieu. General workplace studies and GMC surveys have shown that satisfaction and performance are linked to a balance of workload and support (referenced in Gregory, 2017) and both are tough to guarantee in the current climate.

Against this background, modern education leaders must also champion and roll model exemplary equality, diversity, and inclusion (EDI) practices and there is increasing discussion in the literature of the benefits to patients of privileging EDI in healthcare delivery (Baillie, 2013; Kelly-Blake, 2018; Wilber, 2017).

Sadly sexual, and racial discrimination as well as bullying appear to be rife amongst groups of clinicians (Camm, 2021; Kurdi, 2020; Huang, 2018) and DMEs are at the forefront of identifying, investigating, and rooting out such practices.
Along similar lines, DMEs are expected to eliminate bias in education opportunities, and guard against differential attainment (Celik, 2008; Bojakowski, 2010; Sharma, 2019; Williams, 2020; Maduakolam, 2020; Elsas, 2022).

Historically, these issues have been overlooked and some are nuanced. Ellis (2021), for example, has recently exposed significant under attainment in 'high-stakes' postgraduate surgical exams amongst those with 'disability' including acknowledged dyslexia.

There is an increasing call for a diverse medical workforce that reflects our population (Mitchell, 2006). To achieve this Ellis (2021), Shah, (2019), Dave, (2020), Linton, (2020) and Tiffin, (2021) all acknowledge the need to widen access to the medical profession. Woolf (2016) and Patterson (2016, 2018) have tried to unpick the underlying drivers of inequality in access to a medical career and to come up with ways to remove current differences. A variety of 'access' programs have been developed and adopted in the UK to assist (Holmes, 2002; Nicholson, 2017; Cleland, 2018).

However, a recent analysis of renal trainees' GMC survey responses. (Graham-Brown, 2021) demonstrated that increasing proportions of female, Black, Asian and minority ethnic (BAME), and international medical graduates are indeed entering the renal workforce. But specialty exam pass rates have fallen and were lower for BAME and international medical graduates. Time to complete higher specialty training has increased for female trainees. Self-reported burnout rates were higher than other medical specialties and highest for male BAME trainees. Burnout was only partially mitigated by less-than-full-time working. The authors call for effective support for a more diverse group of trainees, to enable them to succeed and reduce previously unacknowledged differential attainment.

At the same time there is a growing requirement for health systems to demonstrate person-centred (Eaton, 2015; Ulin, 2016; Price, 2006) and value-based models of care (Tinetti, 2016; Porter, 2008; Conrad 2015; Damberg, 2014). Co constructed healthcare initiatives with patients, community and hospital services are increasingly recognized as important (Radl-Karimi, 2020) as is trainee involvement in learning resource design and delivery. Simultaneously, leadership training (Aggarwal, 2015; Till, 2018; 2020, Swanwick, 2017; 2019; Frich, 2020) and quality improvement (Swanwick, 2020) activities are increasingly making their way into undergraduate and postgraduate medical curricula. Organising and fitting these 'new' activities into a crowded timetable is an administratively heavy and time-consuming task.

Meantime, student, and trainee feedback has become the new currency of 'excellence', driving application preference for medical schools and governing renumeration for higher level institutions (Schuster, 2017; Gibbs, 2013). Immediate mandatory requirement (IMR) orders can be levied on trusts (by HEE) requiring them to (immediately) fix problems that come to light during trainee visits. DMEs are usually the brokers of such IMRs. Many of these issues are in turn played out real time in social media spheres with 'twitter storms' often erupting unexpectedly and an expectation of instant response and action. Cork (2016) and O'Regan (2018) rehearse some of the perils of using social media in healthcare education.

Yet, there are benefits too. Diug (2016) demonstrated that students who actively engaging in Twitter activities, had significantly higher end-of-semester grades compared with those who did not. They noted greater student-staff engagement by developing an ongoing academic conversation. Maggio (2019) rehearses the potential

to enhance journal article access and downloads as an educational benefit of twitter. Some hospitals have used tweeting to improve patient care (Gomes 2015). Thus, DMEs need to keep abreast of these trends, containing any risk while anticipating and participating when social media may be of value.

3.1.3 Changing medical and professional practices

New and increasingly accepted modes of care delivery are very different from the traditional model of doctor, nurse and orderly. The challenge of reflecting the increasing emphasis on working in complex teams in education and training is vexed (McPherson, 2001). Interweaving the postgraduate training priorities of various staff groups who work closely together but have trained separately is difficult. Even within established multidisciplinary team (MDT) communities of practice Osborn (2010) found that interdisciplinary collaboration was "*not so much to learn from each other's talk, but to learn to talk, in this new arena*". The traditional hierarchies are difficult to break down in practice (Wilcocks, 2017).

Mental health services are particularly difficult, and Henderson (2018) acknowledges how teams often straddle care in the community with specialist in-patient care and social services. The NHS is determined to continue its efforts to shift care from hospital to community and many trainee placements have as a result moved into the community in recent years http://www.england.nhs.uk/community-health-services. Supervising trainees who rotate across these primary, secondary, tertiary healthcare boundaries adds further complexity to the DME role (Rowe, 2012).

Thus, as the practice of healthcare continues to transition from that provided by individual experts to care provided by teams there is increasing need for multi-disciplinary education (Barr, 2013; Park, 2010). While learning across communities of practice and enhancing team identification provide exciting opportunities to innovate and improve (Van Der Vegt, 2005; Oborn 2010), Kovacs (2015) highlights the pressing need for research, into team working. He points out that there are almost no remaining standalone activities for cardiologists and the composition of their teams is everchanging as practice evolves, new members join, and others are no longer needed. He cites the inclusion of genetic counsellors (for patients with inherited long Q-T syndromes) as an example. He calls for increased research and innovation to discover what the best composition and training for these new teams is and how best to identify and disseminate good practice. He also exposes a need to advocate for new

"team members" so that they are credentialled and welcomed into the care team in a timely manner. Leaders in healthcare education need to be at the forefront of this research.

Similarly, physician associates (PAs) and advanced care practitioners (ACPs), are emerging as new deliverers of care in the NHS ([fparcp.co.uk)](fparcp.co.uk). For many veteran employees, these new roles are foreign and confusing. Some colleagues remain unsure of their background and capabilities despite being grateful for the increased manpower. Regarding attitudes to this (PA) new professional group Drennan (2017) performed an in-depth analysis of policy documents, multi-stakeholder interviews and observational work and concluded that *"stratification within professional groups created differing responses" …." from acceptance to hostility in the face of a new and potentially competing, occupational group*". Others have studied barriers and facilitators to integration of PAs into GP and hospital practice (Jackson, 2017; Edwards, 2019). However, staff including doctors and patients (Williams, 2014; Zaman, 2018; Drennan, 2019; Kim, 2020) encountering PAs in the workplace appear to value their contribution which has been found to be equivalent to FY2 level in an acute medical unit in England (Halter 2020). Drennan (ibid) reports that patients often think that PAs are doctors. Importantly, the impact of PAs on training has been reported as generally positive (Roberts, 2019). A further complication here is that regulation for PAs and ACPs has not yet been formalized in the UK (Mahase, 2019) and meantime clinical and education supervision of these new professionals has fallen to GPs and hospital ESs across the country (Agarwal, 2021).

In hospitals, DMEs generally take leadership responsibility for the education and development as well as integration of PAs and ACPs into the workplace. Many trusts accommodate placements for student PAs and there is much work to be done to ensure they have meaningful experiences (Brown, 2020). Successful integration of these new roles into care should impact on workload and satisfaction of other workers particularly trainees. This new responsibility is a hefty ask for DMEs and other leaders who may themselves feel uneasy, as they have not worked with PA/ACPs before, are not experienced in the PA/ACP curriculum or examination processes and are not-experts in each of their assigned multi-disciplinary fields.

Meantime, assuring individual patient safety in a world where transparency and blame make failures very public (Bates, 2018; Lark, 2018) is of paramount importance. Hence, learning assurance systems such as the GMC postgraduate trainee doctor surveys discussed in chapters 1 and 2 and the National Education and Training Survey for multi-professional learners undertaking clinical placements http://www.hee.nhs.uk/pir-work/quality/national-education have grown substantially out of this need. In the UK, old apprenticeship style training has been largely taken over by formulaic GMC approved curricula and assessments which place much more onus on trainees, supervisors and DMEs to demonstrate competence and performance. These surveys aim to enhance training but also have a wide remit to address patient safety issue, rotas, clinical and education supervision, working conditions, bullying and harassment and so the DME is required to respond to a breath of issues not directly related to training delivery. It is my experience that such demands can pitch DMEs into battle not only with operational and other managers. Further, conflict can arise with colleagues who are advised in e.g., Kilminster (2007)'s 7-point framework for effective supervision that "supervisors must be aware of local and postgraduate training bodies' and institutions' requirements". While apparently obvious, potential for conflict becomes obvious as this framework forms only a small part (ASMEE "Guide No. 27: Effective educational and clinical supervision" https://doi.org/10.1080/01421590701210907) of the effective supervisor's obligations.

Further challenges for DMEs that warrant more attention is the move away from the trusted administrator or secretary inputting data to a new model of, large data sets, technology, on-line portals, and portfolios that medical educationalists must navigate. In some cases, secretarial and administrative support has been significantly reduced. Thus, creating bespoke opportunities for trainees is even more challenging. This challenge for healthcare leads, to be managers as well as trailblazers and innovators is explored by Swanwick (2019). This problem is not confined to PME increased administrative burden has been cited amongst the reasons why GPs leave practice (Doran 2016).

The professionalisation of medical education (Swanwick 2008) requires DMEs to upskill themselves repeatedly to adapt to the many and frequent changes while simultaneously continuing to remain on top of their own specialty advances. The situation demands that they maintain expertise in two very tough arenas and Sethi

(2017) explores the convoluted tensions that can result from wearing an educational hat in a clinical environment.

3.1.4 Changing organizational expectations and structures

3.1.4a Historical perspectives (styles/attributes)

Leadership remains a popular solution to the problems of healthcare. Hartley (2010) points out that leadership is a disputed subject and difficult to define. He rehearses the three ways of conceptualising or defining leadership according to focus: by person, position, process (cited in Wilcocks, 2017). Hackman (2009) asserts that, "*effective team leadership is ensuring that the functions that are most critical for achieving team purposes are identified and fulfilled*" (Pg. 4). Yet, Lord and Maher (1991) cited in Haslam, 2015) on the other hand defined leadership as 'the process of being perceived by others as a leader'. The former lens privileges action and the latter perception. Accordingly, even the definitions and theories around leaders and leadership are nuanced.

The NHS needs leadership/leaders "*of the highest calibre* "if it is to respond to the unprecedented pressures that prevail in healthcare (West, 2014). A quick Google search reveals more than seventy adjectives to describe leaders. Predominant styles have changed dramatically over the past 8 decades (Figure 3.1) (Harrison 2018).

Here, I include an illustrative list (with brief descriptions) intended to orient the reader. These span the main approaches and represents a continuum from commander-style use of authority to team centred approaches.

- Autocratic: decides or resolves the problem using information given to them.
- Democratic: consults with others about how things should be done.
- Laissez-faire: uses the minimum level of authority and allows teams to find their own solutions.
- Situational: choosing the right leadership style for the right people.
- Visionary: ensures the vision becomes reality by stating clear goals and outlining strategic plan to achieve them.
- Transformational: works with teams to identify needed change and executes them in tandem with committed members of the group.

- Transactional: focuses on supervision, organisation, and performance (Desjardins, 1991).

Leadership Research and Theory ...
link.springer.com

Figure 3.1 Dominant leadership approaches spanning 8 decades 1930-2010 (in Harrison, 2018, pp. 15-32).

The underpinning ethic of much of the more recent terminology connect with words like appreciative, enabling, empowering that are used to represent more modern approaches. In health and care, there has been an accelerating shift from the hero, the position, and the process to more collective and compassionate approaches (West, 2014; West, 2017). There is less emphasis on individuals who “turn organizations around” with more emphasis on invisible styles (Hickman, 2013). In collective leadership cultures, responsibility, and accountability function simultaneously at both individual and collective levels. Proponents claim that the ethos is refreshing, pragmatic and likely sustainable as “*They (the organisations) breed regular reflective practice focused on failure, exploratory learning and making continuous improvement an organisational habit*” (Pg. 15). Collective approaches to leadership focus on the extent to which formal and informal leaders work cooperatively in support of the organizational goals and embody the values that underpin the desired culture (West, 2014). This system acknowledges the need for formal leaders to be chosen wisely from outside but also to be promoted and supported on merit from within the organization with the intention for any individual to have “permission” to step up to lead when an everyday or extraordinary situation demands.

Compassionate leadership, discussed in more detail in section 3.2.3 below, is increasingly promoted within healthcare organizations. It privileges more than just being a compassionate individual and caring for colleagues. It encourages compassion and caring in the wider organisation by encouraging employees to talk about their problems and provide support for one another. Compassionate leadership is about creating a culture whereby seeking or providing help to alleviate a sufferer's pain is not just acceptable but is seen as the norm (de Zulueta, 2016; Poorkavoos, 2016; West, 2017; Foster, 2017; Hewison, 2019).

Many groups have tried to characterize what leadership styles and traits are 'good' or 'bad' or that determine success or failure (Datnow, 2001; Muller, 2011). In my IFS (Burns, 2019) I was impressed by literature around 'ethical leadership' defined as" the *demonstration of normatively appropriate conduct through personal actions and interpersonal relationships and the promotion of such conduct to followers through two-way communication re-enforcement and decision making* "(Brown, 2005: pg120). Individual characteristics such as agreeableness, moral reasoning, and conscientiousness (ibid, P4, P9 & P5 respectively) are privilleged. Proponents point to ethical decision making (p13), follower satisfaction, motivation and commitment (P16) as the rewards. This type of leadership overlaps with the ethos of compassionate leadership above but also overlaps with aspects of collaborative, and authentic leadership (de Zulueta, 2016; West, 2017; Abbas, 2021; Brohi, 2021).

Authentic leadership pivots on the idea that these leaders are "real". The theory is attributed to George (2003) who proposed that being yourself is key to finding success. Self-awareness, including strengths weaknesses and values is important. According to George the character of the leader matters most. Employee's perceptions of authentic leadership are the strongest predictor of job satisfaction according to Wong, (2013). The essence of authentic leadership is said to be EQ (Ilies, 2005) but critics point out that it is impossible to be authentic all the time and that such leaders can get locked into a 'teenage' version of themselves (Shaw, 2010). Thus, collective, ethical, authentic, and compassionate leadership that all challenge the older models of leadership that privileged great man theories, competency, transactional and transformational models are generally considered to be more relevant in modern society (Avolio, 2005). In relation to the NHS West (2017) highlights the 'sympathetic joy' resulting from compassionate and collective

approaches when team members co-create and take pleasure from the successes. Many hope that staff will be attracted and retained, as well as empowered to deliver more kindly care because of these movements.

De Zulueta (2016) however, recognizes the importance of differing situational demands and adapting leadership style as required. Popper's (2005) seminal works on leaders who transform society focusses on prominent leaders in history to explore the relationships between leaders and followers. We tend to think of leaders as positive role models, but Popper (ibid) shines a light on the negative 'dark side' which he believed had been neglected in psychological research on leadership. He examines regressive relations, symbolic relations, and developmental relations, focussing on followership and suggests directions for a more integrative conceptualization of leader-follower relations. Wilcocks (2017) too warns that relying on person or position i.e., individual perspectives of leadership is problematic in circumstances where leaders display inappropriate or unethical behaviours. Thus, a shift is clearly visible from heroic styles and reliance on leadership traits to more collaborative ways where positive relationships are privileged (explored in Harrison, 2018; King, 2009).

Yet much of the literature features a search for or definition of desirable leadership attributes. Although the extensive catalogue is almost certainly unachievable by a single individual, an awareness of self and making sense of experience, seem particularly relevant. This is summarized by Bennis's (1989) aphorism that "*The process of becoming a leader is similar, if not identical, to becoming a fully integrated human being ... grounded in self-discovery*". Support for this perspective and particularly the focus on self-awareness, continuous development and the role of failure, comes, too, from Shale (2019) who explored the lived experiences of clinical leaders in the NHS. She concludes:

> "*Medical leaders' thinking about leadership and culture clearly develops over their medical management career, a period likely to be two decades or more for many. Their approaches to leadership and culture are a response to their environment, the challenges presented to them, and their own experiences of success and failure (p 23).*"

Even if survivorship bias influenced these findings, it is likely that the leader's seniority, self-awareness, and ability to learn from past experiences (good and bad) is key.

Regardless of the individual characteristics of the leader the culture they create is also

key. A recent study by West (2022) used NHS datasets from staff surveys in England to show how leaders support, as measured by staff influence over decision making, was negatively correlated with staff work pressure and positively correlated with patient satisfaction. Thus, more perceived leadership support towards autonomous decision making led to less perceived staff work pressure and higher patient satisfaction.

The modern DME's challenge is to support, role model and enable the move towards the new goals of collective, compassionate, authentic, ethical, and collaborative cultures. They also need to help develop these skills in current trainees who will be the future leaders and continue to mature and hone their own positive leadership abilities.

3.1.4b Realizing the need for leaders in clinical care and healthcare education

At my consultant interview 30 years ago, there was no requirement to evidence any leadership training. A perfunctory 'management course' became a popular pre-interview 'desirable' in the 1990s.

However, over the past decade, there has been a resolute emphasis on leadership training for clinical staff of all grades and professions in the NHS (Swanwick, 2010; Storey, 2013; Sultan, 2019; Swanwick, 2017). The leadership tasks are many and range from e.g., ward management, outpatient service configuration, to domestic or bereavement services and to the more traditional divisional clinical and medical directorships. This change has resulted partly because research has shown that effective leadership of healthcare teams not only improves outcomes, but also patient and provider satisfaction across a broad range of clinical settings (Wong, 2013). 'Poor leadership' on the other hand, has contributed to very public failures in NHS delivered care (Daly, 2014). The establishment of the NHS leadership academy http://www.leadershipacademy.nhs.uk, and the initiatives of the Kings fund and the centre for creative leadership are all determined to improve leadership across all NHS healthcare areas.

Medical students and graduate doctors have been a particular focus of these endeavours. NHS leadership fellows are being appointed in many regions. Yet, despite these initiatives, the healthcare leaders recently interviewed by Shale (2019) expressed concern that younger doctors were reluctant to take on leadership roles

(p19) and considerable challenges remain in achieving the grand vision of leaderful healthcare organisations (Swanwick, 2011). Moen (2014) too, corroborating this view, reported that senior trainees did not identify themselves as leaders in the NHS and uptake of a recently developed leadership spiral toolkit to assist trainees and supervisors has been poor (Charlton, 2019). Swanwick (2019) has found that supervisors lack confidence in this domain and reports that many significant barriers including workload and lack of support from trusts remain.

Support for senior clinicians in leadership roles is also a problem. Shale (ibid) concluded that consultants taking their first steps in clinical leadership roles (e.g., heads of clinical specialist services) are often left to "sink or swim" and Rimmer (2019a) argues that more support is needed. Some additional roadblocks are highlighted by Sultan (2019) whose systematic review of leadership training for postgraduate doctors revealed that training interventions lacked grounding in conceptual leadership frameworks, provided poor evaluation of outcomes and focussed primarily on cognitive leadership domains. Of note, this author proposed better programmes that address character development and EI. Others commend earlier exposure and involvement as well as continued mentorship (van Diggele, 2020).

Debating these issues with a non-medical friend who lectures on healthcare leadership at the 'Judge business school' was interesting. Her observation was that few senior trainees really want to embrace leadership skills at this point in their careers but they do want to be able to 'survive' consultant interview questions and certainly Grewal (2015) provides "great answers" to a range of "tricky" leadership and management type questions. However, some groups including the Royal College of Physicians (RCP) have set up popular training and mentorship schemes for 'emerging women leaders' (Boylan, 2019) and 'chief registrars' (Vaux, 2019) with the aim of developing, embedding, and catalysing individual leadership skills using a mixture of collaborative project work and theory, to create a strong cadre of confident role-models and teachers. As part of their offering, the RCP privileges apprenticeship type experience with committed senior leaders in the participants' trusts as well as extended mentorship. In recognition of the importance of supporting clinical leaders, hospitals and increasingly offering leadership support and training as well as coaching and mentoring opportunities to all staff who aspire to or have stepped up to lead (Cabral, 2019; Storey, 2013).

But leadership happens within situated contexts and gender as well as culture has been shown to influence developing styles (House, 2004; Jogulu, 2010).

A leader cannot lead alone. Michie and West (2004) presented a framework (reproduced in Figure 3.2) for understanding the links between organizational context, people management, psychological consequences for employees, employee behaviour and organizational performance. Leadership and importantly support were highlighted as facilitators of people management together with training and development, job design and workload, employee involvement and health related management and strategies within the organisation. According to this framework, to achieve the goal of organisational performance each of the elements need to be facilitated.

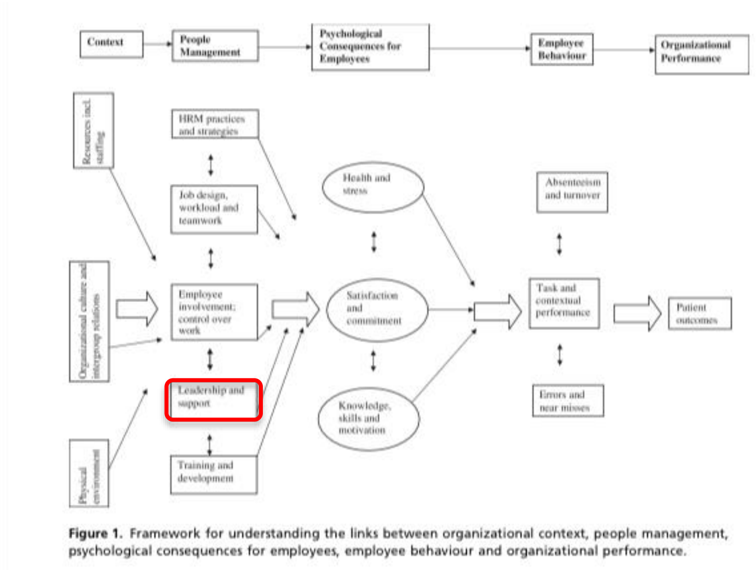

Figure 1. Framework for understanding the links between organizational context, people management, psychological consequences for employees, employee behaviour and organizational performance.

Figure 3.2 Framework for understanding the link between organizational context, people management, psychological consequences for employees, employee behaviour and organizational performance. reproduced from Mitch and West 2004

Meantime, there is less evidenced work on leadership pertaining to medical education duties. A bewildering array of idealized personal characteristics including: "*educational visionaries, instructional and curriculum leaders, assessment experts, community builders, public relations experts, budget analysts, facility managers, special programs administrators and expert overseers of legal, contractual and policy mandates, and initiatives"* have been suggested, empirically, to characterize effective leaders (see Çitaku, 2012, p. 2). Rich (2008), identified the following four generic categories of 'desirable qualities', amongst 11 'seasoned' American medical school

deans interviewed in a 2006. They include 'Management' and 'leadership' skills as well as 'knowledge' and 'attitudes'. Qualifying leadership skills the authors included visioning, maximizing values, knowing self, mentoring, building constituency, challenging, and making sense of experience.

3.1.4c Leading or managing

This distinction between leading and managing is important. Swanwick (2019) highlights the need to distinguishing the creative forces of leadership in healthcare from the management activities. Bush (2007) links leadership to values or purpose while relating management to implementation or technical issues. The former privileges change while the latter maintenance and stability. "Leading and managing are distinct, but both are important…", Bush claims but "…the challenge of modern organisations requires the objective perspective of the manager as well as flashes of vision and commitment wise leadership provides" (p 392). Transactional leaders clearly favour the administrative activities.

Cottrell (2016) explored the personal, professional and organizational socialization of 7 newly appointed head teachers in the UK and exposed the many stresses they endured. The administrative and management load of their headship was particularly burdensome. It was clear they struggled to balance the many different fragments of their roles juggling, staffing, curriculum, parents, governors, policy, and the children under their care, even when they were given specific training in these areas.

Paperwork, targets, and regulations similarly burden leaders in healthcare education. However, added to these layers is the additional risk of insuring against clinical failure and possible liability if rogue practitioners are certified from your programs or institution, so called vicarious liability (Reuter, 1994). Thus, managing the competing agendas of the multiple intersecting agencies and bodies while keeping up the horizon scanning and adapting education in the fast moving science and healthcare arena (van Diggele, 2020) is vexed. It is easy to see how focus can be pulled away from the substance of what we do and how performance assurance has insidiously taken center stage.

3.2 Emotional Leadership

3.2.1 Emotional Intelligence

Feelings and emotions play a central role in the leadership process (George, 2000). "Moods are infectious, and they can govern a business's fortunes or failures" (Goleman, 1996 a; 1996 b). It is proposed that emotional intelligence (EI) measured as an emotional quotient (EQ) contributes to effective leadership in organizations (Palmer, 2001; Batool, 2013; Mills, 2009; Prezerakos, 2018). The scholar and psychologist Goleman (ibid) defined EI as "a person's self-awareness, self-confidence, self-control, commitment and integrity and a person's ability to communicate, influence, initiate and accept change". He is credited with introducing and legitimizing EI in the workplace (Cherniss,1998). Tests of EI are complicated (O'Connor, 2019, Siegling, 2015). More than 30 widely used tools are currently in use to measure two conceptually different forms of EI, termed 'trait' (TEI) and 'mixed' forms and 'ability' EI (AEI). Most gauge facets of emotion related to perceiving emotions in self and others, regulating emotions in self and others and strategically utilizing emotions (O' Connor, 2019). They vary in structure, reliability, and validity. Some are freely available, and some require payment. AEI is a test of maximal performance, while TEI is a determination of typical behaviours in an emotionally relevant situation and is measured by self-reporting. AEI measures are valid but weak predictors of job satisfaction (Miao, 2017) and performance (O'Boyle, 2011). Individuals, found to have high TEI have been found to have high levels of self-efficacy and tend to be competent at managing and regulating emotions in themselves and others. Unlike AEI, TEI has been linked to job satisfaction and organizational commitment as well as job performance. Issues of reliability, validity, reproducibility are beyond the scope of this work but suffice it to say that unlike IQ, EQ can improve with time as well as coaching (Bar-On,1997)

There is an increasing emphasis in medical student selection and training on EQ and developing EI. Traditionally, doctors are viewed as having high IQ and many operate at the top of this pyramid. Yet increasingly, EI is viewed as important having the potential Grewal (2008) believes to deepen and enrich students' understanding of competency during medical training. Burnout which may be linked to EI was found to be associated dropping out of medical school (Dyrbye, 2010). EI, as measured by an abilities test at admissions, does not appear to reliably predict future academic performance (Chew, 2013).

EI and IQ are not in opposition but according to Stein (2011) complement the potential to succeed in a people orientated environment.

According to Goleman (1996) EI is almost wholly responsible for the "superior performance in leadership roles" and Fareed (2021) contends that combining the two could form the foundation for leadership effectiveness, inspirational workers, high levels of achievement and ultimately job satisfaction.

EI has been linked to multiple positive outcomes including performance (Carmeli, 2006; Slaski, 2002; Wong, 2002) and 'effective' leadership (Akerjordet, 2008; Prati, 2003). Rode (2017) found that EI measured during college is positively related to salary 10–12 years later and that mentoring mediated this relationship. Goleman (2002) went so far as to proclaim that "*emotional leadership is the spark that ignites a company's performance, creating a bonfire of success or a landscape of ashes. Moods matter that much*". Clearly, the methods of measuring EI may impact on the trustworthiness of these studies and measures of effective leadership too are subjective making definitive interpretation of this area of work difficult.

High EQ levels are generally believed to enhance creativity, encourage helping behaviours and co-operation. Emotions can also be used to frame new events in a positive way. Leaders can express confidence in an individual by appearing to like and respect them. Conversely, negative emotions have been found to drag down the mood of an organisation yet, on the other hand, they can also force a leader to examine information more thoroughly and come to a more informed opinion (Amabille, 2005).

Though mostly considered a positive asset Yang (2015) demonstrated that, in some situations, positive emotions can constrain, and low EQ scores foster creative performance. More specifically, they found that love constrains creativity, whereas anger may facilitate it.

Although strong EI traits are usually considered advantageous, there is a dark side to emotional intelligence. Psychologists Joseph and Newman cited in Grant (2014) analysed every study that has ever examined the link between emotional intelligence and job performance. According to their work, across hundreds of studies of thousands of employees in 191 different jobs, emotional intelligence was not consistently linked with better performance. In jobs that required extensive attention to emotions, higher EI translated into better performance and importantly those with high EI were able to deal more effectively with stressful situations and provide

“service with a smile”. However, in jobs that involved fewer emotional demands, higher EQ individuals were less productive.

Hyde (2020) and colleagues measured emotional willingness to manipulate against EI in over 700 workers of varying occupations. Their study was the first to demonstrate that good EI skills can facilitate undesirable workplace behaviours. They found that emotional manipulation (e.g., maliciously making people feel guilty or deliberately reassuring someone so that they go along with what you say) “*was elevated in males with a relentless drive to achieve goals, and in females with broader deceptive tendencies*”. Others have raised similar concerns about the use of EI for nefarious purposes (Austin, 2007; Davis, 2016; Kilduff, 2010; Furnham, 2016; Khanna, 2017; Wood, 2020).

However, neurological, psychological, and organisational research all support the importance of emotionally intelligent leadership. Leaders with empathy for others, self-awareness and self-control are likely to realise when pride and other emotions are influencing their thinking and choices and to re-evaluate. They are also more likely to achieve their own and their organization’s goals (Pinos, 2013). They are said to feel and show less aggression towards their organisations (Quebbeman, 2002).

The neurologic explanations for emotion and emotional influence and connectedness are complex and interesting. The brain’s limbic area and system appear to be of key importance. The term limbic resonance is used to describe how we are linked emotionally to those around us and those with whom we share a close connection (Tucker, 2000). Some workers have claimed that we even “*change one another’s brains through limbic revision* “(Lewis, 2000). Animal models of behaviour and functional MRI scanning are being extensively used to unravel some of these mysteries but, although interesting to me as a scientist, exploration of this literature is beyond the scope of this narrative.

There are many courses and modules where strategies designed to help aspiring leaders to exploit and capitalise on emotions and develop their EI are taught. One such course draws on an iconic book exploring the science of human emotion “The general theory of love” (Lewis, 2001). It points to attributes of “great leaders” that can be cultivated deliberately and “*make imparting a positive emotional charge a conscious part of their leadership repertoire*” The coveted skills are said to be: the art of being in the present (stopping oneself drifting off into the past or being lured into

imagining the future), emotional self-monitoring, awareness and sense-checking of the whole environment, deep listening, eudemonic well-being (enjoying the success and development of others), ease and finally the art of straight talk (Isbister, 2022).

In the context of this thesis, it is interesting that the first skill "the art of being in the present" both contrasts and aligns with the notions of "nodal moments" in SS (Tidwell 2010). I will return to the topic of linguistics and the "art of straight talk in the results section.

In a recent article, van Diggele (2020) lists personal issues including self-management (time and work-life balance) amongst the specific challenges encountered by leaders in healthcare education and this supported the notion that creating time to reflect and get to know one's self is of key importance. These skills he concludes need time for maturation and development. They align with self-awareness and managing emotions which are recognized components of EI. Qualities such as self-motivation (Arribas-Galarraga, 2017) at least in sport and, an ability to manage and build networks of relationships (Lopes, 2003; Freshman 2004) also feature as EI competencies.

Çitaku (2012) utilized a questionnaire involving 229 multi-national (Canada, Austria, Germany, Switzerland, UK, USA) academic healthcare educators, from various professional groups: physicians, nurses and other health professionals to identify "principle components" of education leadership as they viewed them. Social responsibility, innovation, task management, justice orientation and again self-management emerged. Once again, the parallels with EI qualities are apparent. He attempted to weight each "component" and make differential comparisons, by professional group. Social responsibility was rated higher amongst the non-physician educators as was innovation and justice orientation, meaning that physicians rated self and task management more highly than their multidisciplinary colleagues. I speculate here that this finding might reflect how physicians may have higher expectations of their own personal resilience, EI and agency or feel obliged to live up to public expectation. There is some evidence to back this interpretation (Sawicki, 2011). I also wonder whether high achieving clinicians demand the same exacting standards of their own and colleagues' leadership performance and that these same standards may even lure them into leadership roles.

Regardless of whether leaders in healthcare education self-select unawares or are selected for certain traits or characteristics, Steinert (2012) reported, in a systematic

review of faculty development initiatives, that they appear to have an appetite for interventions designed to develop and promote their leadership skills. In her study high levels of satisfaction, as well as gains in leadership participants' reported knowledge and skills were described. There was evidence of positive change in self-perceived leadership capabilities and behaviours, as well as attitude towards their own organizations. This latter suggestion links with the apparent benefits of well-developed EI described above (Quebbeman, 2002). Steinert (ibid) also found that methodologies including reflective practice, individual and group projects, peer and institutional support, mentorship and developing communities of practice all contributed to positive outcomes.

3.2.2 EI, burnout and recovery from stress

Although EI is an ability which focuses on the accurate perception and expression of emotion, the understanding of emotional knowledge, the use of feelings to facilitate thought and to regulate emotions in oneself and others (Salovey, 2003), it has also been defined as a non-cognitive capability that influences one's aptitude to cope in various situations (Bar-On *et al.*, 2003).

A growing number of studies have begun to investigate whether EI protects or buffers against anxiety and the effects of stress. Lea (2019) systematically reviewed experimental studies that explored the relationship between both types of EI, (AEI and TEI) ability and acute stress reactivity and/or recovery. EI was only effective at alleviating stress in certain contexts, and the findings differed according to stressor type, and how EI was measured. In terms of stress reactivity, higher TEI was associated with less mood deterioration during sports-based stresses, physical discomfort, and cognitive stress but did not appear as helpful in other contexts (e.g., public speaking). Moreover, effects of TEI responses, such as heart rate, were inconsistent. Outcomes of AEI on subjective and objective stress reactivity were often non-significant, with high levels detrimental in some cases. However, importantly, the data suggested that both higher AEI and TEI related to faster recovery from acute stress. In conclusion, results provided mixed support for the stress-buffering effect of EI. The mixed quality of studies made interpretation unreliable. Clearly, these findings could have implications for EI and healthcare as well as leadership training programmes.

Whether emotional burnout or attrition numbers are high amongst DMEs or those involved in PME in the NHS is not, to my knowledge, known. The relationship between leaders' experience, (measured) competence and burnout in counsellor educators has been studied by Harrichand (2021) who found that the leadership subscales, gender, faculty rank, and teaching load were significant predictors of burnout. Another study by Weng (2011) emphasised the importance of positive psychology, and examined the inter-relationships among EI, patient satisfaction, doctor burnout as well as doctor job satisfaction. Higher self-rated EI was significantly associated with less burnout ($p < 0.001$) and higher job satisfaction ($p < 0.001$). Higher patient satisfaction too was correlated with less burnout ($p < 0.01$). It is hard to know which component of this reciprocal benefit carries more weight.

Worryingly, there is evidence that modern trainees are suffering more anxiety, stress, depression, burnout (Zhou, 2020; Looseley, 2019). In a recent review of the literature Harvey (2021) presented evidence that between a quarter and a third of physician trainees report increased symptoms of mental illness. Changes in medical training and health systems and the additional strain of the recent pandemic he notes may have amplified these problems. The issues of burnout and stress are not confined to trainees as GPs, surgeons and physicians are similarly afflicted (Brooks, 2011; Spiers, 2017; Garada, 2019; 2020; George, 2019). Historically, physicians, particularly females, are at increased risk of suicide and have a high prevalence of suicidal ideation and planning (Schernhammer, 2004, Hem, 2005, Petrie, 2020, Lindeman, 1996) Norwegian longitudinal studies suggest that suicide feelings decreased between 2000 and 2010 (Aasland, 2011). The COVID-19 pandemic has boosted interest in how physician mental health can be protected and optimised. Harvey (ibid) declares that new initiatives are required and recommends a new framework for how individual and organisational interventions can be used in medical schools, healthcare settings and by professional colleagues. At the same time supportive events such as the "Wounded Healer" conferences have become very popular http://www.practitionerhealth.nhs.uk/ and supporting the workforce recovery features prominently in much recent healthcare literature (Gerada, 2017; 2018; 2020; Moberly, 2022). It is hoped that acknowledging mental health issues will lessen the traditional stigma associated with admitting to such problems. While there are excellent agencies to help very often the 'first line' pastoral care for these trainees falls to the PME team and the DME to whom they are initially referred (Kilminster,

2000, 2007). This is a hefty and growing burden. Early discussions and signposting of individuals is time-consuming, challenging and emotionally draining.

3.2.3 Compassionate leadership

Dictionary definitions of compassion include “suffering with” or a deep awareness of the suffering of another, coupled with a wish to relieve it. An empirical model of compassion formulated using semi-structured interviews with cancer patients defines compassion as “virtuous response that seeks to address the suffering and needs of a person through relational understanding and action” (Sinclair, 2016). Identified as a hallmark of quality health care, its heft is evident within many codes of patients' rights, best practice guidelines, health care reform (reviewed in Sinclair (ibid). Health care providers and institutions characterized as compassionate are less likely to receive patient complaints and malpractice suits (Sloan, 1993). The importance of compassion was highlighted in the Francis Inquiry report, which identified a lack of compassion as a leading cause of the failures at the Mid Staffordshire Health Trust and within the NHS in general (Francis, 2013). Recommendations included that all health professionals be trained and evaluated in compassion. Whether compassion can be manipulated by training is uncertain (Wilcocks, 2009). Although the relevance of compassionate care seems self-evident, studies have repeatedly identified the emergence of a gap between patients' and clinicians' perceptions of compassionate care.

In recent years there has been great talk and much support for compassionate leadership strategies in the NHS. The professed core values of care and compassion in the NHS are often discussed in healthcare education settings. These principles have been launched in various guises e.g. ‘6 C’s (Stephenson, 2014) to get more traction and to try to enhance patient centred approaches and the ‘compassion to care’. West (2017, 2019), an organisational psychologist and co-author of the GMC and King’s Fund documents “Caring for Doctors Caring for Patients” and “Caring to Change” focusses on the medical profession and champions the choosing and nurturing of leaders who have the “courage of compassion”. The findings and views expressed in these documents reflect a lifetime of his work in the field and assert that when we work in organisations that mirror these core values, our motivation, our wellbeing and creativity are sustained and nurtured and we demonstrate compassion in our

interactions with patients [Michael West | The King's Fund](https://www.kingsfund.org.uk.) https://www.kingsfund.org.uk.

For clarity and expedience, I have reproduced, here, a table from the King's Fund document that summarizes the concepts and benefits of such approaches to leadership in healthcare. These proposed benefits West (2017) believes extend beyond the individual, team, inter-team, and organization to influence the whole healthcare system. Recognizing and valuing diversity ties in with the earlier sections in this chapter. Good relationships, appreciating each other, building awareness of mutual need, and understanding all align with EI. The notions of trying and failing as individuals while the wider system embraces failure as human and an opportunity for improvement underpin the ethos of compassionate leadership and are very much relevant in the context of this thesis. This table also aligns with the personal professional and organizational perspectives that became important in the analysis of this work.

Table 1 Compassionate leadership and the processes that lead to innovation, from the individual level to the system level

Level	Compassionate leadership activities	Cognitive/emotional processes	Other processes
Individual	Listening Role-modelling reflexivity Coaching	Self-efficacy Self-worth at work Good relationships	Suggesting Noticing opportunities Trying, failing, learning
Team	Creating a psychologically safe environment Discovering meaningful differences and similarities Facilitating purpose	Psychological safety Appreciating each other Team identification	Discussion Review and implementation Team efficacy and potency
Inter-team	Exchanging information empathically Role-modelling perspective-taking Building awareness of mutual needs and interdependence	Multi-level perspectives Organisational identification Diversity matters	Lower inter-team conflict Higher inter-team collaboration Higher-quantity and higher-quality innovation
Organisational	Having a realistic vision Creating a culture of belonging Personalising purpose Using strategy as practice/ a learning process	High levels of inclusion Secure attachment/high organisational identification	Organisational agility and responsiveness Organisational resilience Faster adoption of innovation
System-wide	Showcasing compassionate leadership practice Using strategy as a reflective learning process	Embracing failure as human and an opportunity for improvement System resilience Adopting a learning perspective	System-wide learning Robustness/resilience Faster diffusion of innovation

Table 3.1 Compassionate leadership and the process that lead to innovation from the individual to the system level (reproduced from West, 2017, p. 6)

However, watching one of West's King's fund videos I was struck by a comment when he advises that the "starting point is compassion for self". In line with the awareness of self, discussed earlier, I was further heartened, by the prominent line in the (2017) King's Fund document:" *In order to nurture a culture of compassion, organisations require their leaders-as the carriers of culture- to embody compassion in their leadership*" (p. 4).

Thus, I once again pondered the emotional toll on leaders and how their roles impacted on themselves, on those around them and on their actions. I wondered how often healthcare bosses attend to, make sense of, and understand their own feelings? It may be that high EQ assisted or determined an individual's rise to leadership roles and this may mean that such leaders are equipped to "manage and monitor their own emotions" (Bliss, 2006).

3.2.4 Emotional Labour

Emotional labour is defined as the process of managing feelings and expressions to fulfil the emotional requirements of a job. The mental activity required to manage and perform the routine tasks necessary and present oneself and interact with other people in a certain way expected in the role. Put simply it is when someone feels the need to supress their own emotions. Hochschild's (1983) foundational text "The managed heart" described emotional labour as "*having to induce or supress feelings in order to sustain the outward countenance that produces the proper state of mind in others*". Recently the term has taken other lighter (being fed up with life administration and routine housework) and heavier meanings (pretending you are not bothered by the microaggression in the workplace- any situation where you feel you have been stereotyped and/or your identity has been attacked and you must pretend it is fine.

Emotional labour has been studied in many areas of industry and healthcare most notably nursing (Abstract, 1989; Ahmad, 2019; Brotheridge, 2002; 2003; Erickson, 2001; Kempster, 2019; Kerasidou, 2016a; 2016b; Larson, 2005; Lartey, 2019; Pugliesi, 1999; Schaubroeck, 2000; Van Dijk, 2011). Most chart it's presence and degree while speculating on the cause and consequences. Humphrey (2012) on the other hand, examines how leaders in business and industry exploit their own and manipulate their workers emotional labour.

Horchschild (ibid) divided emotional labour into two regulation strategies surface and deep ‘acting’. There is little information about the prevalence and consequences of surface acting, deep acting (sometimes referred to as fake acting, (Grandey, 2003)) and expression of genuine emotion in education and leadership. Ahmad (2019) linked measures of emotional labour with job satisfaction, in a random selection of university teachers in Pakistan. He demonstrated a significant influence of the former on the latter. He reported that surface acting was significantly and negatively associated with commitment and loyalty to leaders and organisations, while deep acting and measures of displaying genuine emotions positively so. Ahmad did not report if and how ‘acting’ impacted on others. Prentice (2013). examined the relationship between emotional labour, burnout, and the moderating effect of EI. She found that EI did indeed mitigate the labour of acting and protect against burnout in worker sin the tourism and hospitality industry.

Kempster (2019) utilized analytic co-constructed auto-ethnography to examine a senior hospital manager’s experience of seeking to be authentic during a period of intense challenge as he pursued the closure of a hospital ward. A first-person account was developed. This is interesting and relevant to my study for several reasons. The manager used his own ‘case study’ to explore aspects of his emotional journey in a similar manner to my work. Clearly, the healthcare setting too resonated with mine. The fiscal tensions and wider care improvement aim was also like mine. The manager spoke of the necessity of hiding felt emotions and displaying his perceptions of the desired emotions he believed were warranted in the context. Balancing the demands of performing such emotional labour while achieving the desired workplace transformation was clearly stressful for this manager. It is not clear what price the leader paid for this emotional burden, whether he recognized its occurrence and what steps if any he took to overcome or lean into the discomfort. I wondered how I would have behaved in this situation. I considered whether the ‘others’ involved could sense the ‘faking’?

Latterly, I found evidence that acknowledging emotional labour as well as compassion for self and others are now being encouraged and promoted in modern NHS arena. In 2021 the leadership academy produced several aids to support NHS staff, particularly those in leadership. Amongst these, a Ted talk by Brene Brown

(https://www.ted.com/talks/brene_brown_the_power_of_vulberability?) outlines her research into human stories of worthiness and the importance of acknowledging vulnerability. Her thoughts on the courage to be imperfect and compassionate starting with kindness towards self, seem removed from the perception of the traditional leader but resonated very strongly with my work. It also benchmarks a further evolution in leadership approach where compassion and authenticity are viewed as key in developing a culture of care, patient safety and likely learning.

3.2.5 Bullying and undermining

Other influences, too, need to be considered. 'Relational professionalism' is a well-recognised, though not extensively researched, concept in teacher education (Frelin, 2013). It is described as a positioning that reflects a professional ethic of care values as well as historical 'maternalistic' views. Sadly, and by contrast with the ethic of 'relational professionalism' a recognized part of the lived experience of doctors in healthcare is bullying often in the form of rude, dismissive and aggressive communication (Crowe, 2017). In one example Bradley (2015), a postgraduate medical education fellow, found that 31% of responding doctors endured such behaviour on a daily or weekly basis. She identified 5 key themes in response to "why rudeness happens?" They were workload, lack of support, patient safety, hierarchy, and culture. Junior members of staff were more likely to be on the receiving end of such communication. Consultants found that their seniority protected them. Thus, poor culture as well as status and hierarchy were linked to these bad experiences. Central to this thesis is the notion that collaboration and respect are likely antidotes to these destructive influences and could create positive learning cultures if championed effectively, enabled, and enacted. And for this work to succeed, I recognized that I needed to unpick the culture in my workplace looking at our leadership styles and hierarchy as well as our relationships within the organisation.

3.2.5a Organisational educational culture

There is widespread recognition in the literature that executives create the 'tone at the top' that shapes the ethical climate and culture of an organization (Clinard, 1983; Posner, 1992; Treviño., 1998; Victor,1988; Weaver, 1999) as well as the organization's strategy (Freeman, 1988). These dimensions of executive leadership

are thought to be uniquely important because of the executive's potential to influence employee and organizational behaviour. Yet, Yukl (2002, p. 251) raised, and many social scientists have also noted, a 'dark side of charisma' (Howell, 1992). Parry, (2002) suggested that transformational leaders who manipulate behaviours might reasonably be labelled 'narcissistic, manipulative, and self-centred'.

I pondered, many times, while undertaking this EdD journey how the culture of a healthcare organization and, particularly, the import apportioned to education and training is linked to success. In a recent GMC commissioned report, medical ethics consultant Shale (2019) drew on 27 in-depth interviews with senior medical leaders (conducted during 2018) to examine their understandings and lived experience of trying to establish and maintain a positive "patient centered culture" in their healthcare organizations. Only one, a GP, was described as an educationalist while, two others were past presidents of Royal Colleges and so by implication, were steeped in postgraduate medical training[16]. The participants all acknowledged that a supportive approach to trainees results in desirable feelings of security and belonging. Shale found that the interviewees frequently referred to this support as a feature of group culture and how trainee/management interactions were indicative of good culture, clinical outcomes and predictive of good or bad communication with patients. Several leaders cited the quality of the training environment within NHS hospitals as critically important to overall culture. On a pragmatic note, the interviewees professed how good educational practices supported trainees effectively and as a reward more junior doctors were eager to apply for posts in places where they had enjoyed training. Shale's work (ibid) not only suggests the high value leaders placed on trainee experience but also demonstrated the power of qualitative research to explore complex organizational issues and additionally supports the methodological framework I used to explore my professional practice problem.

Analogously, it is likely that DMEs leadership values and styles, like those of school principals, influence trainee doctor experience and outcomes. Research points to the significant impact of school principals' behaviour on student outcomes. This is believed to be chiefly, mediated through the principal's impact on school culture, climate and the strategies they employ to support and encourage high quality teaching practices in their schools (in Houchens, 2012). The term instructional leadership

[16] Royal colleges have important roles in setting curricula for post-graduate medical education and in examining to ensure standards of training are met.

emerged in the 1980s when the belief that the key to running successful schools lay in the head's role (Hallinger, 2010) was popular. While acknowledging the importance of the individual leader, this style of leadership aligns to distributive, shared and transformational models. Linking back to EI, relationships, building bonds and nurturing instrumental relationships (Bliss, 2006) between teachers and principle, building trust, collaboration and prioritizing a supportive work environment are key elements that resonated with my work.

3.3 Ways of working collaboratively in healthcare

Traditionally, healthcare organizations have set out to learn lessons from practice to improve care through focussed project work, external reviews, and tribunals. These exercises have usually resulted in recommendations and often mandated interventions. However, Cousins (2008) points out that it is very difficult for organisations to achieve desired changes in practice (his setting was in Carolina, USA). Deeply embedded professional boundaries and relationships have been found to inhibit collaboration in healthcare (Gittell, 2013). Thus, there are many examples where expensive reviews and recommendations and well-meaning collaborations have failed to make a difference. An alternative perspective is to take a more 'social' view of the phenomenon of learning. Much work has been done to understand the "collaborative advantage" (Gittell, ibid; Lasker, 2001; Smith, 2015; Suter, 2009; Nystrom, 2018) in the hope of taking better advantage of it.

Healthcare communities of practice (CoP), although known by different terms, all share a common interest whereby healthcare workers collaborate to enhance their practice, promote professional expertise, and augment institutional knowledge.

Lave (1991) first developed the CoP concept to represent deliberately devised situations where more experienced members impart their knowledge to less experienced colleagues. This was later refined by Wenger (1998) as "the continuing interaction by a group of people with common concerns and problems or a passion for a subject, or who are looking for practice improvement". The word practice implies action as well as learning and learning through action. Characteristics such as high trust, strong shared cognition and mutual commitment are key.

Turner (2017) posed the question "Why would busy, dispersed, knowledgeable project professionals want to join and participate in a deliberately-organised CoP?"

His 2-year collaborative action project allowed the research team to observe the CoP and its membership at close range. Their conclusions aligned very much with West (2017) i.e., that autonomy, belonging and competence (ABC) underscore participation, co-production, and diffusion of innovative problem-solving and practice even beyond the CoP to local personal networks. They observed aspects of community formation and participation (i.e., membership, attendance, and outputs from joint activities). They perceived that learning in more organic emergent communities is unintentional and contextualised through working closely together on a shared problem. In contrast, they concluded that learning in the modern deliberate communities of practice is goal-oriented, solutions-focused, and individualised. Lindkvist’s (2005) presented a similar view that some groups were characterised by strong goal and task orientations with notable transient relationships and transactive socialisation as opposed to deep or lasting bonding. Roberts (2006) too was unconvinced that management for example can engineer a CoP successfully. The need to balance control and autonomy is a dilemma that he and others claims in unresolvable especially in dispersed networks (Agterberg, 2010).

Chapter 4 Research design and methods

Chapter overview

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4.2 Self-Study: What is it and why did I choose it?

4.2.1 Key theories underpinning SS research (Appendix IV)

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Chapter 4 Research design and methods

Chapter Overview

This chapter builds the case for using SS with autoethnography and collaborative action research in this work. It describes the study design, the research tools used and how data was generated, managed, and stored. It charts how participants were selected and recruited and how the study was extended and adapted (within the agreed study framework) as the COVID-19 crisis took hold. It describes and justifies the triple inductive, deductive, and abductive approach used to analyse and interpret the largely qualitative data.

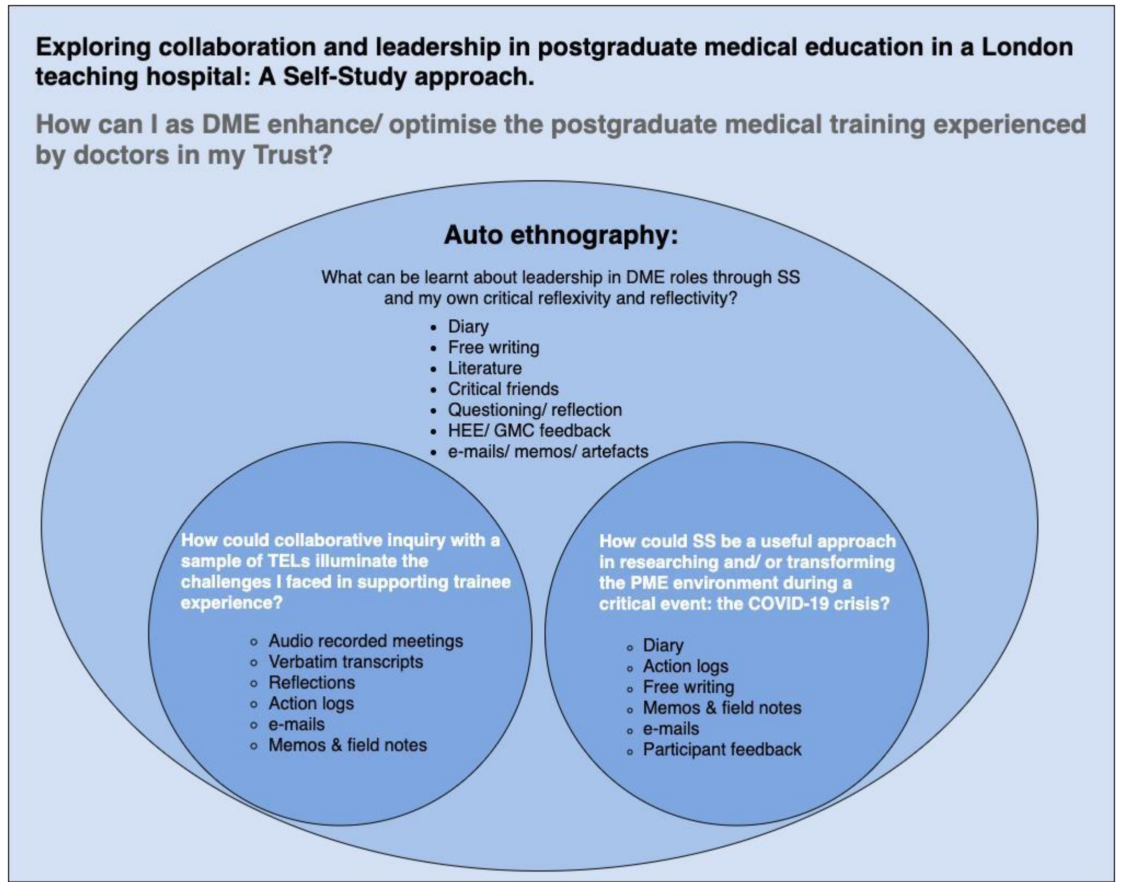
4.1 Overview of study design

This chapter is structured to first describe the rationale for using SS and details the methods used in each portion of the design. It then charts how data was consented,

collected, validated, triangulated, actively examined from different perspectives, analysed, made sense of, and finally, how theories were developed. It explains how I linked all three portions of the study and considered wider relevance.

It is worth noting however that, although a reader will be able to replicate the steps I took, the situations described were unique and cannot be reproduced precisely. Similarly, interpretation of events and analysis of data is necessarily partially subjective. For this reason, I have paid particular attention to how I ensured the work was valid and trustworthy.

This SS consisted of three separate but linked parts (see Figure 1.1 reproduced again here for clarity).



Importantly, as this study unfolded, the emotional capital of the DME role emerged more and more strongly. Thus, the following emergent question arose. *How does an understanding of compassionate leadership shape/change the DME role?*

The first component of the work was an overarching auto ethnographic case study that I used to explore my performance as DME and my relationship with others in the senior faculty especially TELs, rigorously. The second was a collaborative venture with a small group of volunteer TELs following a collaborative AR framework, referred to as the CAR study. These projects nested within an overall SS paradigm. The third portion of the study is an account of, and reflection on, my COVID-19 (wave 1) crisis response as DME within my NHS hospital trust. The co-incident timing of the crisis and this SS research thesis very much shaped my leadership thinking and my actions. The PME COVID-19 taskforce emerged and together the group researched in a collaborative and active fashion. The inclusion of the COVID-19 response section in the thesis study was within the ethical approval envelope and was in line with SS philosophy. Loughran (2007) acknowledges the ambition, in SS, to address evolving questions. Thus, I interpreted the COVID-19 crisis as a real-time

opportunity to conduct emergent collaborative action research and, enhance the unique contribution and value of this research to the literature and to the healthcare community.

4.2 Self-Study; What is it and why did I choose it?

To justify SS as the chosen research methodology, I will briefly explain relevant aspects of its provenance.

SS is an increasingly popular and reputable research paradigm, in teacher education (LaBoskey, 2004a; 2004b). While components (action research and reflective practice) of SS research are already practiced in healthcare education and other parallels (e.g., quality improvement) are apparent, to date SS methodology has not been specifically used to research undergraduate or postgraduate medical education and, as such, a substantial research and literature gap exists.

SS of Teacher Education Practice (S-STEP) has been heralded "the single most significant development ever in the field" of teacher education (Zeichner, 1999, p. 8). Established officially in 1993 as a special interest group (SIG) of the American Educational Research Association (AERA) it has developed into a 'movement' which has been adopted widely amongst the international education community (reviewed in Vanassche, 2015). Examples of the personal, professional, and institutional benefits of this approach abound (LaBoskey, 1996; Loughran, 2007; Ritter, 2018). However, despite Zeichner's (ibid) bold claim, clear-cut definition of SS has been elusive. Bullough and Pinnegar (2004) write 10 years after the inception of SS:

> *"The struggle for definition has been central at every gathering of self-study researchers. Even now a satisfying definition remains elusive. As we consider this quest for definition, we find ourselves wondering: Is a definition needed?* "(p. 314).

Although precise explanation of SS is difficult, proponents do not advocate sloppy or imprecise thinking. Five, well established pillars are central to SS: 1) self-initiated, 2) improvement aimed, 3) highly collaborative, 4) uses mainly qualitative methods (often multiple, sometimes invented or unconventional) (Mena, 2017) and 5) must be demonstrably rigorous to assure trustworthiness, so that findings can be exploited by others in the education community (adapted from LaBoskey, 2004b). The SSist purposefully takes a particular stance as an 'insider' viewing his or her own environment through various lenses but also as an outsider drilling into and out of his

or her own praxis from many perspectives with a view to bettering it. Accordingly, SSists deliberately 'hold a mirror up' to their own thoughts, biases and actions actively seeking alternative views and perspectives on their own performance and how others perceive them (Pinnegar, 2009a, pp. 11-16). Sometimes, the SSist may also acquire different views through examination of key events or relevant literature (Hamilton, 1998b, p. 236), by using collaborative research (Samaras, 2010) and/or engaging with critical friends (CF) (Schuck, 2005). The perspective of CFs is recognized as particularly important in authenticating, interpreting, making sense of (framing and reframing) what is largely narrative data (Bullough, 2004). Samaras (2010) refers to this as "dialogic validity" (p. 211).

Importantly however, for my purposes, the SSist is simultaneously both conducting research and being the agent of change. This latter objective highlights the parallels with action research. Furthermore, despite the apparent solipsistic nomenclature SS does not limit itself to recording personal feelings and experiences only, but that SS provides an alternative entry into emotional as well as social and structural aspects of the phenomenon being described and explored.

4.2.1 Key theories underpinning SS research

For wordcount reasons I have included this section in Appendix IV: notes on SS and ethical considerations.

4.2.2 An absence of Self-Study in healthcare education

Vanassche (2015) identified 241 publications in journals and books, 'outside' the S-STEP community, between 1990 and 2012[17]. A total of 88 scientifically peer reviewed journal articles were eventually included in their "state of the art" data set of which 77 were empirical reports of SS research. Using the same keywords[18] but

[17] Vanassche et al. searched *Librissource Plus*: *Education Sciences*, *Google Scholar* and *Google* Books online. I used the same resources in my search. The key words used by this group were: "Self-study", "Self-study research", "self-study inquiry" and "teacher education" which needed to be used in the abstract, keywords or title. After screening the abstract and/or title the publications included needed to contain definitions, models and/or examples of empirical SS research.

adding several terms to capture medical education, post-graduate medical education[19] and/or healthcare training, in two Google Scholar searches[20], I found only 2 articles where SS (excluding those describing self-directed learning) was referenced in a healthcare education setting. One gave an account of a nurse researcher and educator who used his own experience of a retinal detachment in an autobiographical commentary on the lack of compassion he experienced when he transitioned from an outsider to an insider in the healthcare world (Mercer, 2007). In the other, Fragkos (2018) a UCL medical educator, proposed SS as part of a 'chain' model of teacher educator improvement.

4.2.3 Autoethnography

Autoethnography is a form of qualitative research often used under the SS umbrella. In it the author uses self-reflection in diaries and other writings to explore anecdotal and personal experiences and connect this autobiographical story to wider cultural political and social meanings and understandings (Ellis, 2011; Hayes, 2015). It has advantages, disadvantages, limitations, and criticisms. Many of these overlap with those levelled at qualitative research and the overall SS paradigm. Yet, I contend that it fitted my study purpose well. Thus, having used this method successfully in the IFS portion of my EdD, I returned to it once again, to explore my local practice problem, mindful of the quality guidelines in autobiographical forms of SS (Bullough, 2001; Méndez, 2013).

Boucher and Ellis (2006) are equally credited with popularising autoethnography and describe it as a "genre of writing that displays multiple layers of consciousness, connecting the personal to the cultural" (p 739). I reasoned that my diaries and free writings would provide a 'millefeuille' of situated data to work on. Studying the complexities of everyday life using organisational ethnography, Ybema (2009b) includes amongst the advantages: studying of phenomena in their own natural setting; issues under study being interpreted in terms of the meaning people bring to them; a more holistic and humanistic stance; researchers drawing on their own experiences to understand a problem. Further, the auto ethnographer can reflect and comment on their experience of the research process as it unfolds and on how the research of the

[19] "medical education", "medical teaching", "medical training", "healthcare education", "healthcare teaching", "healthcare training", "post-graduate medical education", post-graduate medical teaching", "post-graduate medical training",
[20] Google Scholar search last conducted on 1/12/19

specific question affected them. My intention, therefore, in this thesis, has been to take advantage of all these elements as I reflect on my leadership role and work relationships.

Kyratzis (1997) described auto ethnography research as "… *(a) double narrative process, one that includes the narratives generated by those participating in the research, and one that represents the voice of the researcher as narrator of those narratives*" (p. 23). Ellis (cited in Méndez, 2013) contends that the narrative should be intimately related to the particular phenomenon under study and that the narrator should be able to capture the minds and the hearts of their readers. Some authors speak of 'analytical' versus 'evocative' approaches in autoethnography reporting. The former privileges factual details, while the latter is more concerned with the cultural interpretation (in Bochner, 2016). Throughout, I have been true to the facts of events but have taken a more evocative line in my writing up, purposefully setting out to draw the reader into my world by telling the stories of events pertaining to my lived experience of postgraduate medical education leadership both during ordinary and extraordinary times.

Clearly, positioning within an inquiry is an important concept. Reed (1997) suggest that the auto ethnographer asks where he/she stands in relation to the research: 'inside' or 'out' and whose voice is being heard (p 3-4). However, Ellis (2007) proposes a more adaptable interpretation suggesting that the successful auto ethnographer moves back and forth between experiencing and examining a 'vulnerable self' and observing and revealing the broader context of the experience. Hitchcock (1995 cited in Méndez, 2013), too, contends that writing in the first person provides the researcher with a transition from being an outsider to an insider, in autoethnographic research. Along similar lines, Richards (2008) reflects on the emancipatory nature of autoethnographic reports and believes that, for many, it represents the right to tell the truth as experienced, a view point that certainly resonated with me.

Proponents of autoethnography consider that the data is easily collected. Yet, if the ethnographer chooses an evocative approach, honesty, and willingness to self-disclose, going beyond the mere recording of events, is required. Some researchers find this uncomfortable and deliberately avoid first person, in favour of, third person

more dispassionate narration (Wyatt, 2006). According to Ellis (2007) just as feelings may be unpleasant for the researcher chronicling their story, the effect on the reader, whose interpretation is subjective, un-predictable and possibly profound, must also be considered.

Likewise, the problem of evaluation (as with all qualitative research) is vexed. The limitations of analysing personal narrative, necessarily extend backwards to the validity of methods and forward to conclusions. Walford (2004), for example, clearly does not rate autoethnography. He goes so far as to comment "if people want to write fiction, they have every right to do so but not call it research". From his perspective the aim of research is to 'reduce distortions' not to invite them (p 411). Atkinson (1997), analogously, criticises 'illness narrative' accounts as often therapeutic, rather than analytical and calls for increased rigour. Yet, Thomas (2010) uses her own cancer research study of illness narratives to partially counter Atkinson's stance. Richardson (2000) advocates that autoethnography should be "treated as a science and as an art" (p 254) i.e. reports making substantive contributions while also having aesthetic merit. Bochner (2006), on the other hand, believe that the autoethnographic researcher should "show people in the process of figuring out what to do, how to live, and what their struggles mean" (p 111) so as to generate new knowledge but also provoke thoughtful reflection on similar experiences the readers may have. These latter three views chimed well with my thesis purposes.

The consequences of writing up, too, can be problematic and are more relevant in evocative autoethnography where relational ethics need to be considered. Ellis (2007) advises abiding by the familiar principles of 'do no harm' (p 6) while Medford (2006) suggests, "writing the truth as if all those involved were listening" (p. 862) paying attention to what to put in and what to leave out.

For Myers (2019) compassion and nurturance rather than simply avoiding harm became important in her study of accounting students' experiences in South Africa. Indeed, she found that even the process of acquiring data by interviewing students was emotional. Being a neutral observer seemed disrespectful and she had difficulty asking for revelations of others while revealing nothing of herself. She decried the alleged 'professional or neutral' stance of the interviewer and claimed she would not have had such honest engagement with her students if she had not changed her

approach. Similar anxieties related to the concepts of compassion and nurturing were, I believed, at the heart of my motivation for and conduct of this work.

By choosing autoethnography, my intention was to follow SS principles to recreate my personal DME experiences in a reflexive and truthful story on which to reflect to expose wider issues and possible lessons for healthcare education leaders. This is, to my knowledge the first time this has been attempted in a postgraduate healthcare education landscape.

4.2.4 Collaborative Action research (CAR)

Action research is already a familiar tool in healthcare arenas, particularly nursing. The scale and breath of problems addressed is large (Koshy, 2010; Nichols, 1997; Titchen, 1993). Here, I have used one healthcare 'case study' example to illustrate the possibilities. Haddad (2011) and colleagues used CAR to help vulnerable communities in the south Indian state of Kerala, where relatively inequitable provision of public resources marginalized vulnerable groups and communities. Certain indigenous sets and women were particularly side-lined, meaning that their welfare lagged behind other social groups. The resulting goals of the, socially engaged, CAR initiative was to reduce inequalities in access to healthcare, in the rural community by designing and implementing a community-based health insurance scheme to lessen financial barriers to health care. To achieve this, they set out to strengthen local governance in monitoring and decision-making, and develop an evidence base for appropriate health interventions. This was a large-scale project involving Canadian economic and local public health expertise as well as a decade of funding and resident collaboration. Notably, the authors concluded that the positive micro-interventions developed and implemented succeeded solely because of this engagement. Other methods would likely have failed. Thus, this and other examples in the CAR literature, suggested real and meaningful potential that I was keen to explore. I determined that the TELs were perfectly positioned to be ideal collaborators in this SS action research work.

4.3 Data gathering

4.3.1 Autoethnographic SS

I set out, purposefully, to collect, reflect on, analyse, and make sense of a rich tapestry of data to inform my autoethnographic inquiry. Throughout the study period, I made

regular detailed diary entries that recounted, facts and feeling about day-to-day events and interactions with education faculty, particularly TELs. In addition, I collected related but non-attributable e-mails, memos, and other artefacts to supplement, validate and contextualize the diary entries. Using field notes and from memory, I documented, as contemporaneously as possible, meetings and conversations with colleagues. Simultaneously, I diarised summaries of discussions with critical friends and other parties e.g., trainees, managers or consultant colleagues that related, directly or indirectly, to education and training and to my interactions with the faculty and TELs. To ensure capture, I put an evening reminder alarm on my phone, when I mentally rehearsed my working day to ensure that I have not missed any key events for the diary entries. I took special care to avoid any identifiable references unless expressly agreed with the relevant party. TELs, trainees and 'others' were coded in the records. The entries were dated, and time stamped and filed in chronological order. Throughout, I prioritized documentation and reflection of my own thoughts and behaviours as part of the diary exercise.

4.3.2 Collaborative action research (CAR) study

Overturning my historic governance hierarchy (Figure 2.2), I proposed that a portion of this research would be co-constructed, with a sample of volunteer TELs using collaborative action research (CAR) methodology (Samaras, 2010; Titchen, 1993).

This study stream involved 2 rather than the 3-4 TELs originally planned. This reduced number was the result of the unexpected and disruptive COVID-19 pandemic interruption to normal activity. The two TELs had already volunteered, and the CAR was well underway when COVID struck. A third and fourth TEL had been identified but not consented. I was unable to pursue these TELs once lockdown began. So, we worked in the two remaining collaborative pairs for scheduling and later social distancing reasons. AR principles and practices underpinned this work (Feldman, 2004; Kember, 2000; Kemmis, 1998; Meyer, 2000; Whitehead, 2019; Winter, 1998).

Each pair met face to face on at least 3 separate occasions, in accordance with the original research plan. We also met informally, communicated by telephone, and exchanged e-mails (recorded in diary entries) during the study period. Each formal meeting was audio-recorded and transcribed verbatim by me. These recordings lasted a total of 310 minutes. During the first meetings, we considered and reflected on the

current state of training in the TEL's landscape using GMC trainee survey data, inspection reports[21], local feedback information or the judgments of the participating TELs. We aimed to focus on specific examples of trainee experiences, where possible. Together we considered what factors may have influenced any findings. Using this dialogue, we generated ideas for making small/achievable changes and considered how to introduce or implement them. Action logs were generated, towards the end of each meeting, to record what was decided and how we planned to research specific queries prior to the next meeting. I took care to ensure these logs were co-constructed, were specific, relevant, owned, measurable, time-bound, and achievable (example Appendix VII). On several occasions the actions involved seeking additional or alternative evidence or views and necessitated detailing how this data could be gathered. The logs were then used as the starting point for the next meeting's dialogue. At each meeting, the CAR pair worked collaboratively to develop and then refine further plans that were recorded contemporaneously in further action logs. When the formal meetings ended further updates were added following telephone and e-mail correspondence. Additionally, I made brief field notes during the CAR meetings to aid transcription and recall.

As soon as possible after the meetings I captured my first impressions of the meetings in diary entries. Within 2 days, I transcribed the conversations verbatim (examples Appendix VII). Then, having finished the transcriptions and using the action logs, I reflected on the meetings and the related events and correspondence as diary entries. Meantime, I sent the transcripts to the TELs to ensure validity and give them an opportunity to redact or add any further comments or reflections as agreed in the consent.

After each CAR meeting, I asked the participating TEL to record or write a reflection. I made specific efforts to avoid the TELs feeling pressured to submit these. Each TEL was also given the option of providing his or her own written diaries for use as evidence.

[21] I used inspection reports that were already in the public domain with additional permission from the trust's research ethics committee and the medical director.

Throughout, I paid strict attention to making any sensitive or identifiable data anonymous[22] and I assigned each TEL a (flower) pseudonym of their choice. All material was stored securely on a password protected, secure, non-shared laptop device and backed up in a secure cloud space.

During the CAR study period, in addition to typing the recordings myself, I set aside additional time to listen uninterrupted focussing specifically on my interactions with the TELs, actively hunting out assumptions and considering alternative meanings and perspectives. I listened for silence, aiming to capture any important 'unsaid' (Bruner, 1986, pp. 5-7; Brandenburg, 2011) elements. I documented my thoughts and findings in dated and timed diary entries.

As the study progressed, the recorded entry dates evidenced changes in my attitudes and behaviours as well as those of other colleagues, TELs, and trainees. I built these observations into further dated diary reflections. By doing this, iteratively, I purposefully held a mirror to my own practice in search of gaps between what Whitehead called my cognitive and lived consciousness (what I think I do and what I actually do) (Whitehead, 1996) and to see if this approach was making a difference to my personal, professional and organisational world.

4.3.3 Timed free writing

As mentioned previously, I skirmished with what I termed timed free writing (FW) in an earlier EdD assignment but discarded the results in favour of a 'safer' survey project. I was, however, very taken by the power, of this methodology, to unearth tensions, memories and assumptions I had little awareness of. I speculated that FW would help me in this current research endeavour. Thus, throughout the study period, I conducted regular (3-5 times per week) timed (5 minute) FW. These were marked FW, dated, and stored next to the closest diary entries. This activity was conducted mostly in the late evenings when the business of the day had been completed. Dewey (cited in Rodgers, 2002) suggests that the purpose of the FWs (stream of consciousness) was to unearth subliminal thoughts and emotions and to "*serve up the very questions that reflection can (could) productively tackle*" (p 849). I argued that I needed to (nominally) limit the time devoted to this activity and to formalize it to

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[22] In my writing up I altered some (and evidenced where) details to make sure departments could not be identified.

ensure it did not become too burdensome and fall into disuse. I placed an alert on my phone as a reminder and set a five-minute alarm before starting each entry. Some entries grew as I (deliberately) continued typing well beyond the allotted time. I continued this practice through the COVID pandemic. Thus, the free writing material developed into a parallel commentary or internal dialogue on contemporaneously diarised events.

4.3.4 COVID-19 crisis experience

On March 16th, 2020 the enormity of the approaching COVID-19 crisis became clear to me. By March 20th I was aware that I needed to re-deploy all our trainee doctors to care for the surge of patients presenting with respiratory failure and other symptoms of this previously unknown, potentially lethal, virus. By then, the hospital's medical director had charged me with ensuring that, not only were there sufficient non-consultant doctors available, around the clock, but that they worked in tight knit, stable teams with appropriate skill mix and senior supervision to minimize communication errors and encourage supportive relationships. This was a mammoth reorganisation exercise to be implemented after a 48-hour time window. I was (technically) assigned all the resources needed to achieve this. I slept in my office on the first night and in an adjacent hotel for the following week while the changes were planned and enacted and the pace and scale of the pathological storm grew. Over the ensuing 6 weeks I continued my diary and FW entries as time and energy permitted.

I reasoned that our best resource (for the re-organisation and delivery task) was the body of bright, motivated, and talented trainees. It quickly became clear that some should not be patient facing because of pregnancy or underlying medical conditions. An emergency CAR group became established quickly in an emergent fashion. The group met for one hour every morning (9-10am) after 'handover'. Some participants joined via Microsoft 'teams'[23]. We recorded minutes and created action plans (example Appendix VII) for each meeting. In addition to the non-patient facing trainees the "COVID-19 PME taskforce" as we designated ourselves, were joined by the elected trainee representatives who attended the meetings (when their medical duties permitted) and one volunteer TEL (not involved in the previous CAR study).

[23] This was optional to minimize the risk of virus transmission amongst the (largely vulnerable) group. However, later when individuals became positive for the virus and were isolating at home remote access became essential.

Formal administrative support was patchy so the team absorbed most of this activity[24]. I captured the essence of my early fears and hopes on a 'letter's live' radio event https://youtu.be/.cgAxKqfaLq4 (transcript Appendix VIII). I used my diary and free writing accounts of this time, together with reflections and communications from the trainees' involved, other colleagues and some contemporaneous general trainee survey feedback as data for this portion of the thesis.

4.4 Informed consent

For the CAR study, first, I invited expressions of interest, from all TELs, (see Appendix V for letter of invite) with the intention of selecting 3-4 TELs from the willing participants. I intended to purposefully select TELs to reflect different areas of practice (e.g., surgical, medical, paediatric, obstetrics, gynaecology), historical commitment to education, personality as well as age, gender, vintage, and experience. In the event and because of the COVID-19 intrusion, I was only able to select 2 TELs but they represented diverse areas of training and PME experience. One was male the other female and there was a 10-year gap in their age profile. Their backgrounds, education, management experience, personal preferences and ethnicity were also very different. Prior to final enrolment, I gave each a comprehensive plan of research and received written informed permission for the TEL/CAR encounters to be recorded, listened to repeatedly and typed verbatim. Once typed, I gave each participant the opportunity to comment on and/or retract any or all, of their recorded contributions. As soon as possible after acquisition, recordings were deleted and the participating TELs were informed, by e-mail, when this was done. At each session, consent was reconfirmed verbally.

Collaborating TELs were accommodated regarding times and duration of the meetings but although a minimum of 4 collaborative sessions were prescribed in the original six-month study period, I was forced to take a pragmatic approach once the COVID-19 pandemic hit and halted the face to face, transcribed TEL CAR component of my research early. At time of pause, I had completed 3 recordings with each TEL. Several further interactions occurred by e-mail, telephone, and videoconferencing as well as face to face with one TEL whose area struggled

[24] Once lockdown occurred the administrative team was advised to adhere to this national imperative and formal administrative support was largely lost for a period of 4 weeks.

significantly during the crisis. These latter dialogues were not recorded and typed. I did, however, continue to write diary recollections of these interactions and used e-mails with permission.

I discussed my research proposal with the trust medical director and the research lead. Neither wanted to read the details of my project as both felt UCL ethics approval was sufficient especially as the TEL participants were fully informed and as adults had agency over their participation and no patients were involved. Further, the medical director confirmed that he had no objections to my continuing to diarise the activity of the PME COVID-19 taskforce and reflect on these writings and events. The hospital's chief executive gave express permission for the "letters live" radio transmission.

4.5 Data analysis (inductive, deductive, and abductive reasoning)

In the first instance, for the autoethnographic SS, I read and commented on the written material at monthly intervals. I then subjected the written material to preliminary inductive thematic analysis using NVIVO software to order and store data. I conducted 2 cycles of this to ensure capture and saturation of new ideas. I did not attempt to perform exhaustive thematic analysis once this was done. Later, I re-examined the data deductively through pre-defined, purposefully separate, personal, professional, and organisational lenses in search of any missed insights and understandings. In addition, I re-categorized the initial inductive themes into the same personal, professional, and organisational themes as a mechanism to impose structure on the large amount of data and triangulate the evidence. In fact, each theme lent itself easily to these three categories.

By listening to and personally transcribing the CAR recordings, verbatim, I became very acquainted with their content and nuances. Searching the literature for evidence to support the importance of a researcher transcribing I found that Brandenburg (2011) agreed that transcribing was integral to the development of an analytic focus. As well as listening to transcribe, I relistened to the recordings several times (average 3 times per recording) to capture silence, mood, and hidden meaning. Once transcribed, I read and reread the dialogues together with the narrative data from the diary and FWs and field notes relating to the recordings to further ensure familiarity.

Each entry had been dated and coded[25] to help unearth the evolution of meaning or changes in thinking or behaviour which I actively sought. In addition to the diary, FW, and field notes the other constituent elements (reflection on relevant literature, artefacts, e-mails, recorded discussion with CF etc.) were dated, labelled sequentially, and inserted into a master document to aid the longitudinal analysis. For most of the artefacts I attached contemporaneous narrative explaining the relevance of these elements to the research endeavour. I used Socratic questioning periodically to delve deeper into my thoughts, perspectives, and reasoning and narrated answers to these questions in dated order.

The transcribed data accrued from the TEL transcriptions and narratives relating to the COVID-19 CAR study element was analysed only through the triple, personal, professional, and structural lenses i.e., inductive thematic analysis was not performed on this portion of the narrative.

As the largely written and occasional artefactual material was gathered and interpreted, I moved backward and forwards, through the data to check understanding and interpretation as well as to ensure triangulation and validity. Pinnegar (2009a, Ch 6) was used as a guide. Insights and interpretations were verified, sense-checked and commented on by CFs, at intervals. Throughout the study period. ZK[26] reviewed much of the primary diary data for recall accuracy and offered analytic perspectives. Through regular discussion (3-4 times per week) she also provided checks of meaning or interpretation for additional authenticity. FG provided a sounding board for ideas and dRS repeatedly prodded me to theorise and associate meanings. Both FG and especially dRS pointed me to literature that further informed my thinking and insights. Both also discussed concepts and interpretations as the Socratic questioning helped me understand what was going on and consider the broader (so what?) relevance.

[25] I recorded the time of most entries although there were a handful of entries where I omitted to insert the time. ‘Others’ and departments or locations were coded with de-identifying letters.

[26] CFs details were as follows. ZK was a member the PME faculty (an senior administrator with vast experience in PME) FG was a clinician and educationalist from outside the PME senior faculty. The latter became a much trusted ‘study buddy’ as we completed our EdDs together. My primary supervisor dRS too became a very significant CF. JB (my second supervisor) provided invaluable critical friendship particularly in relation to building and evidencing arguments.

Cross referencing also helped unearth further relevant literature. A systematic review of published SS works by Vanassche (2015) exposed four characteristics tensions (relevance, rigour, understanding, effectiveness) common to SS and provided an emergent opportunity to further examine the validity of my SS using this framework.

Additionally, secondary evaluation was applied to the study using abductive reasoning. This was a search for 'best fit' explanations for what had emerged (Mitchell, 2018). This form of logical inference is credited to the pragmatist and philosopher Charles Pierce (referenced in Kennedy, 2018). Abduction has its roots in expediency and simplicity as well as exploration and discovery. Vila-Henninger (2022) believes it is a "fruitful avenue" for qualitative analysts to build theory from qualitative research work. It works in reverse ('retroductive') order starting with an observation or set of observations and then seeking the simplest and most likely conclusion from the observations. The deductions are thus, plausible but are not wholly verifiable. It is acknowledged that the researcher's social and intellectual position, (aided by methodological analysis of the research evidence) combine to reach the conclusions.

The concrete implementation of abduction is acknowledged to be underdeveloped although the abductive analysis is intended to be enriched through the processes of revisiting and defamiliarization of data. Vila-Henninger (Ibid) has devised coding tactics based on Timmermans' (2012) three stages of abduction: generating an abductive code book, data reduction through code equations and in depth abductive qualitative analysis.

Rivadulla (2010) discusses the benefits using abduction to generate new ideas and commends the complementary role for different forms of reasoning. Inductive reasoning takes specific observations within data sets to reach general conclusions that may be true. It has been criticized because scant theoretical innovation seems to have emerged from studies privileging pure inductive or grounded reasoning (Walton, 2014). Deductive reasoning, on the other hand, applies general rules to data to reach specific conclusions that are then accepted as true. Purists and grounded theorists ask whether choosing any theories to apply to qualitative data is appropriate and how these rules are chosen and justified. Abductive reasoning also has the advantage of acknowledging that any set of observations is incomplete, and the researcher can only

reach 'best predicted' conclusions that may be true. Shank (1998) argues that although abduction "is the ground-state, or default, mode of cognition" all three (induction and deduction) are necessary for any complete model of cognition. According to Behfar (2018) abduction is often present but "unnoticed" and sometimes misunderstood or misused in the form of "over-assertion".

Theory construction from qualitative research, thus, becomes an ongoing pragmatic process of "puzzling out" and problem solving that draws on existing ways of understanding what the phenomenon "is a case of" (Ragin, 1992; Tavory, 2009; Winship, 2006). There are obvious synergies with clinical diagnostic methodology when patients present with a story together with a set of symptoms and signs and the task is to work backwards to a differential diagnosis, with ensuing investigations and ultimately a move towards a management plan (analogies explored in Behfar (ibid). Common ground is the discussion linking data (history, symptoms, and signs) and the generalizations ('best fit' diagnosis) to account for empirical findings and come as close as possible to the truth, while acknowledging that truth. According to this notion clinical investigations and discussion with colleagues, is allowed, to refine the diagnosis. In summary, abduction starts with consequences and then constructs plausible reasons pointing to data or discussions of data to validate the most likely 'diagnoses'. Clearly, this kind of reasoning is very familiar to me after more than 30 years in clinical practice.

4.6 Alternative perspectives

I used a variety of tools to identify alternative perspectives. Techniques used in insider research, to make the familiar unfamiliar and increase trustworthiness were employed (Greene 2014). For example, I cognitively rehearsed events from the perspective of others or asked CFs to recount their impressions of certain events. I used formal Socratic dialogue (Knezic, 2010; Swaminathan, 2017) to question and to clarify concepts, probe assumptions, rationale and evidence, as well as to re-question my own viewpoints and perspectives and assist reflective practice. Further, doodling, mind maps and writing critiques of articles helped me to clarify my thinking. All the time, when reading the literature, I asked myself why a particular article resonated with me and how and why it enhanced my situational understanding. Later, I used the "so what" question repeatedly. I revisited my doodles and mind maps reimagining my thinking and seeking further insights. I actively sought to triangulate using, routinely collected, formal and informal feedback data from trainees and colleagues. I recorded

my new thinking in diary entries. Occasionally these topics became the subject of my FW. Other evidence such as e.g., routine surveys and inspection reports were of limited value as the COVID-19 crisis put an end to the national trainee survey for 2020 and other planned inspections. However, during the COVID-19 pandemic we conducted several in house trainee surveys as part of COVID-19 CAR evidence gathering and data from these surveys informed the taskforce group's actions.

4.7 Validity, sense making and theorizing

My local CF endorsed content validity by variously reading, discussing, and questioning selected primary data, case studies and thematic narrative analyses. Together, we examined professional encounters that appeared to go well and some that appeared doomed, to understand the key drivers. We regularly discussed the organisational influences that affected our personal and professional performance at work. I often admitted my frustration and together we sought to understand the underlying tensions. I recorded our discussions as contemporaneously as possible. Noble's (2015) work on assuring validity in qualitative research was particularly apt here as it pertained healthcare environments.

In my diaries, I questioned why issues and ideas had surfaced in my FW. Thus, the credibility processes of reflection and reflexion, critical friendship and dialogue, triangulation of evidence, positive and negative case analysis (what went well and what appeared to go badly) as well as reference to education and medical healthcare literature was utilized to make sense of the data and generate theories to explain it. As above the 'bricolage' of data was subjected to the triple analytic process involving, induction, deduction, and abduction.

4.8 Ensuring trustworthiness

Questions of truth and trustworthiness pervade the SS literature (LaBoskey, 2004a, 2004b; Loughran, 2007; Mena, 2017; Pinnegar, 2009a; Whitehead, 2004). Several authors have published guidance to help minimize this disquiet (Craig, 2009; Feldman, 2003; Mena, 2017). In keeping with the 'rules' of self-study research my work employed a broad range of qualitative methods, most of which involved narrative in one form or another. My diary entries were created as close to the events described as possible to ensure they were contemporaneous and accurate. Throughout the study period, a nightly alarm reminded me to make diary entries to capture

significant events. Several entries were read and checked for accuracy by my CF (ZK), as mentioned above, with whom I worked closely and conversed 3-4 times per week during this time. Recalled meetings were discussed with ZK to ensure my recollection of factual events was accurate and that interpretation of meeting mood, relationships and outcomes were as accurate as possible. E-mails and What's App messages were transcribed verbatim.

Literature was used to gain better understanding. While studying these articles I created commentary and analysis narratives and captured thoughts in additional narratives. As stated previously these were filed, in date order. together with other diary and FW entries to further sense check, link events and triangulate data.

FW, recorded thoughts, and feelings could not be validated, as such, but were often discussed with CFs to gain broader perspectives and stimulate more reflection. Art, poetry, and cartoons are available for scrutiny and they were linked to diary entries where possible but also dated and stored in a physical journal. A small illustrative number are reproduced in this thesis, but others are available to view and may form the basis for other publications or be used in presentations. The CAR meetings were recorded and transcribed verbatim, after which they were approved by the participating TELs and are securely stored.

The narrative diary data was analysed using initial inductive thematic coding. This analysis was not intended to be exhaustive but rather to encourage different perspectives to emerge. The data was re-read several times to ensure that entries were assigned to appropriate initial themes and that nothing was missed. These opening themes were later reassigned to three pre-defined deductive categories: personal, professional, and organisational. This framework for deductive analysis was chosen to impose structure on the large volume of data. Abductive reasoning was then applied to uncover/identify the "best fit" explanation for the findings. Iterations of the data analysis were read and discussed by several critical friends. Two CFs (SA and DS) wrote commentaries on early drafts that were used to further refine the reasoning and write up. Where possible the views of others were actively sought and recorded in keeping with SS principles. Multiple discussions with supervisors also provided further dialogic validity. Relevant literature was consulted and functioned as a CF by triangulating themes, comparing situations, and adding new thinking. In the write up,

direct quotes from the data narratives were used extensively to support insights and further validate the findings.

While SS suggests a single researcher, Samaras, (2010) and others (Louie, 2003; Mena, 2017; Ritter, 2018) champion collaborative inquiry in SS research and maintain that it adds a further rigorous dimension. Thus, the CAR portions of my work add further authenticity. Finally, the written comments from the collaborators in the COVID-19 CAR portion of the study were stored unaltered and sections quoted verbatim as evidence for this portion of the study.

Ultimately, however, this work charts and analyses my lived experience. The facts concerning place, time, role etc. are irrefutable and I believe my diary entries could not have been compiled fictitiously. However, the nature of qualitative research means that interpretation is always open to criticism however credible the narrative. Phillips (1993, referenced in Craig, 2009; Pg. 21) sums up this conundrum as follows "the fact that a story is credible tells us nothing—absolutely nothing—about whether or not it is true or false". I acknowledge that reflection and reflexion can be refracted in the interpretation and the telling. Indeed, truth is a nebulous and complex concept and SS accepts knowledge as a temporary understanding to be built on as more new knowledge, which is often dialectic, comes to light (La Boskey, 2004a).

Yet, the holy grail for SSists is acceptance of the research by a peer community who thus recognize the validity and trustworthiness of the work. Several peer-reviewed papers have emerged from this body of work and again add to its trustworthiness.

Finally, the popularity of SS and its endurance, speak to its perceived trustworthiness and value as a research methodology amongst the teacher education community.

4.9 Exploring wider relevance

Although throughout, I interrogated the data for evidence of change in the attitudes and performance of TELs, trainees and colleagues, the key area of interest (in keeping with SS) was evidencing changes in my own thinking and doing as a leader.

In addition, I actively considered at all stages how SS methodology helped me to view my DME role through different lenses and how these new insights influenced my

conduct. Importantly, I also used this data together with literature insights and formal HEE documentation to ask the ‘so what‘ and ‘what now’ questions so as to determine what wider relevance my research had and how I could create a useful epistemological legacy for other healthcare educationalists to use.

4.10 Linking the strands of this SS research

Although, the purpose of the CAR recordings, field notes, transcripts, TEL reflections and diary entries was primarily to enhance the CAR project efficacy, participating TELs were consented specifically to allow me to, additionally, use this data to hold ‘a mirror’ up to, and examine my interactions with them as part of my auto ethnographic, parallel, SS. The arrival of COVID-19 and the emergent third component of the research study was informed and nurtured by my prior lived experience of SS and the TEL CAR project. The autoethnographic analysis and ensuing insights traversed all the research elements and helped me to tease out further aspects of leadership. However, I was also able to compare, contrast and link insights from the three elements and different methods. By taking this approach, I intended to enrich my understanding and learning and strengthen the trustworthiness of this work.

Chapter 5

Chapter Overview

Housekeeping notes
Introduction

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5B 1.1.1 **Understanding organisational culture**

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5B 1.2.1 **Painful reflection, and reflexion**

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Stage 3 **Responding to crisis: the COVID pandemic**

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5B 3.1.3 **Responding to crisis: the COVID pandemic: Complex Relationships**

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5B 4.1.4 Leadership reflections after action: Self-actualization as a leader

5.5 Reimagining the DME role

"…You are neither here nor there,
A hurry through which known and strange things pass
As big soft buffetings come at the car sideways
And catch the heart off guard and blow it open"
'Postscript' Seamus Heaney

Overview

This chapter is divided into two sections. The first (5A) describes how four key themes (context, tensions and emotions, complex relationships, and self-actualization as a leader) were identified by analysing the data using inductive, deductive, and abductive reasoning and explores their interrelationship.

The second section (5B) explains my DME leadership in evolutionary stages that move from dissatisfied struggling leader through to mobilizing collaborative actions to enacting a new leadership style during the COVID pandemic and finally after-action reflections. Each stage is framed using the four thematic headings to detail my 'lived experiences' and demonstrate how and why I changed my style from a traditional positivist/hierarchical triangular approach to a more collaborative/collective/compassionate/trusting one. It reflects what forces drove my personal incremental insights interweaving important contextual administrative, bureaucratic, organisational, professional, and political influences. It evidences how the new positionings and approaches I adopted were both effective and satisfying and encouraged me to continue in this vein. It recognises and exposes both organisational cruelty and professional injury but also underlines a dogged commitment to betterment.

Throughout, the illustrative examples showcase the rigour and value as well as the joys and challenges of the varied SS methods used as a gateway to this previously unexplored world. Thus, the chapter sets the scene for how the DME role could be usefully reimagined and I suggest a framework for approaching this in the final section.

Housekeeping notes

Direct quotes from the research data are placed in italics. Quotes from literature are in normal font and are attributed.

The written ‘data’ was extracted from the extensive diary and FW entries as well as from focussed reflective inquiry (RI), purposeful questioning pieces and critical analysis of selected literature. Some artefacts are also reproduced and placed in the context of the study. Accordingly, I deliberately illustrate the ‘bricolage’[27] (Kincheloe, 2011) approach as well as the reflexive and reflective philosophy of SS. I have adopted a deliberative ‘evocative’ as opposed to an ‘analytical’ narrative style to chronicle this auto ethnographic research as discussed by Bochner (2016).

Introduction

The title of this chapter, in particular the choice of the word ‘insights’, caused me, a great deal of hard thought. Rejecting more conventional summative words such as results and findings, I settled on ‘insights’ with deliberate intent. ‘Insights’ echo the real-life comprehension and potential transformative importance of SS as well as the spiralled ‘growth’ philosophy this work embodied. It reflects particularly LaBoskey (2004a) belief that SS shifts the discourse from “definitive answers” and the “rhetoric of conclusions” to “discussion of conjectures and possibilities” (p 1170).

Section A

5A 1 Inductive analysis: codes

Figure 5.1 illustrates the initial codes I identified during the first pass inductive analysis. I found that the discipline of coding and labelling diary and FW material was helpful. It deepened my understanding of my DME role, performance, and governance structures as I considered which category to assign each piece of text and the events or the thinking behind them. The initial codes also required me to begin to consider what, who, why, and so what, questions in relation to each entry and code. In the context of my study this approach further benefited my thinking and chimed

[27] Bricolage is a French term meaning ‘do-it-yourself’. It is also the name of a chain of French haberdashery stores. In the practical and fine arts, bricolage is the construction or creation of work from a diverse range of things that happen to be available. It can also imply ‘jack of all trades’.

naturally with the questioning and learning principles and philosophies of SS discussed in Chapter 4.

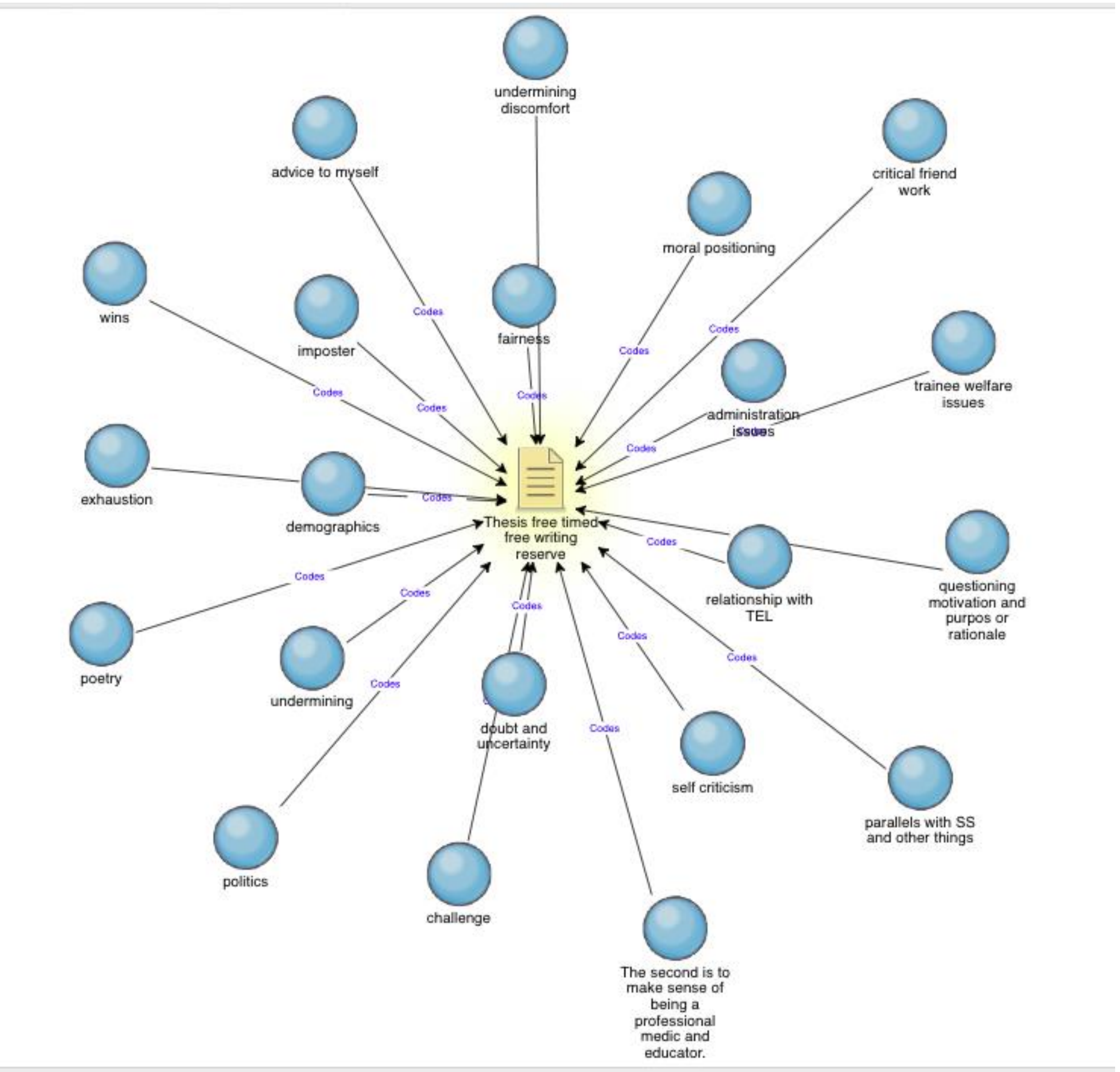


Figure 5.1 Initial codes made during inductive analysis of diary and FW data.

5A 2 Deductive analysis

The application of the planned deductive analysis proved problematic. I found that some of the initial codes identified in the previous analysis and other narratives slotted neatly into the pre-defined triple framework of personal, professional, and organisational groups. However, in some situations I attributed a code to two categories and in one case I assigned the code 'challenge' to all three. I began to consider how e.g., assigning 'undermining and discomfort' evidence to both personal and organizational groups acknowledged that it should not be attributed to my personal perception of feeling e.g., bullied, alone as the organizational issues

permitting it were also relevant. Hence, it belonged in both groups. Figure 5.2 illustrates this deductive process.

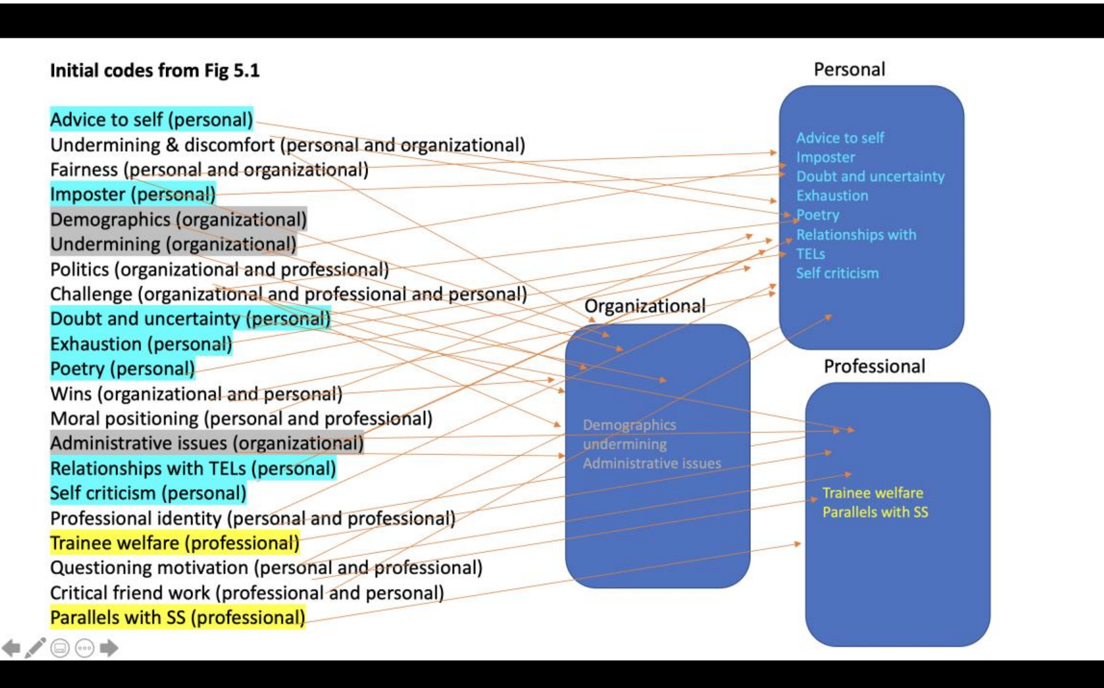


Figure 5.2 illustrates a portion of the deductive analytic process. Codes highlighted in yellow, grey, and blue were assigned to only one of the 3 categories (professional organisational and personal). I attributed those without highlights to more than one group according to the red arrows.

As I forged ahead, I became increasingly dissatisfied as I realized that most of the codes were influenced by personal, professional, and organisational issues. The crossing red arrows in Figure 5.2 illustrates this dissonance.

5A 3 Interim themes

Combining these analyses four secondary themes transiently emerged: emotions, injury, relationships, motivation and phronesis (Fig 5.3). I briefly further labelled them challenges, compassion, injury and mitigators and began to consider connections between them.

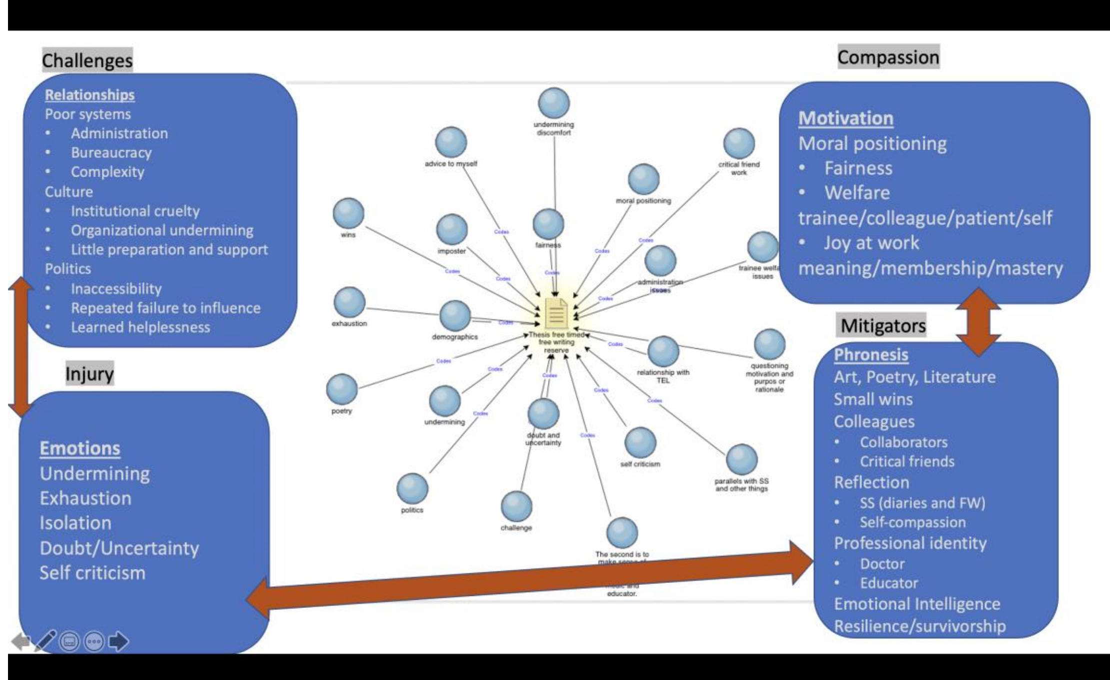


Figure 5.3 illustrates an interim iteration of the core research themes with their key components and inter-relationship.

My first analysis was packed with evidence of personal feelings. My narratives contained many examples of emotions experienced. More than 30 examples are listed in Table 5.1.

Sad "I *am feeling sad and disillusioned tonight"25/2/20* *I struggled to control my quivering voice..." 6/4/20*
Mad "*INFURIATING STURCTURAL OR ORGANIZATIONAL ISSUES.... "16/12/19* *"Really furious we can't get testing done" 27/3/20*
Anger "*How do you drag luddites with you?" 20/12/19* …" *but we can't even get the basic structural stuff right like lighting…AHHHH"* … 20/221 *…I have ranted for a solid 37 minutes. I needed catharsis but was it enough? The lump is still in my throat*" 24/2/20
Uncertain *'Is this a service or an education issue? Is it a personality issue or a professional issue? 6/1/20* *"Perhaps, this is not relevant, but perhaps it is very relevant"13/12/19*
Frightened "*I am reluctant afraid perhaps" 28/1/20*
Incredulous *"Still, virtually no testing! I cannot understand who is driving this thinking. We won't be able to move to the next steps without testing."15/4/20*
Ecstatic *"That would be fantastic D that would just be soo good. ……I think this is fantastic*" *19/12/20*
Satisfied *… I felt good and we both, I think, enjoyed the encounter 18/12/20*
Comfort *" the vast majority were very positive and some very vocal in their support for this innovate session" 13/11/19*
Spent *"I am once again sooo tired my eyes are closing.7/4/20*
Energetic "I am fully of energy"

"We had fun and we were both, I think, energized, I interrupted too much …great stuff" 10/2/20
Depressed *"Today was a weirdly sad day for me on many fronts. The signs of light at the end of the tunnel seem to be solidifying. Yet, I am uneasy that we will relax too soon. The daily death tolls (*national*) are still >800 but several other, on balance, more sad than happy, things happened today…" 16/4/20*
Determined "*I am trying to force the system to flex" 16/12/19*
Scared *"I am so desperate to protect our staff…" 27/3/20*
Confused "*No one has an idea what the right thing to do is." 9/4/20*
Vulnerable "*I won't be so vulnerable to hurt" 14/12/19*
Affronted "*with trainees feeling they are imposed upon…"6/1/21*
Insulted "*We are trusted as trainers and ESs to care for their (HEE employee) family members and they don't trust us to say whether a trainee who has put themselves in harm's way, to help patients, should be signed through"12/4/20*
Worried "*worrying about a trainee who had been flagged as having mental health issues" 14/12/19* *"3 more young colleagues have this now and I am nervous about each one" 12/4/20*
Concerned *"I was worried about being too overpowering" 18/2/2o*
Pride "*Thus, the very first CAR meeting opened a treasure chest of opportunity to improve"18/2/20*
Satisfied "*The ethos was one of deliberately flattening hierarchy so that each member, regardless of seniority, felt empowered to realise solutions to matters arising in real-time Trainee A feedback*
Inspired "*There is an element of self-nourishment that drives why I teach"* 8/12/19
Shocked "*I was shocked at this"*
Admiration "*I like and admire this TEL" 19/12/19*
Jealousy" I *am even a bit jealous of his teaching"19/12/19*
Hurt "*The gut reaction and the hurt cut deep"13/9/19*
Anxiety "…*dealing with my anxiety"14/12/19*
Isolated "*Can I trust anyone to help? I feel as if I am alone" 10/4/20*
Energetic "*I feel energetic. Each day I seem to extend to a new challenge I would never have thought I had space for"28/3/20*
Shame "*I was willing to sweep that 'truth' a bit under the carpet. i.e., I was harbouring double standards, or unconscious bias."18/2/20*
Reassurance "*This is entirely confidential, as we agreed…"6/3/20*
Frustrated *"I can't seem to get the message re. testing 'well people' through. I am cracking up." 14/3/20*
Undermined *I suspect he knows I am upset but is very kind. Yet, he asks me, again, to sooth B* and see what I can do to return his trainees" 25/4/20*

Table 5.1 evidence of 34 emotional adjectives that surfaced (in no order) in the narratives. Each is also identified by the date of entry.

The examples are intended to be illustrative rather than exhaustive and those highlighted in green are positive. These examples particularly emphasize doubts and self-criticism with feelings of isolation and being undermined also emerging strongly. At this point, I labelled these emotions under the heading injury. Similarly,

maintaining relationships in the context of the many challenges, discussed in Chapter 3.1, with systemically poor administration and heavy bureaucracy in a political context that promoted learned helplessness surfaced repeatedly. Against this background motivation and purpose was a key topic. This was founded in evidence of moral positioning, a sense of fairness, a commitment to welfare of patients, trainees, colleagues. Notably, later-on, wellbeing emerged. Along similar lines, the ambition of taking pleasure from work was present and manifested particularly in the CAR and COVID taskforce work. Finally, a strong thread of phronesis weaved through the data and helped mitigate the injury and survive the challenges. Practical tools such as reflection (instigated by the formality of SS), art and poetry, collegiate friendships on a background of professional identity (both as a doctor and an educator) were reflected often. Exemplar data supporting these assertions are evidenced later in section B of this chapter.

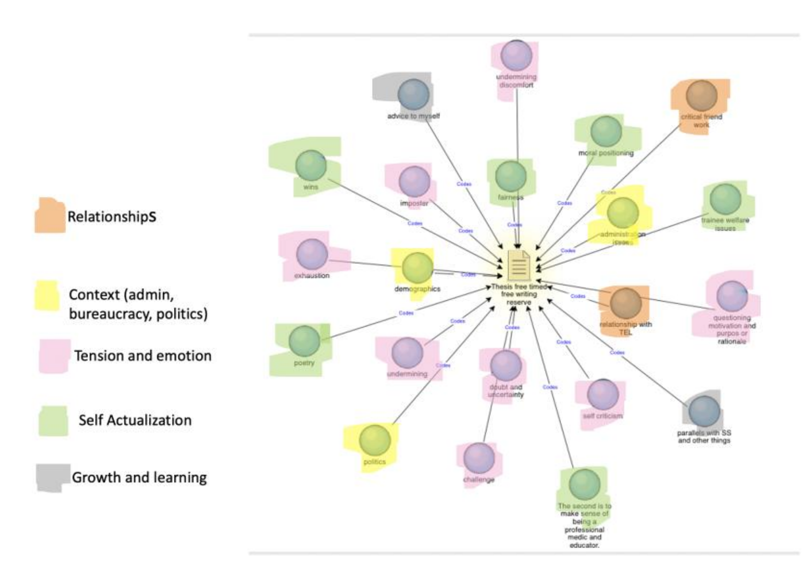


Figure 5.4 illustrates how the initial codes were linked by colour code to the 4 initial themes.

5A 4 Ultimate abducted themes

After several further iterations with the addition of abductive reasoning to find the 'best fit' descriptions, I finally arrived at Figure 5.5 that I contend captures and summarizes the four key themes in the narratives.

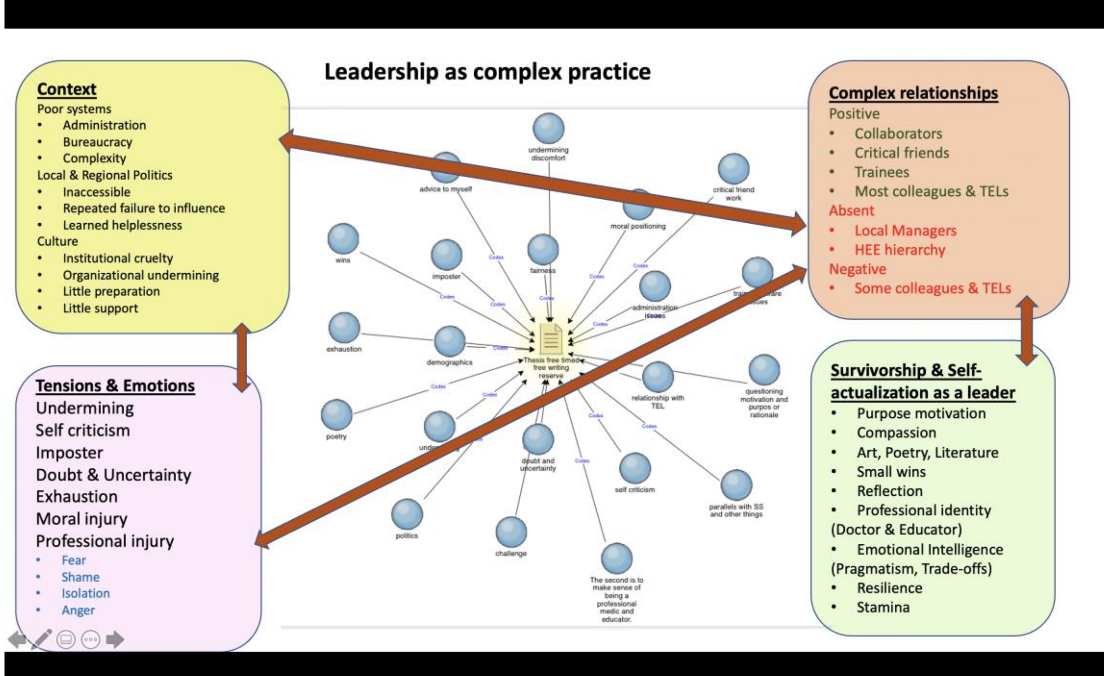


Figure 5.5 Final representation of the key research themes.

These ultimate themes: context, tensions and emotions, complex relationships and self-actualization as a leader are illustrated in Fig.
ure 5.5 with key words that I contend 'best fits' the data.

In Figure 5.5 the arrows purpose to show how the many contextual challenges excited largely negative emotions and made building positive relationships difficult. This in turn lead to professional injury that was mitigated by reflection, a strong sense of identity, emotional intelligence, as well as art, literature, and poetry. Stamina and resilience were also in evidence and I understood them to be important components of survival.

My deliberations led me to understand that the mitigators fit with authentic and compassionate leanings and are motivated by a moral position that privileges fairness, wellbeing, civility, and joy. I posit, that these four final themes, are validated through charting my leadership journey and examples from the data.

Chapter 5 Section B Leadership journey

This second section explains my DME leadership journey in evolutionary stages that move from dissatisfied struggling leader through to realising small changes locally to enacting a new leadership style during the COVID pandemic. Each stage is structured

under the four thematic headings outlined in section A with direct examples from the data, to illustrate and justify them.

Stage 1 **The dissatisfied leader**

5B 1.1 The dissatisfied leader: Context

Before continuing it is worth rehearsing the context in which I was endeavouring to lead. The DME role (Appendix I) is positioned within a complex healthcare organisational delivery system. Figure 5.6 illustrates the myriad of overlapping relationships with education and healthcare authorities, governance bodies, trusts, and university hierarchies as well as colleagues, trainees, locally employed doctors, patients, and other professional groups. Case 2 discussed below (*I've sent a series of e-mails to the 'great and the good'*) illustrates the difficulty of getting through to whoever could make an exception to the rule for this trainee.

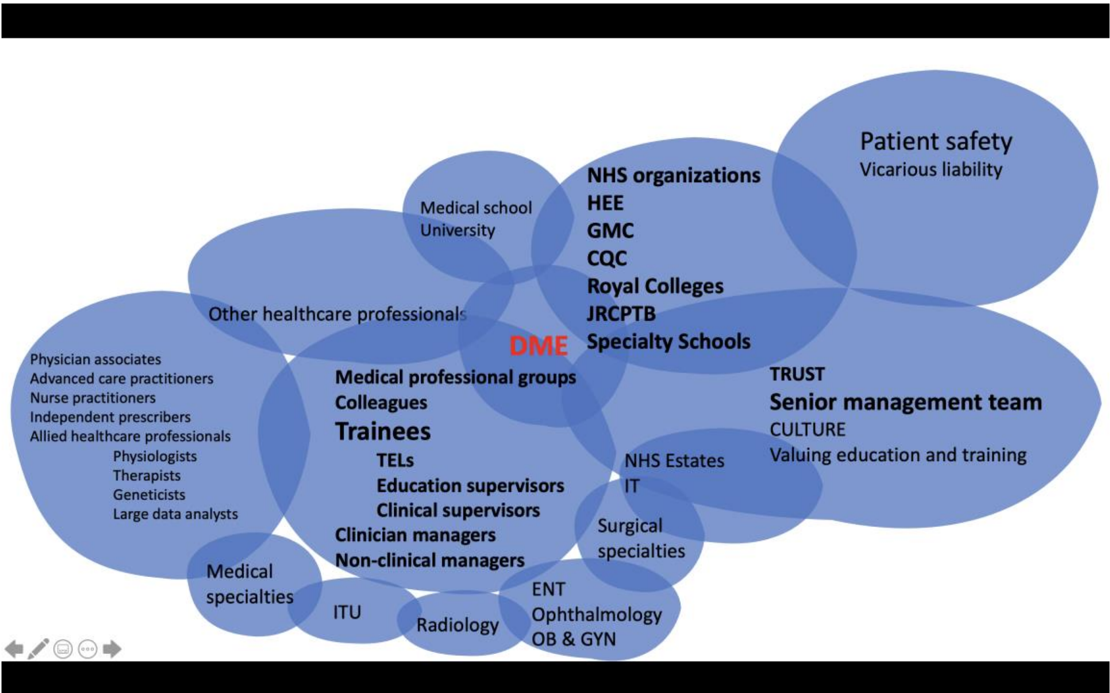


Figure 5.6 DME positioning amid the contextual complexity of healthcare education delivery.

My writings repeatedly raised issues of insufficient administrative support to help understand and manage this complexity. I voiced resulting irritations in my accounts. A code I titled 'administrative issues' (Figure 5.1) proved amongst the most heavily populated with numerous entries documenting evidence of inadequate support.

Examples include: *"It is an administrative task to organise? Can I trust anyone to help? I feel as if I am alone…"* on other occasions *"… if you don't try to fix it yourself it won't get fixed!"*. This tied in with findings in a survey I conducted amongst TELs in MOE2 (Burns, 2017) where once again a paucity of administrative help was identified by the responding TELs.

Yet, while trying to unpick this data, I wondered whether my administrative difficulties partly reflected my own failure to involve the support staff, in my thinking and improvement efforts. I asked myself if I could have privileged my own 'knowledge and skill set' above those in different roles? Did I harbour unconscious bias like many in healthcare delivery (discussed in 3.1.2)? Indeed, perhaps I had not in truth 'trusted' them to get involved or delegated effectively or appropriately. Was this a structural or organisational issue needing more resource or was it revealing a personal or professional deficiency or bias? By completing many tasks, myself as a 'pragmatic solution', was I perpetuating the problem? I concluded that there was indeed a dearth of administrative support but that I had not thought how to address this problem strategically. I had worked around the issue, made pragmatic trade-offs while raging internally. Thus, there was a clear need for me to improve my leadership style.

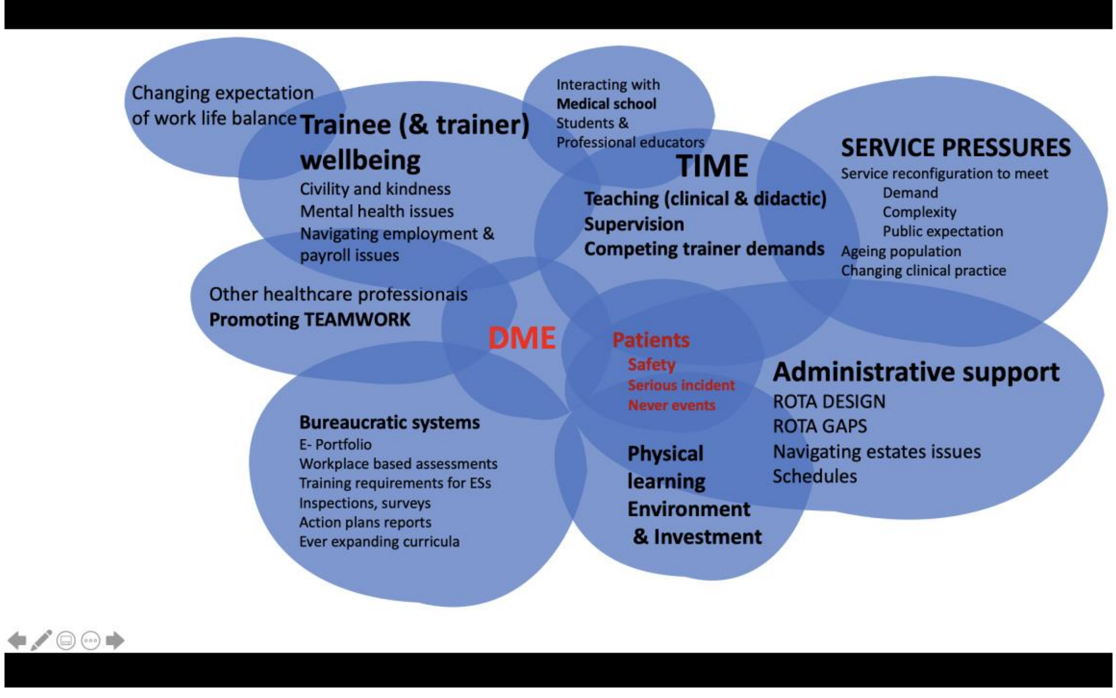


Figure 5.7 illustrates the many daily challenges faced by DMEs.

My data support that complex competing pressures likely hindered 'good' ESs and TELs in conducting their roles. Inadequate time allocation and competing service demands in the context of little administrative support and poor infrastructure for education were particularly obvious. The many challenges in modern healthcare delivery were discussed in Chapter 3.1.2. In the CAR transcripts both Daffodil and Tulip cited examples where pressures of service were privileged over education supervision and training events. Previously, insufficient time allocation in job plans featured in my MOE2 survey of TEL needs. Looking back at the survey sixty seven per cent of responders identified inadequate time and 83% inadequate trust resources (administration support, job plan and PA allocations) as barriers to performing their TEL role well (Burns, ibid). These observations bring critical focus to the resources allocated to education and suggest that despite our proffered Trust's triple mission of service, research and education, administration to support education supervision was under resourced and undervalued.

Similarly, there was much evidence that poor physical environment hindered learning and it was very difficult to orchestrate improvements in infrastructure and estates. In a post-transcription (after action) reflection shortly after a CAR meeting, I record how the 'inadequate' physical environment troubled Daffodil:
18/2/20 Diary: Reflections after action (RaA) (no time recorded)

> *"Daffodil immediately identified opportunities to improve all three learning dimensions when he raised the "Wednesday meeting" issue in the first CAR cycle. He described the 'them and us' seating arrangements as an example of the "hostile/intimidating environment that had inadvertently evolved over the years"*
>
> *"... Reflecting on this we proposed that if the physical environment where we interact with trainees, at a "badged" learning event, is not appropriate, we will likely fail to optimize opportunities ...... if trainees cannot see relevant data displayed on screens, or are discouraged (by hierarchical fear) from opening memory banks; to allow explicit knowledge to be revisited and revised, and most importantly, if they do not witness 'healthy' 'senior' behaviours and interactions, then the session is near wasted. So, our first action was to investigate how we could change the physical learning environment (in order) to not only enhance trainee experience of the written curriculum but also of the so-called 'hidden curriculum".*

Here, the professed and lived culture of the Trust was key. While the organization professed to take PME obligations very seriously and aspired to be in the top 10% of Trusts, this was strong evidence that neither the physical environment nor the

administrative support could be relied upon to optimise learning and there was a sense that “senior behaviours” were not “healthy” but they too were frustrated by similar issues. Daffodil too reported many ‘estates’ issues that felt small but were massively difficult to resolve.

In addition to the frustrations, we experienced in trying to achieve small improvements in the physical environment, (20/2/21 FW 23.20…” *but we can’t even get the basic structural stuff right like lighting…AHHHH” …*) a colleague and ES complained bitterly about the imposition that obligatory e-portfolio filling and signing-off placed on her ability to support trainees effectively. She asked whether the available funds “are used to prop up” what my colleague described as a “self-inflated” “self-justifying’ PME process. The following e-mail from this respected colleague (11/6/20) illustrates the frustration this ESs experienced in the field:

> *“I think the whole process has become self-inflated, self-justifying, and thoroughly stressful for the trainees to complete. I also struggle to find time to demonstrate ES training annually.*
>
> *If people like K*** are massively relieved to have been signed off, then the hurdles are too many and too rigid - she's amazingly good. Likewise, C*** is worried about getting through the process - one of the best IMT[28]s around...excellent doctor, great colleague to have on your team.*
>
> *… it is the process that is frustrating, the trainees are usually lovely…*
>
> *… I guess I think it penalises the competent majority.*
> *The incompetent minority just find people to fill electronic forms, who have spent little time with them and are happy to say they are "acceptable".*
> *The numbers being appropriately pulled up by this must be tiny relative to the work and worry it generates for trainees…”*

This extract also serves to illustrate how DMEs can come into conflict with colleagues who appear to hold the DME responsible for the entire PME/HEE/GMC/College ‘system’. Analogous convoluted tensions have been described by Sethi (2017) as discussed earlier (Chapter 3.1.3). Thus, a DME can be caught between enacting mandatory rules, (they may not agree with), looking after trainees’ wellbeing, protecting training posts in their organisation, and retaining the commitment of ESs. I felt powerless to address my colleague’s frustrations. I felt I did not even know where to begin. These ‘mandated’ requirements appeared to grow and grow becoming chiselled into hard stone. This consultant had been a wonderful ES

[28] Internal medicine trainee

and was much valued. I had witnessed how she stayed late or did whatever it took to support her trainees, often at the expense of spending time with her own young family. I pondered what sort of ‘acting charm’, or emotional labour (Chapter 3.2.4) would fit the bill in responding to this ES? I respected her too much to ’fake’ my support for the regulatory practises. I wondered whether high levels of scrutiny (required e.g., for ARCP) harm and undermine the holistic nurturing and developing of doctors rather than enhancing it as intended. The implicit lack of trust in supervising colleagues could be deleterious and certainly seemed to be breeding contempt for the processes. Perhaps a more ‘laissez faire’ trusting approach would achieve more? I asked myself in a FW entry whether you *“would pull up a plant every week to look at the roots and expect it to thrive*?”

In search of a better understanding of these contradictions I looked to literature again as a CF. I found Wallenberg (2010) who explored the Dutch experience of the introduction of a competency-based curriculum for PME. She used a mixture of qualitative and quantitative (“Q”) methods to investigate the different perspectives. She identified four distinct angles. The ‘accountability’ view expressing the importance of formal regulation and monitoring of results. The ‘educational’ perspective suggesting that the training process should be more formalised. The other views related to ‘work-life balance’ and finally a strong ‘trust’ based perspective emerged and was felt to reflect the ‘classic view’ of medical training in which role modelling and trust were considered most important. Reflecting on this work, I saw that each perspective had merit and that getting the right balance every time in every situation was impossible. The authors concluded that these four views evidence an interconnectedness between what they refer to as “old” and “new” values in medical work. This exercise allowed me to come to a more mature understanding of the conflicts and the interpersonal tensions I experienced in my organisational context. It helped me to see the historical drivers being played out as medical practice and views on professionalism changed. It forced me to begin to accept that “new” values in medical work demanded demonstrable competence acquisition but that the “old” values should not be neglected. It reminded me of how extensive the changes in healthcare have been (Chapter 3.1) and how education must adapt accordingly. A modern DME, I now see, is required to recognize these “new” contexts, and balance the variables as best they can.

However, my leanings, I concluded, still veered towards Crisp's (2020) views of "developing relationships (with)… less (emphasis) on systems and rules" (p. 65). My past and present experiences wanted to propel the pendulum backwards to re-enable ESs and trainees to flourish with more trust, agency and autonomy backed up by simple supportive, accountability structures. I began to believe that this change would make the experiences of supervisor and trainees more satisfying and may help to retain both in their respective roles without compromising patient safety or standards of care.

I could also appreciate that some leaders in healthcare education identify as administrators (transactors) actioning 'directives from above' regardless. Such leaders and like-minded TELs and ESs might find it difficult to hold the uncertainty of a more autonomous approach. The dilemma of balancing supervisory autonomy with assurance of optimal patient care is evident, in the literature as discussed in Chapter 3.1.4c. On the other hand, those who identify with the "classic" professional view may even resist and try to subvert unwanted directives.

Meantime, my day-to-day challenges, and operational position oscillated depending on the directives and my personal philosophy. The personal, professional, and organizational influences (illustrated in Figures 5.2) overlapped, expanded, and contracted constantly. Occupying this liminal and conflicted space was confusing and energy sapping for me. Stepping sideways to examine this case study helped me to understand what was happening and why I felt such powerlessness and irritation. The case also highlights how colleagues view work situations from different perspectives. They undoubtedly have their own training experiences and views on how to deliver meaningful education in parallel with healthcare provision. They each apportion their own heft and significance to varying power pressures. Acknowledging these influences was helpful.

5B 1.1.1 Understanding organisational culture

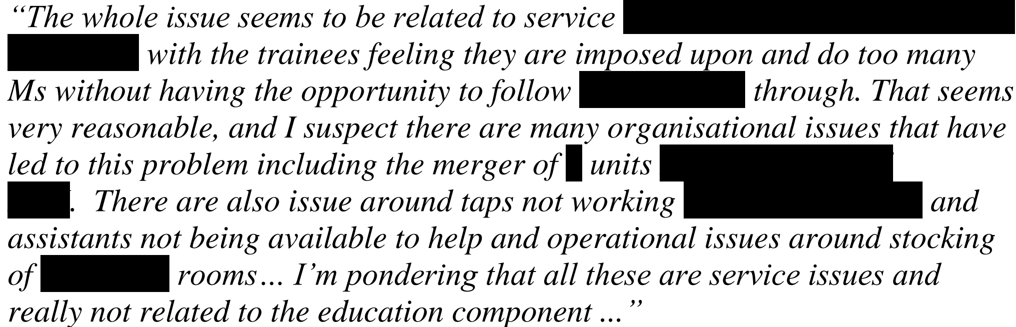
In Chapter 3.2.6 I reviewed some of the literature or organisational culture. The demands of service delivery getting in the way of training or creating a negative culture featured prominently in my writings. In this section I consider my annoyance and sometimes despair at our 'poor' organisational culture. However, I found that categorising the source of tension was difficult. The grounds for my frustrations were

often blurred, and uncertain and in many situations were tangled in a complex mix as illustrated in the following two diary entries.

20/12/19 Diary (no time recorded)

> *'Is this a service or an education issue? Is it a personality issue or a professional issue? My heart is sinking just prior to Christmas as I envisage a snake pit of issues and already with the tone of the e-mails, I sense a real tension. How can we/I unravel this?*

6/1/20 Diary (11pm in relation to the entry of 20/12/19 above)



> *"The whole issue seems to be related to service [redacted] with the trainees feeling they are imposed upon and do too many Ms without having the opportunity to follow [redacted] through. That seems very reasonable, and I suspect there are many organisational issues that have led to this problem including the merger of [redacted] units [redacted]. There are also issue around taps not working [redacted] and assistants not being available to help and operational issues around stocking of [redacted] rooms… I'm pondering that all these are service issues and really not related to the education component ..."*

Clearly, though not directly related to education these day-to-day frustrations impacted on trainee experience and has a negative effect on the learning culture.

Reflecting on why service needs appeared to be repeatedly prioritised over training/education, I wrote the following 27/1/20 FW (10.25am)

> *"The service seems to always trump the education/training. The service is immediate all pervading, measurable… the missed education and training opportunities are not immediately a cost to the dept. Everyone wants everyone trained to a very high standard, but they think this happens without any investment of time or any cost to the service!!"*

In another example, I had encouraged a newly appointed TEL to attend an event entitled, "Educational Leadership: Secondary Care Educators" on 31 March 2020. The e-mail correspondence (into which I was copied) between the TEL and their clinical director 2 months prior to the event, went as follows:

> *"TEL to clinical director (CD): Hope you can support me attending this day. It will be the day after I return from annual leave.*

---

[29] Obscured to avoid identifying the area at the request of the TEL. The TEL responsible for this training area was very concerned that any material I used could not be traced back to the department so I have blacked out all references that could identify the specialty but not materially changed the issues.

CD to TEL: Sounds like an excellent opportunity. We just need to ensure that the service is covered."

The TEL reported a sense of helplessness, as they understood the "*We just need to ensure…"* as "you need to ensure" and that the organisation/administration rearrangements would fall to the TEL. Further, in that department no backfill arrangements were approved for such activities. Permission for consultants to attend career development events was at the discretion of clinical leads, on the understanding that service took priority.

The experience of tension and lack of support with pressure to deliver service was not confined to trainees and TELs.

16/12/19 Diary (8.40 pm)

> *"I'm not home long as I stayed to type my own clinic letters: an extra 90-minute task that I could have done in 10 minutes via dictation but no facility for same was available and secretarial support is erratic! INFURIATING STURCTURAL OR ORGANIZATIONAL ISSUES...."*

At the time of writing, I continue to rile at the paucity of 'bread and butter' support and what I believe is an 'over' reliance on portals with the near impossibility of talking to humans (in administration/management) continuing to impact on my own and our trainee experience. I was copied into the following e-mail from an ST7 (very senior) trainee on 25/6/20:

> *"I have still not been paid properly. This is 3 months now, and I have had basic pay docked several times - this is stacking up to be a reasonable sum and I have new commitments like the increased nursery fees …*
> *… Now I am in the unenviable position of liaising with a "portal" as there is no one in pay roll I can call."*

Enhancing trainee experience and creating an environment and culture that supports learning was clearly made more difficult by the large and varied number of operational problems that individually seemed surmountable but together amounted to a very challenging mountain. The common contours were lack of resource allocation and/or system organisation, as well as bewildering system complexity, over reliance on IT systems that were not fit for purpose and relentless service pressures.

These examples provide evidence of creaking infrastructures and systems as well as a negative even bullying culture in our Trust and in HEE during this time. The literature

relating to culture and bullying is explored in Chapter 3.2.5 with much evidence that our trust does not stand alone in this area.

I also felt conflicted as I harboured fears that in some respects I was colluding *("how can you drag luddites with you?", "I bypassed this TEL"*) with this culture while at the same time being oppressed by it ("*I felt tired and disillusioned*"). Reading my entries, I became aware of a learned helplessness ("*if you want something doing do it yourself"*) that I had developed unawares. The irony of how in medicine we learn how a bully supplicates his victim was not lost on me. Was the bullying systematic?

Here too, I refer to literature and my observations on language used to befuddle/oppress and the need for leaders to use clear unambiguous not artful/ lying/ disrespectful/ weasel language. Ibister (2022) talks of great leaders and the "art of straight talk". As an insider researching one's own world, there is a need to unmask what is hidden in plain sight. Figure 5.8 presents an example of how SS facilitated this. While reading through memos of HEE PME meetings, I was struck by the phrases I had jotted down. I selected 3 meetings at random and examined my field notes in greater detail. One meeting related to core medical training another, to foundation and the third to all training within the region. I listed the 'jargon' phrases and created a word cloud with them. This activity forced me to reflect on what I called "linguistic acrobatics". Why had I done this in the first place and what had I achieved by it? Furthermore, what implications did these reflections have for my work? Could these observations have a wider relevance? Firstly, the why was one of discomfort with what I perceive as an increasing overuse of buzzwords many with little true meaning? For me, this exercise exposed how pretentious and even treacherous organisational words can be. They can clarify and reassure even generate shared visions, but they can also dupe the unaware into hearing the words' clever cadence rather than heeding the actual or obscured content. Of course, from another perspective, it can be argued that managers using such terms are merely exploiting agile creative ways to bring their knowledge to the table expediently while in search of collaborative problem solving. The paradox (I admit) is that, as DME, I have often used such phrases. I resolved, forthwith, to take more care and to avoid the flavoursome 'mot du jour' for short-term gratification in favour of "straight talk". Thereafter, I endeavoured to speak unambiguously so that my genuine intentions were clear.

Advanced clinical practice programme
Tap them not sap them
Knowledge made useful
Accentuate gap
Detailed review
Public engagement
Speed mentoring days
Big-ticket items
Work streams
Learning with
Visualizing the what ifs
Daily aspirations to do better
Training hubs
You matter
Investing in what service needs
Rotation aligned approach
Walk in the patient's shoes
One single source of truth

Figure 5.8 Word cloud created using phrases identified from notes made during 3 randomly selected PME regional HEE meetings illustrating the extensive use of 'convenient' jargon.

I wrote in a diary entry which I classified in the initial inductive analysis as 'advice to myself' (see Figure 5.1) *"If using clever language, then explain why you are using it and where it came from"*.

5B 1.2 The dissatisfied leader: Tensions and emotions

Much of my early writings evidenced the pressures, challenges, and frustrations in my lived DME experience during ordinary (pre-COVID) times. As outlined in Chapter 3 many are familiar to other areas of healthcare education and organisations in general. However, notwithstanding the problems, my commitment to trainee welfare and education was evident.

An early FW entry illustrates the strong self-actualization I experienced from teaching and reflection. Critically examining one's own behaviours and 'knowing self' underpins emotional intelligence and effective, authentic leadership as discussed in Chapter 3.2. It provides a good starting, perhaps even an anchor-point, for my journey.

8/12/19 FW (8 pm)

> *"There is an element of self-nourishment that drives why I teach, part of me thinks I am only enacting what is destined for me: … Sometimes, I have an almost compunction to teach, an irresistible understanding that this is the right thing to do …"*

Throughout my writings there is ample other evidence that my professional commitment to trainees' learning and welfare was strong. While, gratifying to acknowledge, I recognized that I needed this 'nourishment' to sustain me. Initially, I drew parallels with Diacopoulos (2019) who used SS to work out his true purpose for teaching and understood that this process was necessary to improve his teacher supervisory skills. Then, I considered the balance between giving and receiving 'nourishment' in leadership roles. This is an interesting dynamic and I recognize now how, to some extent, I was 'othering' (see Appendix IV for further discussion) to renew myself and nourish my own resilience. This reflection has elevated aspects of my leadership style to a more 'conscious' and satisfied level. I fear that, previously, I may have unintentionally "lied to myself "about my DME motivations. At the time, I would almost certainly have viewed helping trainees as tacit or unconscious actions baked into my 'being' or that I was role modelling good practice which I hoped signalled the learning culture I wanted to create. Thus, even at this early stage in my journey my thinking was maturing as was my understanding of how this apparent altruism could be interpreted.

However, the following two diary entries illustrate how while trying to 'care for' trainees I experienced a wide range of emotive challenges. In the first case a trainee's mental health caused serious concern. The delicate balance between keeping the individual trainee safe while respecting their confidentiality is evident. This entry also links to and underlines the prevalence of mental health issues amongst contemporary doctors as discussed in Chapter 3.1.2 and the growing evidence that such problems were becoming more prevalent even before the COVID pandemic. A report by Harvey (2021) estimates that 50%-75% of trainees have experienced mental health issues.

[1] 14/12/19 Diary (1.15pm) *Concern for trainees' mental health*	*CS* a member of our senior faculty and I were worrying about a trainee who had been flagged as having mental health issues. A physical health issue means he has to work particularly hard to keep up with the busy ward environment. CS* met him and they spoke for an hour. Frankly, it sounded as if he was exhausted from having to be so alert all the time. He has a history of descending into an anxiety state and described himself as having had a breakdown. He has just come back to fulltime work, as I understand it. The*

	team has recently changed over, and he has reported in sick a few times! Hence, the referral to PME. He disclosed to CS that he has had suicidal thoughts in relation to buses trains etc. so out of fear of what he might do he stays home afraid to go out even to the shops. Clearly, he has insight, but his needs are beyond our abilities. We have suggested he refer himself to Practitioner Health Programme PHP (mental health services for doctors) asap. CS had text him in the morning and had not had a reply. He was scheduled to be at work. We text the consultant he was working with asking if he had arrived for work: • Hi *could I just check if *** is in today • He is • Thanks • He is on your radar? An interesting character • Yes, can't really say too much but we are keen to keep track of him: (at this point I was unhappy with the text and was not sure how I should phrase what I felt I needed to say. CS then proposed that we change the words to: • *Yes, can't really say too much but we are keen to keep track* ***of & look after[31] him.*** • I know Thanks A

The second vignette illustrates how rigid and inflexible systems made it difficult to realize an individual trainee's potential. The bureaucratic roadblocks frustrated and infuriated me. I struggled to reconcile what I saw as the trainee's obvious and correct career path with the inflexible rules. Further, despite my position of 'power' I had no local autonomy and feared my appeals would fall on deaf ears. Within the HEE system, my judgement was (I felt) neither trusted nor respected. My only option at this point was, I concluded, to "*send a series of e-mails to the 'great and the good' hoping we can work something out*". I was aware that because of working time

[31] I felt the simple words "*look after him*" were perfect and was grateful to CS for the input.

directive and rest requirements the trainee could not use holidays or other leave days to make up the time. Had there been an individual available to talk to who had the power to authorize a bespoke bending of the rules I might have chosen that option. It seemed inconceivable at this time that I would have the trust or authority to sanction the necessary flex myself or in consultation with my PME team. My tone suggests that I had little expectation of a satisfactory resolution. In the end, the system did not bend, and this trainee left the training system.

[2] 16/12/19 Diary (8.40 pm) *Wanting to realize trainees' potential against bureaucratic significant odds*	*I have been helping one TEL with a highly academic trainee. Essentially, I am trying to force the system to flex to allow him to break his training to go abroad to work in a research lab. Gosh, the system is not for flexing! This trainee is brilliant, has done a PhD already. If the system does not flex, he will be lost to clinical medicine forever. If his clinical life is kept alive this experience will likely benefit his area of science. If he is forced to make a choice, he will choose science over medicine, but we need the great scientists to be grounded in what is important clinically. In any case, after an hour chatting to this boy, I've sent a series of e-mails to the 'great and the good' hoping we can work something out. I think the system is against this. A one size fits all paradigm! This boy could be a Nobel prize winner. Google would snap him up and make it work! What are the roadblocks?*

Table 5.2. Two illustrative vignettes demonstrating concern for trainees, the breadth of serious (day-to-day) issues DMEs encounter as well as inflexible and autocratic training systems.

This second case above (Table 5.2) also exposes how I linked 'global' responsibility for future patient care to my more parochial DME role "*we need the great scientists to be grounded in what is important clinically*".

The connection between trainee fulfilment and physical as well as mental welfare and safe clinical practice was never far from my consciousness. 27/3/20, Diary *"... If we*

are not well, we cannot mind our patients!" This insight aligns to literature discussed previously that privileges this important association and that happier healthcare workers deliver safer patient care. This reality has recently been endorsed by Shaw and colleagues (2020) who proclaimed that "If the environment is not safe for health workers, it cannot be safe for patients. Health workers cannot provide high-quality and safe care to patients in environments where there is a physical threat to their safety, and they are fatigued and stressed."

As DME I often felt I was left alone to fight numerous battles that were rooted in moral positioning or what I perceived as unfairness. Over the years the DME leadership role had often felt lonely and liminal. *I feel as if I am alone" 10/4/*20 (see also table 5.1). Similar sentiments are rehearsed in classical (Shakespeare Henry V) and empirical literature. I empathised with Zumaeta's (2019) perspective of a leader as a person with fundamental personal and social needs rather than an "overly heroic" and romanticized figure with exaggerated power and influence but with a fundamental need to belong. Analogously, I have sometimes felt that I did not belong to any one group. Even within my own specialty, where I had always felt clinically respected and at home, I often heard criticism of the PME hierarchy for various reasons from inadequate staffing (numbered trainee allocations) to inspections and action plan requirements and I took this, partly as, personal criticism.

My positioning too, I recognized oscillated sometimes insider, sometimes outsider within the varied groups; clinician/educator, advocate/tyrant, leader/follower, oppressor/oppressed, bully/bullied. As discussed, in Chapter 4 and by Ybema (2019) this is a recognize risk of ethnographic research. Acknowledging this pain and shame in my FW has been difficult.

I also experienced much tension and varied emotions in the decision to employ SS methodology and digress here to illustrate this point and evidence how I was seeking a 'way in' to understand and better my performance as a leader.

5B 1.2.1 Painful reflection, and reflexion

Effective reflective practice requires honesty and insight. SS provides a vehicle to do this, but the process can be painful. The IFS portion of this doctorate described the successful use of SS research in improving training in the struggling emergency

department, of an adjacent teaching hospital, to which I was seconded, part-time. I concluded that the unit had lost sight of its purpose and I was able to initiate some effective remedial actions (Burns, 2019). Although, I recognised the power of SS, in line with the SS literature, I first had to examine my own history, biases, and prejudices and had found that process painful. Thus, I knew this current intense self-scrutiny would also cause similar discomfort. Appendix VI provides insight into this intensely personal portion of my journey.

5B 1.2 The dissatisfied leader: Complex Relationships

Like many modern leaders as discussed in Chapter 3.2, I struggled with relationships. I was certain that I fell short of my aspirations to give my individual ESs and TELs the same offerings that Clarke's (2006) workers wanted: autonomy without ultimate responsibility, collective belonging most of the time, yet individual recognition at others, guidance some days, freedom others and if necessary, a figurehead to blame for change and frustrations if that helped them to adjust to change. Acknowledging that most leaders also struggle helped me to arrive at a place of (some) acceptance. Moreover, as time went on, I came to recognize that I too made similar demand on those I looked to for leadership. It was clear that I too sought West's (2019) ABC: autonomy, belonging and competence.

At this stage in my leadership journey the relationships I had with my TELs were varied as illustrated in Figure 5.10 below and the following extracts. FW and doodling proved to be a space to unpick and debate them.

On 14/12/19, I found myself penning thumb nail character sketches of my TELs:

> ***R:-** funny old fashioned in methods, volatile but in truth I like him v much…**S:-** excellent but a worrier, great potential, **H:-**slightly scary but very good…**Js:-** growing nicely, **Ja:-** superb very caring conscientious, **A:-** funny super, transformational, **I:-**brilliant, dedicated and sensible, **N:-** not very engaged doing it because he has been earmarked despite being enthusiastic at interview, **S:-**laid back not really committed, **Do:-**super but gets quite disillusioned with organisations, **Da:-** superficially committed but passive aggressive and difficult, **N:-** does a great job considering the service pressures.*

I read these over several times asking myself what lessons I could learn? Was I making subconscious judgements? On what had I based these impressions? Was I biased? I concluded that I was quick to judge character often based on a few encounters or difficulties that resonated with my moral sense of right and wrong. I recognized that I barely knew several, yet, had opinions. I challenged myself to spend more time getting to know the TELs and understanding their perspective. Thus, the journey towards a more authentic and compassionate leadership style had begun.

This thinking further underscored how researching my PME environment as an insider and privileging reflection using a broad range of eclectic tools produced useful insights. As I tried to make sense of this data, I recognised Ybema's (2009b) cautionary notes regarding ethical practice, friendships, power, boundaries, and reporting, explored in the ethnographic literature (Chapter 4).

I understood, the TELs to be an eclectic group and this was reflected in my varied relationships with them. Table 5.3 outlines the basic demographics of the group and my diary entry on that day follows on to reflect on it.

28 active TELs
1 job sharing pair
1 pair in same specialty
9/28 women (30%)
Median age 45, range 40-60
7 Asians 1/7 female
2 orthodox Jewish
1 self-declared LGBT

Table 5.3 TEL demographics

14/12/19 Diary 3pm

> *"I just spent the last hour pouring over an 'official' list of my TELs. Firstly, I did not know 5 names: 2 community and one 'off-site' so perhaps expected but there were a few I would expect to know. I was shocked at this and will investigate... That left 28 operational TELs: again, more than I had guessed. This seems obvious but, in truth, I have never thought of it like this before. The next surprise was that only 1 in 3 are women. My guess would have been higher. Regarding ethnic diversity all were White English, or Scottish except for 7 Asians only one of whom was female. The median age was 40-45 suggesting this is a role people take on relatively early in their careers. Only one was in his 60s and he has just demitted."*

My initial thoughts focussed on the paucity of administrative/ infrastructural support to help me keep track of the key team members whom I strove to support and to lead. However, my focus at this time was on how I perceived my relationship with others. I realised that there are TELs whom I respect but, in truth, experience as ‘prickly’ or ‘needy’. There is also a minority whom I fear and feel threatened by. I recall, earlier in this EdD thesis process, as I struggled to define the, yet, unnamed, ‘troubling’ that led to this work, I doodled the diagram that I present here as data in Figure 5.10. It summarizes how I subconsciously perceived these relationships in March 2019.

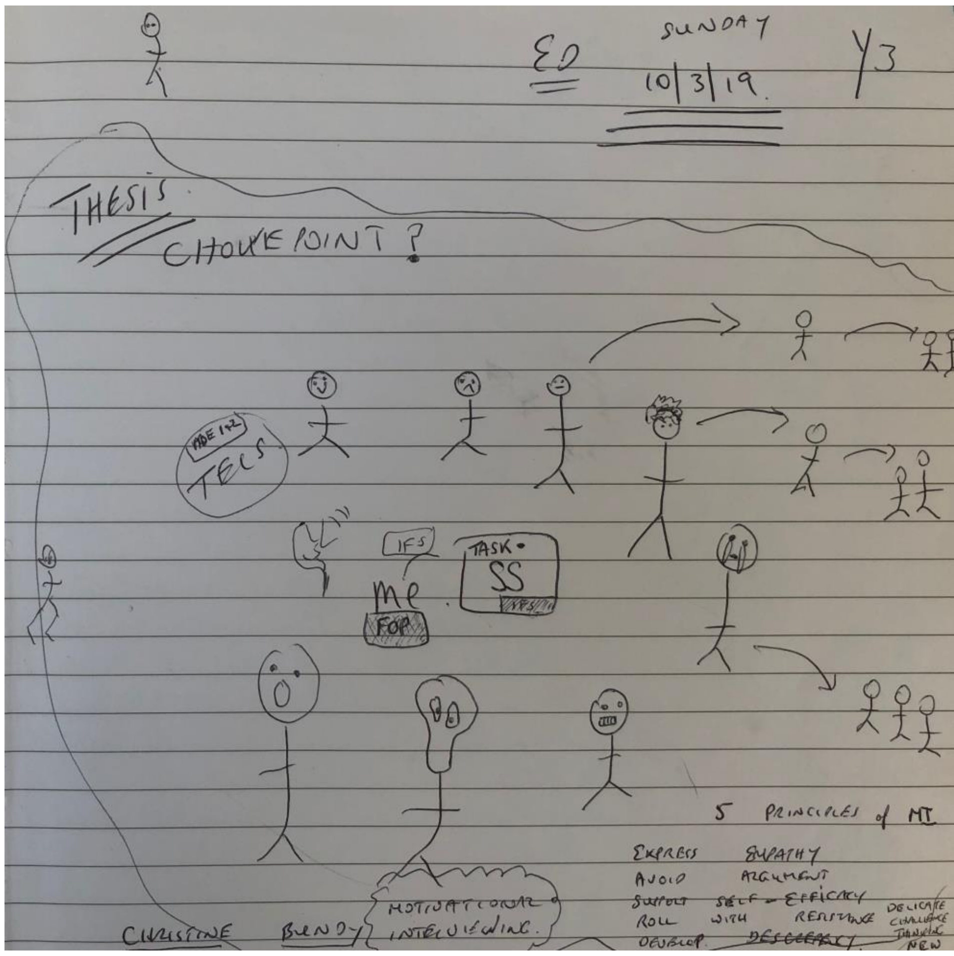


Figure 5.10 A cartoon depicting my impression of TEL characteristics in March 2019.

While I fashioned the cartoon apparently ‘absent-mindedly’, I can see now that it depicts my impressions of TEL characteristics and my relationships with them. Close inspection reveals a mixture of happy, sad, undermining, displaced but active, passive, horrified, loud-voiced, angry, late, and fearful colleagues. Interestingly, (on careful examination) it also witnesses how the FOP, IFS and thesis work surround and arguably provide a barrier shielding me from the various personalities except the apparently angry shouting one to my immediate RHS. This also fits with my FW character thumb-nail musings from 9 months later described above. I summarize that

this is evidence that I was largely dissatisfied as a leader and was seeking solutions. Close inspection of writing at the lower end of the figure reveals how I also considered motivational interviewing enunciating the 5 principles as a mode of improving what I perceived as the poor engagement outlined in Chapter 2.4 where I rehearsed my professional practice problem.

My writings reflect how relational tensions with TELs were complex, sometimes capricious, and confusing. In the next extracts I expose these relationships further.

19/12/19 Diary (11.49 am)

> *"I like and admire this TEL; I am even a bit jealous of their teaching skill but if you don't try to help your situation and expect someone to come along (knight in shining armour) and solve your problems… (This TEL says repeatedly) "I've been telling them that for years…"*

Following previous HEE inspections in this TEL's department, a new electronic system was mandated to replace an old paper-based system. I record here my diary entries altered to conceal the identity of the TEL and the department but maintaining the awareness of strain.

> *"The TEL, despite the evidence that the newly deployed system was preferred by trainees and working well, was still supporting the old system. What was that about? A fear of change? An uncertainty regarding electronic solutions? ... More work and hard thinking needed here."*

My role was to enact a directive resulting from a previous inspection. On this occasion one that I believed in but that was not supported by the TEL. Clearly frustrated, I wrote in my diary of 20/12/19 a further entry related to this TEL:

> *"I hope we (A* and I) made more of a personal connection in one meeting and one telephone conversation than that TEL and I have made in a decade. Q: How do you drag luddites with you? Should I be trying to drag them, get rid of them or embrace them? Is there any merit in what they say? Is it that* ***I*** *do not want to hear the truth, as they perceive it???"*

In the example above, I evidently wanted the 'errant' TEL to see things my way or get in line with HEE requirements. My obvious emotions and resulting tensions were impacting on my relationship with this TEL. Yet, I was unsure how to proceed. I cognitively rehearsed the merits of hierarchical approaches *"drag them…. get rid of them"* versus collective, compassionate leadership styles "*embrace them*". Later, I began to wonder if I might have had more joy had I engaged the TEL in discussions or CAR (distributive…or … co-created models). In the case of this TEL, required to

implement a new IT system, I had failed to take the time to understand the TEL's views or communicate, my own (and HEE's) perspectives.

I was also articulating a dissonance that related in part to changing organizational expectations and structures (the new electronic system) discussed in Chapter 3.1.4 above. My more compassionate 'self' began to ponder whether I was missing the true reasons (*? a fear of change*) for this TELs reluctance to engage with the new technology. I felt caught between the imperative to deliver the requirements of the inspectors and reluctance to really understand all the convolutions of the department where this TEL worked. The latter approach, I knew, would be a time consuming and complex task and I had little appetite, time, or support (I felt) to pursue it at this time. I also, in hindsight, should have grappled with this nettle many months, if not years, earlier. I had hidden from the problems allowing them to fester. This TEL and I clearly had history and I had avoided facing him let alone getting to know him and his world properly. I had observed him and admired aspects of his work from a distance. Possibly because of this poor relationship, when COVID-19 struck, this TEL (from my perspective) faded into the background, performed clinically, but showed little initiative and failed to lead or support the trainees in that area. Instead, many came to me for help and support. Therefore, to enact the necessary emergency changes, I overlooked the appointed TEL, identified another consultant (A* above) and several trainees and together we found successful solutions to many of the departmental problems, iteratively and collaboratively. It is still my firm belief that the electronic system mentioned above was literally lifesaving during the COVID crisis. I contend that the paper alternatives would have cost lives. I realised that in the end, I could not make progress with this TEL. I had unconsciously but pragmatically circumvented them to achieve my goals. I now view these events, in leadership terms, as a combination of failure and triumph. I called intuitively upon and deftly enacted many of the leadership styles and attributes discussed in Chapter 3.1.4a. I was debating and trying out leadership styles and approaches to achieve my objectives.

Clearly, this 'case study' on its own provides a myriad of opportunities to explore leadership. However, the issue that stood out for me as I contemplated this entry and my DME role was that I regularly found myself trapped in a middle 'liminal' ground, torn between delivering what was required by external regulatory bodies and internal resistance to achieving the 'target'. Sometimes, I appeared to be reluctant to push an

issue either because of my own misgivings or my inability to break the stalemate locally. My writings, sense-making and analysis attested that the labour of balancing aspirational demands with reality, often lead to personal, interpersonal, inter-professional and organisational tensions in my workplace. I think that I would have squared away or brushed past some of these 'thoughts' were it not for this research foregrounding them. I concluded that I would benefit from looking beyond my immediate irritations to examine what lay 'under the bonnet' of interactions and relationships as well as considering local and national organisational contexts.

Paying attention to the TEL demographics and my (often unconscious) relations with them, I reached some important conclusions. In my positions of 'power' I likely inclined towards and preferentially employed like-minded people and make assumptions about other colleagues I hardly knew. I reflected that my biases were often uninformed or based on (particular) prior experiences. While homophilia (the gravitating towards like individuals) has some physiologic and evolutionary footing, leaders need insight and emotional intelligence to recognise when such biases are at play, out of control or inappropriate. Thus, I became aware that I avoided interacting with those TELs I found difficult or threatening. I set targets to meet-up with and appraise them but often gave up as appointments got cancelled and new meetings proved difficult to organise. Similarly, I called on 'friendly' TELs to enact my own or HEE wishes.

I also realized that I was invoking strategies, manoeuvrings, and tactics to deal with the varied characters. I endeavouring to engage those who might be amenable to helping me and bypassed those I suspected would not. I was making constant often subconscious trade-offs to survive in this environment. Was this a sign of mere survival or was it a sign of resilience or adaptive leadership?

Through all this time, I harboured concerns that my difficult relationship with individual TELs influenced trainee experiences and that engaging the non-engaged was essential. The literature too discussed in Ch 3.2.5 supported this notion that the culture I oversaw had likely percolated down to impact on individual trainees.

The FW narratives and doodling, tapped into perspectives previously, at least partly hidden from my consciousness. They attest to Dewey's (referenced in C. Rodgers,

2002) belief in the value of 'stream of consciousness' and provided me with material for deep reflection. Of interest, 40% of the FW entries stood alone but the remainder either followed a short time after diary entries or were merged immediately after them. They often related to the event diarized as well as universal workplace tensions with many overt and covert examples of power plays and rivalry described. They reflected, I believe, the precarious cultural environment that DMEs preside in ranging from friendly and supportive to hostile and accusatory.

A novel element too was how my subconscious tensions were uprooted and presented to my conscious brain for discussion and analysis. FW provided a channel for my unconscious mind to be heard and analysed by my conscious self. I also became another 'other' commenting and debating on my own thoughts and actions (see Appendix IV for a discussion of 'othering'). I realized that I was exploring my relationship with myself. I was actively exploiting my own emotional intelligence as discussed in Chapter 3.2.1 in the dual act of self-reflection and reflexion.

5B 1.4 The dissatisfied leader: Self-actualization as a leader

Even before COVID struck, I was becoming aware of the value of this autoethnographic SS. By stepping back, I could move from the emotional distress or labour and catharsis to theoretical critique and readiness for change. I sensed the beginnings of positive transformation in my leadership understanding.

More importantly perhaps I began to understand that my insights were likely not just applicable to me but were transferrable to leadership situations and human interactions in many areas of endeavour. My anecdotal narrated events were disarmingly both singular and collective.

As part of my EdD IFS, I penned a cathartic poem that related to the negative, defensive culture I encountered in the emergency department where I was seconded. I titled this work "Welcome to the snake pit". In this next section, I transcribe a second 'found' poem that, once again, I used as a metacognitive tool to understand and come to terms with a tension that emerged in this research through my FW. Found poetry allowed me to express sentiments and reach conclusions that might have otherwise proved elusive. Penning and refining the poem was both liberating and enjoyable.

Others have used this technique in similar fashion (Butler, 2002). Here, I tell the story:

One of the TELs and I had arranged an all-day workshop with CSs and ESs in her department in the hope of supporting her professional educator identity and creating a more supportive learning culture in her area. There had also been repeated 'poor' GMC trainee survey outcomes and the department was in danger of losing its trainees and hence a large portion of their service delivery capability. Without trainees the whole service would be forced to close and there would be significant consequences for the local community and our hospital. Thus, all routine activity was cancelled to accommodate the workshop. The most recent GMC issues seemed to relate to a poor culture of support and learning with hints of microaggression and undermining. There were 14 consultant specialists in attendance. The majority were ESs. Most engaged well, the atmosphere was positive and the PME faculty and the TEL unanimously felt the day had been a success. However, a single anonymous feedback sheet was acerbic in its criticism. The TEL, the faculty and I all felt slighted. My diary entry on that day explored this thorny issue of criticism and how its effects linger. It also prompted me to write the poem below.

13/11/19 Diary (1.49pm)

> *"On the other hand, the vast majority were very positive and some very vocal in their support for this innovate session. On reflection we tend to be disproportionately fixated on negative feedback. Why? Is this a defence of our self-image? How important is it for us to feel good about what we do? Seeking feedback can be painful. So what? Beware of over-reacting to negative feedback it is very draining and can demotivate people. So, GMC surveys etc. have the potential to achieve the opposite to what is intended. Only close reflection brings out the rational understanding that the negative feedback is from a minority and should be viewed as such. The gut reaction and the hurt cut deep."*

Poetry is the stuff at the back of the head: 10/2/20: reflecting on the power of the negative word I penned the following poem.

The malignant weight of words!

A negative word lives more treacherous than its docile twin.

Opposite poles through magnetic sameness although one has sturdy sway to hurt and harm!

'Thank yous" mean so little to the receiving ear! We question, are they Just, Polite, White noise, Expected? They float away in whispered fog.

But the malignant word burrows deep, sharp. No doubt about the authenticity of its booming voice, heard bell clear and reverberating.

Is it even fair?
It taps the inner insecurity, the imposter within, whose voice echoes in a cavern of self-doubt!
Could it be True?
This murky mirror does not lie. While the good words and gratitude float away in silent floods.
Deserting the conscious, rational mind.

Forcing thoughts of quitting that endeavor, our lifeblood, our soul, our being: - our Is

Table 5.4 Found poetry: the malignant weight of words.

Without much forethought, I titled one code "advice to myself" (Figure 5.1). Reading and re-reading the entries under that heading, I came to understand that through constructing, articulating, and listening to my own advice my behaviours had changed. In this case the advice was a reminder that "*negative feedback is from a minority and should be viewed as such".* A compassionate and authentic leader would discuss the hurt with the TEL in question and listen to their perspective. I set out to do exactly that.

My 'earlier self' felt a powerful need to control most aspects of my DME world. I had appointed TELs but, as discussed earlier, used the excuse of how 'busy' they were with service duties and how difficult meeting were to arrange, to exclude them from involvement in areas where they could/should have acquired and developed their professional education identity and socialization. E.g.

16/12/19 FW (8.40pm)

"Writing this now I remembered I had not fed back to the TEL about my progress, I had pushed on alone and just realised the TEL was unaware of my efforts"

In short, my data evidenced how I had disempowered the TELs. I failed to recognise the implications of my controlling actions and further, I too had privileged service over education/training.

At this stage, I was forced to recognize the complexity of the DME position. It was clear that I felt a professional obligation as well as a personal need to improve the experience of our trainees. I had to acknowledge my own leadership deficiencies especially in areas of management and strategy as well as the emotional cost of my DME responsibilities. I recognized the unquestionable need for a myriad of leadership qualities (discussed in Chapter 3.1.4a) to include doggedness, authenticity, compassion, commitment, problem solving and pragmatism nearly all of which have been articulated by other researchers in general life situations as well as in education. Standing back, I was gratified to see evidence that, on some occasions, I exhibited a few of these traits, at least to a degree. Looking back, I think I was ready to begin the CAR portion of my project and keen to explore other ways of leading.

Stage 2 Mobilizing collaborative actions

5B 2.1

In the next stage of my journey, I enacted the CAR plan. I approached this task with hope and expectation. The plan, however, was truncated by the arrival of the COVID pandemic. By this time, I had recruited only two TELs and had held three recorded meetings with each (circa 300 minutes in total of recorded conversation). Two other TELs had been identified but not yet consented and there was no immediate prospect of pursuing them. Thus, I limited this portion of the study to the two TELs and did not conduct any further recorded meetings. We continued on-line and telephone interactions and I occasionally encountered them in socially distanced clinical settings. Here I use the same quadruple framework (context, tensions and emotions, complex relationships, and self-actualization as a leader) to evidence my findings.

5B 2.1.1 Mobilizing collaborative actions: Context

Despite the COVID interruption the CAR project yielded much rich material for me to ponder. My diary reflections on the first transcriptions are replicated here to give a sense of the possibility I sensed.

10/2/20 Diary (0.33 am)

> *"... I typed out my first CAR exchange with Daffodil. I had another moment of such pleasure as I re-listened to the 37-minute meeting. We covered so much ground, were not afraid to go into the hard stuff of bullying and behaviours, we thought deep thoughts about pedagogy and role modelling, and we truly brainstormed possibilities. We went deeper than our first obvious thoughts. I don't think I would have caught all this without re-listening and typing the conversation. We had fun and we were both, I think, energized, I interrupted too much ...great stuff."*

Notwithstanding the mirth and green shoots of hope the CAR analysis demonstrated, one topic that pervaded the six recorded conversations was the often intense, frustration at, futile bureaucratic time-wasting e.g., rostering issues, filling unfilled posts, and an inability to achieve even, apparently small, organisational wins aimed at improving individual trainee physical environment or experiences. My reflections on the second CAR meeting recorded with Tulip[32] on 20/2/20 exemplify this:

> "*…We covered a wide range of stuff but came back again and again to rota co-ordination and to the time taken in this thankless task…would self-rostering help them (trainees) to feel empowered? …but… we can't even get the basic structural stuff: -lighting water and benches right …AHHHHH*".

Deconstructing the roots of this grievance using the pre-specified personal, professional, and organizational theoretical framework helped me to understand the pervasiveness of the organizational issues and their impact on morale and professional pride. My newfound efforts to really understand issues from various perspectives were obvious.

6/1/20 FW:

> *…" and I really tried to understand the detail and the helicopter view…".*

Yet, my personal and professional persona felt let down and affronted by the organizational failures. I felt impotent and that I was failing in a basic area.

25/2/20 FW:

> *…" I am feeling sad and disillusioned tonight..."*

In many evidenced examples practical fixes should have been easy. Basic maintenance or cost neutral improvements e.g., taps to be fixed, teaching spaces

[32] Tulip and Daffodil were the chosen pseudonyms of the two TELs who took part in CAR portion of this thesis.

equipped and reconfigured were nigh on impossible to achieve even before COVID changed everything. Yet, these simple improvements were outside of my control and battling to achieve them sapped my energy reserves and likely those of my TELs.

The burden of rota and manpower management and the organizational apparatuses needed to resolve this issue felt inaccessible. Daffodil constantly articulated and (in retrospect), I became aware for the first time how enormous the burden of recruiting doctors to fill rota gaps and of rostering was. It was clear that such tasks subsumed all others and for many eclipsed any chance of attempting to quality assure training and supervision. The distinction between management (transactional) and leadership (strategic) capabilities, highlighted by Swanwick (2019) in healthcare was, I now knew relevant here. Reading my narratives, I realized how I was especially poorly prepared for the management/transactional elements of leadership. It took hard work and perseverance to influence the physical environment or develop facilities when operational 'know how', space and financial resources were either stretched or inaccessible. I questioned whether I could have achieved more, whether I needed to be a leader or an operations manager? My pleas were falling on deaf ears. I concluded that much of my frustrations stemmed from the management rather than leadership aspects of my DME performance. Yet, I could see little evidence of strategic planning on my part to overcome the problems. I rolled with every setback making the most (as I thought) of the situation. I now know that successful leaders need both transactional and strategic prowess and/ or strong collaborators or administrative support to make up for shortfalls. Acknowledging, my limitations in this area has forced me to prioritize strategic planning and be more assertive in co-opting and engaging help with transactional processes.

5B 2.1.2 Mobilizing collaborative actions: Tensions and emotions

The 'pilot' CAR meetings were generally very enjoyable for Daffodil, Tulip, and me. Both TELs appeared to value our time spent together and the space we created to think beyond keeping our heads just above water. Listening to the recordings there was much mirth and a sense of invigoration. This positiveness contrasted with the many sullen sentiments recorded in my earlier diary and FW entries. In the second transcript with Tulip, I counted eleven occasions where I have inserted 'laugh" (see Appendix VI for sample transcript). Re-reading my diary entry following the first

CAR meeting with Daffodil, the promise and excitement, I sensed, is clear. I felt that, at last, true progress could be made.
18/2/20 Diary (no time recorded)

> *"Thus, the very first CAR meeting opened a treasure chest of opportunity to improve the trainee experience in Daffodil's area and we set out to explore ways of exploiting the prize.*

Tulip was grateful for what (s)he appeared to perceive as mentoring or assistance in her/his relatively new TEL role. (S)he commented towards the end of one CAR meeting "…*I think this is fantastic*" and later "… *definitely, no, it has been great"*. Tulip, however, was fearful of being identified or of being disloyal to the department. Tulip insisted repeatedly that nothing said could be traced back to the department.

Extract from CAR 2 with Tulip 6/3/20
"T: *...but keep it confidential, as I don't want anyone to get hold of it…"*

Tulip appeared torn between a desire to improve trainee experience and a wariness or mistrust of more senior colleagues and managers. Yet, within weeks of our first CAR encounter, Tulip organized an LFG meeting that contrasted starkly with previous LFGs described, where attendance and commitment had historically been dismal.

30/1/20 Diary (11.50 am)
*"The ******* LFG happened today there was a superb attendance with circa 12 consultants, two trainees and two departmental others (technical and managerial)"*

This contrasted sharply with my obvious frustration when trying to convene an earlier conventional local faculty meeting to be attended by another TEL and all their ESs.

19/12/20 Diary (11.49 am)

> *"…a long-awaited LFG meeting sorted for this dept. Despite lots of attempts to get this organised before. We had finally sorted the room, the time, had printed an agenda and the action plan sheet from the last HEE inspection. Only two out of an expected 6 turned up (both late). One, a new locum was very keen and enthusiastic. … The other the TEL had a problem for every solution"*

In Tulip's area particularly the CAR pilot again highlighted the tension between service and training. Immediate patient care priorities regularly took precedence over education and made trainees and colleagues feel exploited.

6/1/21 Diary

> " *the whole issue seems to be related to service …with trainees feeling they are imposed upon and do too many * without having the opportunity to follow up the cases…*

6/1/21 FW

> "*…I detected a real pressure on getting results out even when the (cases) are very complex…*"

We explored ways of rebalancing or streamlining duties to mitigate this. We identified the importance of engaging with technicians and managers and successfully invited them to their first LFG "*….and two departmental others (technical and managerial)"*. I recall that this small win felt like an important triumph. Consequently, in the time since this work, I have begun to focus on encouraging multi-disciplinary LFGs to include representation from educators in nursing, pharmacy, operations and other AHPs. Figures 5.6 and the expanding number of professionals group who make up healthcare teams discussed in Chapter 3.1 underline why I now believe such changes are needed.

The iterative action logs (Appendix VII), created towards the end of each meeting became useful starting points for the next meetings and led to appropriate and measurable targets that were largely specific, attainable, relevant and time bound. The loose structure imposed by this process felt important and reassuring as it guaranteed continuity and naturally invited scheduling of the next meeting but was not too constrictive. Furthermore, reviewing the previous action plan at the start of each meeting forced us to acknowledge and celebrate small achievements. The propulsive power of small wins was very apparent as I listened to and typed the meeting conversations.

I concluded that the fledgling CAR enterprises with Tulip and Daffodil had borne more immediate fruit and evidenced a greater commitment to understanding and lowering the barriers to supporting trainees, than many of my previous efforts put

together. For me however, the most satisfying part was the evolution of what I sensed were strong, personal, and professional relationships with Tulip and Daffodil that I hoped would continue to develop. I found myself buoyantly looking forward to our next meetings.

5B 2.1.3 Mobilizing collaborative actions: Complex Relationships

Listening to and transcribing the CAR meetings, however, I was shocked to observe that my behaviour towards the TELs was occasionally overpowering. I found evidence that I dominated the conversations and butted in with suggestions or ideas that I had come across in other areas of education or reading. Rather than allowing the TEL to arrive at their own solutions or truly arriving at them in collaborative fashion I often imposed my solutions. Here, I have chosen examples of my controlling language and I also noted (with horror) from the transcripts that I interrupted Daffodil ten times during our first meeting.

CAR transcription 2 with Tulip

AB: *"I definitely recommend that that happens and probably the sooner the ...better"*

CAR transcription 1 with Daffodil

AB: (interrupts) *"…and I wonder if we, I'm just thinking out loud…if …there was any way they could put a topic in …there...that they would like …"*

CAR transcription 2 with Daffodil

AB:" *... and perhaps we might start with that I suppose…"*

AB: *"... we did, didn't we…maybe we…should do that actually…and the other thing I was thinking about was that realistically it is not going to happen that…"*

18/2/20 FW (00.22) I wrote:

> *"I was worried about being too overpowering …pressing home my own agenda"*

I was also reminded of a similar revelation when I was clearly reluctant to hand over reigns, when working in the emergency department during my IFS. There, because I knew my secondment was time limited, I felt an imperative to delegate. I did not

expect to find that I needed to essentially change my behaviour in analogous fashion in my own hospital.

Further, simply listening to and transcribing and re-reading the CAR transcripts opened my eyes to some eccentric personal styles as well as to some important tensions within Daffodil's department that I had not recognized previously but were certainly relevant.

After this meeting, I diarized the following:

> *"My first analysis and sense making is as follows:*
>
> *1) I interrupted the discussion a few times I thought unnecessarily...*
> *2) I tell stories that pop into my head to illustrate points or help me think through issues. Others might find these a bit tedious. I think I told 4 or 5 anecdotes.*
> *3) Our conversation and brain storming was really deep, and we strayed into some risky but important territory.*
> *4) I did not want to admit that the behaviours I was unhappy about in one of our surgical colleagues was also demonstrated by some of my (revered) ███ colleagues and Daffodil could see this but, until I listened to our conversation again, I was willing to sweep that 'truth' a bit under the carpet. i.e., I was harbouring double standards, or unconscious bias."*

Both TELs who participated in the CAR appeared to enjoy the collaborative aspect of the work. Even allowing for their motivation, demonstrated by joining the study, I detected a new energy. My sense was that, as the meetings went on, our focus shifted from seniors looking into the trainee world to positioning ourselves in trainee shoes.

A section of a CAR transcript captures some of Daffodil's new energy and how (s)he appears now to be walking in the trainee's shoes, considering ways to make protocols and rotas accessible on hand-held devises for ease of access.

D: "*I'm going to try and also do it so that it is more accessible..."*

AB: "*…OK so that you can find the bits...quickly..."*

D: "*…what do you do when XX situation happens …etc"*

AB: "*...right that is …"*

D:" *...it will have all of our protocols and documents attached as well…so rather than having to search through the T drive it is all …at their fingertips…"*

AB:" *...Yaaa yaaa. That would be fantastic D that would just be soo good and if they could have it on their phones then…eventually…'cause it is a great resource I think, PS* started it donkey's years ago … loads of people have put effort into it…*

D:"…*ya they are not flicking through paper books at all are they?"*

AB: "*...no*…"

D: "*…and the teaching rota too can be on there…so they all have it on their phones, so I think that...*"

I hoped that this was evidence of a shift towards actualising Daffodil's professionalism as an educator by beginning to 'other' and feel a real responsibility towards the trainees. I sensed this particularly with Daffodil's responses. I noted also that the idea generation had shifted away from me and towards Daffodil.

5B 2.1.4 Mobilizing collaborative actions: Self-actualization as a leader

My fledgling CAR success with Tulip and Daffodil felt good and I began to appreciate the potential of co-creating collaborative solutions to real problems as a way of building relationships, improving morale, and creating a culture of learning and improvement. I began to envision a hospital where local collaboration and small focussed action research initiatives had percolated and cascaded into everyday practice empowering little but satisfying successes locally.

There are many examples in the healthcare literature of the benefits of collaborative, co-constructed, collective work as discussed in Chapter 3.3. Solving complex problems benefits from collective responsibility where the partners, flatten any hierarchies, exchange knowledge, co-own problems, and co-construct solutions. The solutions are usually considered temporary, as there is an understanding that iterative planning, doing, and acting (PDA) cycles (familiar terms in the quality improvement (QI) literature) are necessary to achieve best and sustainable outcomes. I felt I was dipping my toe into this water and liked the sensation.

During the CAR study period, I purposefully sought and reflected on examples from the literature that described SS situations with relevance to my work and where a collaborative approach appeared to be successful. Diacopoulos (2019) used SS to research his teacher candidate supervision journey. He, like me, had more than 2 decades of teaching experience. He recognized a lack of support for those who supervise despite its obvious importance and complexity. Further, he wanted to be

able to deliver better supervision than he had experienced himself. Reading his work, I felt kindred with Mark and his predicament felt real. I knew also that his needs, as a new supervisor of two prospective secondary school social studies teachers, likely mirrored those of my consultant colleagues supervising trainees for the first time and of new TELs supervising ESs. This synergy was further clarified for me, when I substituted trainee, doctor, or hospital environment where his research questions read 'teacher candidate' or 'classroom'. The questions then became:

1. How would I navigate the problematic space of trainee supervision? Was my experience as a doctor educator of 20 years enough to help trainee doctors find success?
2. How would my learning of supervision affect my emerging practice as an ES?
3. To what extent would I facilitate trainees' connection between theories learned in medical school/earlier training years and clinical practices they were expected to enact in this hospital environment.

This exercise placed me in the shoes of a new ES, and I wondered how a TEL in my organisation might support such a novice. So, I was prompted to examine my data for evidence that I support new TELs (and ESs) in their roles. I questioned what induction packages the PME department supplied after a successful interview. I realized to my shame that the answer was virtually no induction or support unless specifically asked for. I expected my TELs to get on with it and to come to me with problems. To "sink or swim' as Rimmer (2019) put it in relation to NHS leaders.

Accordingly, I came to understand that my TELs needed enhanced support especially when new to the role. They needed to be helped to develop a distinct professional educator identity in addition to their clinical and other identities to, in turn, best support their ESs and CSs. The TELs needed to learn that supervisory styles and aptitudes differ, and they might need to understand and adjust their own supervisory styles accordingly. Cuenca (2010) for example, noted that novice supervisors often focus on replicating their personal experience. By contrast, Diacopoulos (2019) had had such difficult relationships with previous supervisors that he was determined to do the opposite. In any supervisory role, he cautioned that a supervisor should help the supervisee to:

> *"Purposefully learn from their experiences, adopt the roles of mentor, coach, listener and advocate…. coax meaningful reflection through thoughtful questioning and dialogue, encouraging new ways of self-expression, offer emotional support and career counselling" (p 2).*

Such supportive supervisory relationships should I now see be formally backed up by training and facilitated as well as role modelled at every level in PME. The formal

training ESs had received may not have covered the everyday ‘real’ emotions and tensions of supervision. I concluded that I could not expect my TELs to support ESs and CSs unless I proactively supported them and modelled this support using tools like CAR. The importance of this understanding was further underlined by the following brief but cheerful encounter with another TEL. This TEL had felt insecure on starting his role and so, at his request, one of the senior PME faculty members (Z*) had agreed to mentor him formally for the first several months. I wrote:

18/12/20 Diary (8.40pm)

> “*… I felt good and we both, I think, enjoyed the encounter, building a camaraderie that I think helps! He is the TEL- Z* put lots of effort into his induction. This underlines my earlier thinking about setting up a formal induction and mentoring/supervision program for the TELs”.*

Later, I described raising the possibility of a regular induction and mentoring programme for new TELs with our most senior administrators who volunteered to check with her ‘opposite numbers’ in other hospitals in case anyone had such a programme working already. She reported that only one of 12 in her medical education managers’ group had anything akin to such a programme.

Thus, this SS enabled me to stand back and acknowledge that I had not been supporting my new TELs adequately and that forming strong early relationships with them should be an important goal. On Jan 5th 2020, I contemplated, in my FW, the need for TELs to develop their own education identity and I questioned whether they currently felt part of the PME professional group. I also recognized, in that entry, the differences between the transient ‘trainee identity’ needs and those of ESs and TELs who would likely benefit from a fuller socialization.

05/01/20 FW (0.45am)

> *“How can I help them (TELs) form this identity? Clearly a professional group has specialist knowledge but once this is acquired, they need to practice using it and be integrated into their community of practice… So how can I enact professional socialization of the TEL group?”*

I was reminded of the clear identity Ahluwalia’s (2020) GP trainers had possessed and how this distinctiveness appeared to be beneficial. I resolved to try to create a valued education identity amongst my TELs by focussing on enhancing their

induction and bringing them together more often as a supportive peer group. I reckoned that much could be achieved if we shared experiences and if CAR projects with (and between) TELs could be facilitated. Further, I wondered if such actions would encourage similar initiatives between TELs and/or ESs within their local faculty. My CAR project with Tulip (new to the TEL role) encouraged me to continue in this vein. In April 2021 the PME faculty held a full morning induction program for 5 new TELs and we have backed this initiative up with monthly all faculty development sessions where attendance is much improved with an average of 14 attendees. Topics covered have included pressing issues like supporting trainees with anxiety or mental health issues or those who are working less than fulltime or have trained overseas. Anecdotally, some superb ideas have emerged from the TELs and shared during lively interactive discussions. These meetings have been facilitated on-line for the most part which has benefited attendance, but feedback suggests that many miss the extra benefit face to face interactions.

Thus, I began to realise that I would benefit from listening to and trusting others rather than imagining I had all the solutions. Whilst I still must resist the temptation to interrupt or 'just get on with it' 'lone ranger' style, I hope that with time and practice this learning will become tacit and that I will become unconsciously competent in the art of a more distributive/collaborative leadership style.

Stage 3 Responding to crisis: the COVID pandemic

5B 3.1.1 Responding to crisis: the COVID pandemic: Context

The next stage of my experiential journey was not planned. It is already (2 years later) hard to imagine the massive impact that the early days of the COVID pandemic had on our world. Figure 5.11 graphs the daily new patient referrals to our hospital during the first COVID pandemic wave. My "letters-live" (Appendix VII) account comes closest to describing the panic I felt as television footage informed us of how our colleagues across the world were struggling with many failing to cope.

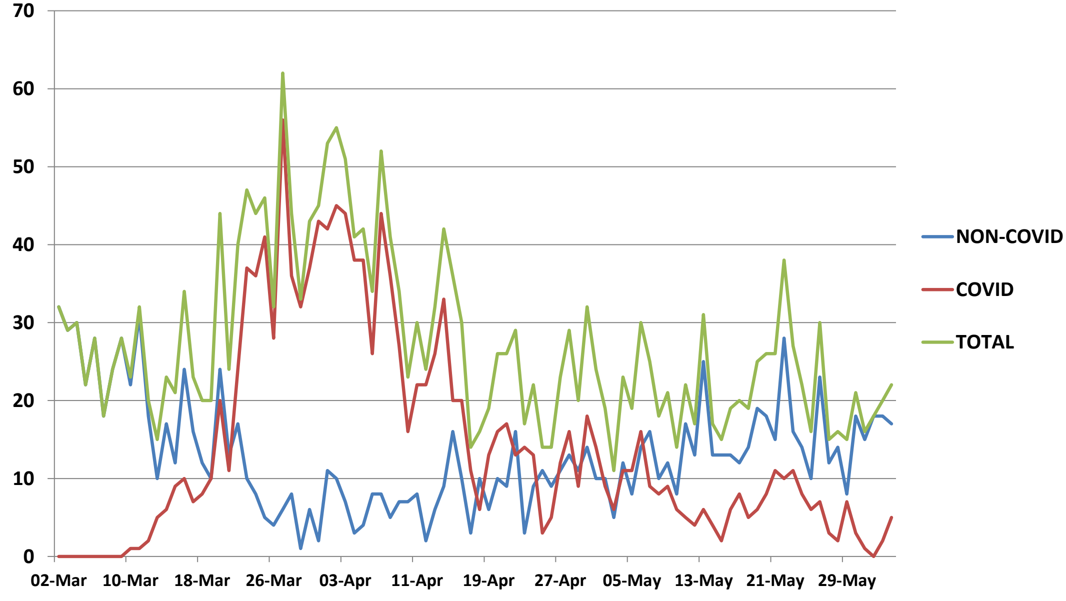


Figure 5.11 COVID-19 case numbers admitted over the study period (with permission and data enabled by the electronic admission system discussed earlier)

As the enormity of the problem began to dawn on many of us, I had a (rare) visit from our medical director who charged me with reorganizing non-consultant hospital doctor staffing to meet the unknown and unprecedented need. I was flattered when he said that he believed I was the only one who "could do this". I was, I admit also very frightened.

Over the first few days a powerful group of trainees and colleagues emerged organically to form what became known as the hospital 'PME COVID-19 taskforce'. Some members could not be 'patient facing' for medical or pregnancy reasons. Others were Trust appointed doctors and expert computer officers or elected trainee representatives. A single human resource (personnel) officer was co-opted/ appeared from hospital management.

Figure 5.12 was created to depict the new leadership model and displayed prominently from the early days on a centrally located noticeboard in our operations room. In this dissertation I have deliberately included the signed version rather than the original to record the participants and to reflect the comradery, sense of purpose

and belonging we felt. The intent to co-create solutions and to be compassionate in our approach was clear.

Figure 5.12 depicts the structure of the PME emergency COVID-19 taskforce signed by many of the trainees and consultants involved[33].

The diagram depicts the 9 equally weighted, prioritized areas the group felt were key.

- Workforce and rota
- Wellbeing (mental and physical space)
- Infection control
- Handover
- Clinical guidance
- Education and training
- Operations
- Medical school
- Information technology

A deliberate collaborative/collective approach was encouraged and orchestrated based on lessons I had learnt from my leadership journey so far. Recognizing the stressfulness of the situation we privileged mental and physical wellbeing by dealing with each separately.

Trainee A described their experience in the COVID taskforce as follows:

> *"The taskforce met each morning virtually or with appropriate social distancing. The ethos was one of deliberately flattening hierarchy so that each member, regardless of seniority, felt empowered to realise solutions to matters arising in real-time."*

The green circles represent the 9 key areas of endeavour. The grey squares were risk areas within the hospital where retention of appropriate staff numbers and skills needed to be assured, to prevent unnecessary harm to non-COVID patients. In addition to enabling 'teams'(on-line) teaching and handheld devices to assist communication between patients and their families, the IT group developed powerful communication resources using e-mails, bulletins, mentimeter and questionnaires.

[33] All signatories and named individuals have given me permission to use this figure. Everyone wanted their signature to be unchanged and received a laminated copy as a memento of this extra-ordinary time.

More than 400 doctors had shift patterns changed within a few days and circa 300 were redeployed to the emergency department, intensive care unit and acute medical ward areas as well as to bereavement services and laboratories to cope with the large number of cases. In addition, some 250 medical students volunteered and were safely deployed to help in various roles from nursing and healthcare assisting to portering and helping out in laboratories.

The taskforce arranged socially distanced meetings, rest and food areas, accommodation, parking, psychological debriefing, and occasionally childcare. We were instrumental in preserving oxygen supplies by embarking on a determined education campaign for redeployed staff who were initially, inadvertently wasting oxygen because of a lack of understanding around the Venturi[34] masks. These latter masks were also is short supply, so our team designed and implemented a collection and sterilization system that recycled more than 200 masks over the ensuring weeks. Together, we also organized for local ‘rag trade’ workers to manufacture much-needed personal protective (PPE) equipment and gowns in the adjacent town hall using disposable theatre sheets and ward curtains as material. It felt like no task was too large or too small to be tackled and I reflect now on how creative the taskforce’ solutions were.

The aspiration to flatten power hierarchy worked well. Hidden expertise was revealed iteratively. Two trainees gravitated to the operations room. There they were able to explain clinical significance and help prioritise requests for help. They were repeatedly complemented for their organizational and administrative skills. Members of the task force learned by doing or experimenting and enquiring (often in that counterintuitive order). The situation was fraught and there was a high probability of failure so, I reflect, the group was not (at this time) hampered by a fear of failure and our focus was to do the best we could.

The 6 months that ensued was, without doubt, the most challenging time of my entire career both physically and mentally. The group published six manuscripts documenting the overall response and various aspects of our PME COVID-19 taskforce work (Appendix IX).

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[34] A colour-coded face mask attachment that delivered predefined Oxygen % or concentration

5B 3.1.2 Responding to crisis: the COVID pandemic: Tensions and emotions

The panic I felt as I realized the implications of the rapid virus spread is recorded in my "letters live" transcript reproduced in Appendix VII. I have included an extract here to illustrate my lived experience.

> *"I was seized by a bad dose of headless panic and a sense of doomed inevitability. I indulged these sentiments long enough to become irritated with myself. I needed to narrow my focus to my sphere of influence and fell into a well-practiced complex problem-solving grid. …Who and what resources or connections did we have to call on? In my role as overseer of post-graduate medical education, in my hospital, I had 450 of the brightest young minds in the country, within earshot. It was clear that they could find solutions. … With the freedom to find solutions these youthful professionals have not disappointed".*

As a leader I was thrust into a different cauldron with instructions to lead from the hospital medical director. There was no time to argue, and I recalled feeling sure that, despite my fear, I was indeed best placed to respond. I reckoned that old leadership styles were unlikely to be successful and I was confident that my new insights and understandings about leadership could help in the task. I made a conscious decision to lead differently to flatten the traditional hierarchy, to utilise the intellect and skills of the available team and to collaborate widely to co-construct solutions, to talk less and to listen more.

Meantime, several events stood out as painful and despite increasing exhaustion I captured them in diary entries and free writing.
7/4/20FW, Time 23.32

> *"I am once again sooo tired my eyes are closing. My family think I am overdoing it. BJ*[35] is in hospital but not intubated. I'm soo tired my eyes are closing of their own accord… I have to sleep…thoughts anon."*

I diarized increasingly desperate accounts of impediments to COVID PCR testing within the hospital. Antigen testing had not yet been developed. I conveyed what I believed were local and national organisational and political shortcomings. I used words like "woefully" and "negligent" and made the following statement to myself "*I feel politics are coming between what is sensible and what might help protect our staff* ". However, at this time, I was also aware of how, making these revelations and

[35] * BJ = Prime minister Boris Johnston (PM)

my views public, would raise further tensions locally and nationally and make future work with some colleagues difficult. Staff and the public would also likely become more frightened. Staff shortages were already a problem. Looking back this could be interpreted as systematic emotional manipulation in this situation rather than by an individual as described by Hyde (2020).

The following dated diary clips foreground the lack of testing during the early days of the COVID-19 crisis. My annoyance is evident, as my repeated efforts to unblock the barriers were unsuccessful. Surprisingly, I am clearly buoyed up by the task in hand. The insistence of the problem strikes me even harder now as I write, than when I typed the entries. I realise that I was once again placed in a liminal position responsible but disempowered and excluded from corporate or governmental thinking. This extract also illustrates, I believe, the impact of evocative autoethnographic narratives. I made eleven diary entries charting this vexed 'COVID-19 testing' problem and have included extracts from each one here as they reflect my lived experiences through this part of the crisis. Of note, I had performed PCR as part of my medical research doctorate in early 1990's (Burns, 1995) so I knew that testing was feasible and that could have been established locally much earlier.

27/3/20 Diary (0.44 am)

> *"Really furious we can't get testing done when this can be done in all other sensible places. Lots of excuses… our staff are being put at risk… if we are not well, we cannot look after patients…*

27/3/20 Diary (10.49pm)

> *"I so hope he can get us up and running with testing. What a situation to be in? Of course, the whole world is wanting these reagents..."*

28/3/20 Diary (12.54 pm)

> *"...My BP is great, and I feel energetic. Each day I seem to extend to a new challenge I would never have thought I had space for: today surgical rotas, tomorrow???? Reagents to get testing done!"*

29/3/20 Diary (11.52pm: day before my 60th birthday)

> *"I am so desperate to protect our staff and to get testing ASAP. Is it around the corner? Can we believe what we are being told???"*

30/3/20 Diary (no time recorded)

> *"… Each day brings new challenges. I'm straying into territory that I am unfamiliar with i.e., navigating testing of our staff. Still no testing at all, to speak of! All promises but only 15 staff tested today."*

4/4/20 Diary (0.18 am)

"I'm not sure how or where the time went today but I am spent but full of energy for this task. CH and I have been battling all and sundry to get some local testing done and today we may have had a breakthrough although it feels like we have been "knock, knock, knocking on heaven's door" against multiple and much resistance. We may be able to contribute a large amount of reagent to the testing pot!! What a relief it would be to be able to test. Meantime, patients are continuing to die."

6/4/20 Diary (11.10 pm)

"…Finally, a call at 4pm to say we had capacity to test 100 more people, samples that would be wasted otherwise. I had the naïve thought that I could offer testing to 70-100 of our doctors (ending their shifts and heading away for a 3-day cycle of rest). How stupid, of course this broke so many politically sensitive rules that despite finding swabs and sample bags and getting agreement from 5-6 emergency department people who were all very supportive, 7.55pm (5 minutes before handover and shift end) I got a call from 'on high' forbidding me from doing this, as it was breaking current infection control policy rules. I went and humbly apologised to the doctors I had given the expectation (of testing) to. I felt foolish and humiliated but mostly saddened that our staff 14 days after we started the new rota and still the testing is pathetically little. I struggled to control my quivering voice. I feel politics are coming between what is sensible and what might help protect our staff."

9/4/20 Diary (9.01 pm)

"Sitting in kitchen at home PCR test equivocal feel fine…that said testing is soo limited. It is a bit of a joke, so people are coming back if they feel OK and my test is a bit of an anomaly as it was done when I was well. No one has an idea what the right thing to do is."

13/4/20 Diary (8.54 am)

"I can't seem to get the message re. testing 'well people' through. I am cracking up. We know we have doctors who are well and spreading.
... I feel we need to get ahead of on the testing curve...
... Arguably testing when symptoms are there is a waste of capacity…
…AHHHH I am also conscious I need to keep my cool… ranting does not work whether you always do it or only occasionally."

15/4/20 Diary (no time recorded)

"Still, virtually no testing! I cannot understand who is driving this thinking. We won't be able to move to the next steps without testing."

21/4/20 Diary (8.40pm)

"… They are only up to 35 or so tests a day in a hospital of 5000 employees! What is that about? They (the laboratories) say they can test many more. Why do we not have mobile testing stations? We could have the whole place tested and bolted down if we had been allowed to test…"

The emotion in the narrative is clear. In an early criticism of this thesis work, one reviewer classified these events as a 'critical incident'.

Louie (2003) found that most SSs could be grouped into three categories: identity orientated research, the relationships between (teaching) beliefs and practice and collegial interactions. Affairs of all three require emotional outlay and SS can give voice to this capital. These data demonstrate how the 'COVID testing issues' touched all three of Louie's categories. I now recognize personal and professional injury, collegiate loyalty, and uncomfortable truths about my organisation and political 'masters'. While I set out to use the triple lenses of personal, professional, and organisational perspectives to examine the data, the interpretation and sense-making process made me realize that internal emotional responses and dialogues weave all three aspects tightly together such that they cannot be neatly separated.

Apart from charting COVID testing inadequacies, these diary entries convey the emotional energy I expended on this topic. Kerasidou (2016a) draws notice to how little attention has been given to the emotional price clinicians pay when they cannot deliver what they believe to be best for patients. As discussed in Chapter 3.2 the term "moral injury" now permeates healthcare landscapes (see Griffin, 2019). Here, I truly felt alone, as a leader rather than a clinician, powerless to achieve what I believed was important and inhibited from expressing my beliefs, except in my diary and free writing entries. From this distance, I recollect how I felt torn as I also sought to demonstrate, loyalty to my seniors and organisation as well as a cool rational and even-minded temperament, while all the while, my anxieties and fears mounted. My emotional labour quotient was high. Rather than experiencing moral injury I felt I was enduring professional injury as I was hampered from being the best professional that I could be. My special experience, knowledge, and education (the essence of professionalism) felt diminished and impotent.

Although I was not conscious of acting to cover my true feelings or reassure others, I was unmistakably conscious of my leadership responsibilities. The formality of SS research forced me to articulate rather than circumvent or ignore these issues silently and to narrate my frustrations privately especially as resources and procurement became increasingly politicised to the detriment (I believed) of patient and staff wellbeing on the ground.

While I charted my (thwarted) attempts to overcome the COVID-19 testing hurdles, at no point (I now reflect) did I seriously consider going 'public' with my views. It is also noteworthy that throughout this time, staff were repeatedly and strongly advised by the trust not to communicate with the 'media'.

Whilst only half the FW entries exceeded the 5 planned minutes, some extended to near 40 minutes. On 21/12/20, I exclaimed, "*11 minutes stop!*" Whilst on another occasion, I wrote 45 words that charted my exhaustion in the middle of the COVID crisis.

Acknowledging, now, the solipsism of my narrative, especially as the crisis peaked, I am amazed how I also sought and drew comfort from SS literature and its many analogous examples of uneasiness, narrated sometimes loudly, sometimes sotto voce.

I have selected here entries to evidence the space the diary and FW narratives provided for reflection and purgation.
24/2/20 FW (00.10 am)
I started the entry with:

> "*In any case, today again feels like a lifetime...*
> *...I have ranted for a solid 37 minutes. I needed catharsis but was it enough?*
> *The lump is still in my throat*"

As my SS began to unearth uncomfortable truths about my own organization and national politics I found analogous situations in the SS literature. Abbasi (2020) and Clift (2020) document similar troubles and Myers (2007) refers to these as 'guilty secrets'.

Building on this thinking, leaders holding similar knowledge, likely feel isolated and conflicted (as I did) when unable to unlock solutions to pressing problems or when they are reluctant to, prevented form or constrained from speaking up. I realized that the silencing forces, in my world, were drawing heavily on both my professionalism and my organisational loyalty.

Additionally, as discussed in Chapter 3.2.4, this example draws attention to how, in many situations, leaders feel obliged to put on a brave or calm face both at times of crisis and uncertainty but also when they are enacting policies and values that are neither of their making nor to their liking.

5B 3.1.3 Responding to crisis: the COVID pandemic: Complex Relationships

During the COVID crisis I charted the sense of belonging amongst the PME COVID-19 taskforce group. However, I belonged to but felt excluded from other groups. I was affiliated to but not part of the hospital or university senior management team and accessing or having my voice heard in these fora proved problematic.

Of note, this liminal positioning became particularly painful during the pandemic when the restructuring I orchestrated was very unpopular in my specialty. I felt thrust out of my group into a limbo I found very painful.

18/4/ 20 FW
"… and my team fared badly during the pandemic (27% of our dialysis patients who contracted COVID died) *struggling to provide dialysis and keeping kidney failure services going with skeleton staffing. I am saddened that they think I did not support them adequately. That has been one of the hardest things as these guys are my tribe."*

While I expended a lot of energy trying to get COVID testing up and running. The table below illustrates my concern for infected trainees and how anxieties and a sense of responsibility for staff motivated this endeavour. Yet, it seemed to me that no one who had the power to improve the situation was listening and some in higher places clearly did not understand the pressure we were under.

27/3/ 20 Diary (0.44am) *Minimising risk to staff*	*...managed to get home again tonight lovely to see everyone* *…* *Our staff are being put at risk… If we are not well, we cannot mind our patients!* *I see evidence of improved social distancing but still groups huddle over patient lists. I can't even think about the risk of spreading germs on notes. We need to eliminate paper notes (archaic anyway!!!).*

	Lots of issues today with staff sickness I am seriously concerned…
12/4/20 Diary (Time not recorded) *COVID-19 hits our staff*	*3 more young colleagues have this now and I am nervous about each one. Two get better 3 sick… Older colleagues are either returning to work and glad they have survived this or still getting symptoms and not out of the woods at all. Then HEE sent an e-mail piling more pressure on DMEs and trainees talking about going ahead with ARCP*.* * I will return to this issue later

Table 5.5 reflects the concern for colleagues during the COVID period.

This thesis set out to examine relationships and my writings charted many professional interactions. Diarising a charged encounter with B* illustrates the personal and organisational 'baggage' that influenced both his and my positioning as well as the deep hurt that unpleasant encounters engender endangering productive relationships. The context was a consultant insisting his trainees 'stand down' from the acute COVID-19 rota and return to his area of service forthwith. I received a telephone call from B* forcefully insisting his trainees (in a non-acute specialty, much of whose routine work had been suspended temporarily) were returned to their original posts (At the start of the pandemic I had redeployed all trainees to front line services, at very short notice). On that day, I had just begun to self-isolate having tested positive for COVID-19 and had already lost a colleague to the virus (B* was aware of these facts). A senior management colleague had also phoned me to exhort me to "see what I could do" to return the trainees.

25/4/20 Diary (no time recorded)

> *"I am outraged that B* gets some senior soothing and I get a call to ask me to see what I can do for him! Either we call out bullies or we don't. I know I could have handled the conversation better and he (B*) caught me off guard and raw after the morning ordeals (*an older friend and colleague had died of COVID-19 after a 27-day ITU battle*) but what human being, not to mind a professional, talks to a colleague whom he knows is at home suffering from this unknown monster virus and fails to wish them well, apologise or recognise that this can wait. Not surprisingly, then he follows with a cynical e-*

> *mail to our medical director and his divisional director (DD). The DD calls me, I suspect he knows I am upset but is very kind. Yet, he asks me, again, to sooth B* and see what I can do to return his trainees".*

It was and still is, difficult for me, to admit that undermining is part of the culture in my organisation but akin to many others in the profession (Bradley, 2015) I experienced many instances when I felt bullied especially during the pandemic. Although Bradley (ibid) found that those in senior positions suffered less undermining than lower grades, here was evidence that as DME and a senior consultant I was not exempt, and I felt the effects deeply. I realized, with regret, that the culture of my organization was such that undermining behaviours though not tolerated 'in theory' were alive and well in everyday interactions and relationships. I pondered the resulting cost to trainees and how the vexed challenge of improving culture could be addressed. I wondered what role DMEs should play?

5B 3.1.4 Responding to crisis: the COVID pandemic: Self-actualization as a leader

Although, I have had no formal management or leadership training, my response (I see in retrospect) to the COVID- 19 crisis fits with many of the lessons from management Nembhard (2020) suggests needed application in this crisis. Acknowledging the major organizational and managerial challenges as well as the public health issues she draws on a U.S. military acronym VUCA (Volatile, Uncertain, Complex and Ambiguous) to describe the situation. In the absence of "evidence-based medicine or (an) established playbook" (p 1) for how to manage the pandemic, she suggests drawing on existing management research insights. She recommended five actions to be taken by health care leaders as follows: put people first, manage operations creatively, attend to teamwork and communication, create outside partnerships, and embrace clear and humble leadership (p 2-5).

Thus, examination of this literature and my data has given me insight into the personal and professional leadership qualities I displayed even when faced with an unprecedented situation and organisations struggled to deliver. My passion for the profession and my "guiding vision of the task to be accomplished "*be able to say, hand on heart, we did our very best*" (Appendix VII) and the strength to persist despite setbacks and failures surely meet Bennis' (1989) leadership requirements.

Without naming it at the time this was a 'VUCA' situation, and I was (unknowingly) following Nembhard's rules. I repeatedly considered all available resources and our group though and acted creatively (e.g., recycling venturi masks). I was determined to put my people first, to champion teamwork and communication and to engage outside help (e.g., rag trade). I was not afraid to fail. Yet, I still question whether I lacked the ability to "communicate my passion" and whether I should have spoken out more controversially and more courageously. Why did I not shout the injustices from the proverbial rooftops? Was I afraid? Was I suffering for learned helplessness or other reluctance? Was I silenced by institutional bullying? On the other hand, I clearly attempt to remain calm to rationalise the situation and provide a collaborative space for teamwork, belonging and affirmative action.

I am consoled that Bennis' (ibid) "integrity" imperative is abundantly clear.
I also recognise in my writings that leadership qualities of perseverance and resilience, of learning from failure and overcoming obstacles to progress towards a clearly envisioned goal, are well illustrated by these examples.

Stage 4 Leadership reflections after action

5B 4.1.1 Leadership reflections after action: Context

At this juncture, I should acknowledge that the 'spring' 2020 COVID-19 crisis period was a particularly difficult time in terms of administrative support in the hospital. Most non-clinical staff followed the government's advice to remain in at home in lockdown for the duration. It seemed that only handfuls could arrange to work from home. A few PME staff relocated their work to our sister hospitals closer to where they lived and where they could work socially distanced. They did what they could, but most were not available for organisational support. Since then, on the positive side, many of the administrative staff in the hospital have been enabled to work from home and hybrid working pattern have emerged.

Perhaps unsurprisingly, it became painfully clear that some of the tensions Daffodil and I had explored in the CAR meetings surfaced so that several trainees asked to be removed to another area of the hospital to 'escape'! While our CAR meetings had to cease during the COVID pandemic, Daffodil carried on working tirelessly on behalf of trainees despite the trying circumstances. Given Daffodil's previous exploration of visible and hidden frictions (s)he was already largely cognisant of the cultural

changes needed to be made, to support trainees but staff illness and the vulnerability of the patient population made the situation grim. However, because of a near boycott by trainees, working in Daffodil's area, and Daffodil's efforts, most of the other consultants showed signs of believing what the surveys and feedback had suggested and appeared to make efforts to support their supervisees and changed many of their practices to improve the trainee experience. New additional staff members (including two physicians associates) have been employed to support and improve the rota. At the time of writing the atmosphere was reported anecdotally (personal conversations with several trainees and consultants) to be better and the area is recovering some of its, historically, very positive training reputation. Prior to COVID Daffodil had arranged for new wall-mounted screens to be ordered together with chairs and tables so that the unhelpful configuration of the meeting room could be altered. At the time of first editing (April 2021) the tables and chairs have arrived and are in use, but the wall-mounted screens were only installed in early 2022. Continued hospital wide social distancing rules have meant that teaching meetings are held hybrid fashion on the 'teams' platform with only a small group present in the revamped teaching room. A plaque on the door expresses our thanks to the patient association charity for funding the upgrade.

Tulip supported nervous trainees during the COVID-19 crisis. (S)he identified one trainee who would likely have suffered harm if forced to be patient facing and this trainee discovered talents ensuring the mental wellbeing of other trainee doctors was attended to during the pandemic and co-authored a paper on trainee wellbeing during the first wave. Tulip has since left the trust for unrelated reasons and I am endeavouring to support the TEL who has taken over in CAR like fashion.

5B 4.1.2 Leadership reflections after action: Tensions and emotions

Reviewing my data, I recognised 'relational professionalism' akin to maternalistic (Ferlin, 2013) leanings in my leadership style. My concern for the physical and mental welfare of trainees and colleagues was abundantly clear.

As I further analysed the data the power of SS became even more apparent. Throughout the pandemic and importantly as the COVID crisis began to ebb, my diary and FW provided a welcome reflective, reflexive and learning 'sieve' as well as a cathartic space. Articulating what was happening, my reasonings, worries, and plans

as well as my frustrations and (at times) anger, likely helped me to process everyday issues, as well as the enormity of the disaster that had unfolded around us. I became aware that although these writings in some way provided a release that counterbalanced and harmonized the discomforts and that literature and to some extent, doodling, art, and poetry helped me, the responsibility of leadership had a lonely darker side (as discussed in Chapter 3.2). The double edge sword of gain and pain was ever present. This is illustrated below:

16/4/20 FW (10.54pm)

*"Today was a weirdly sad day for me on many fronts. The signs of light at the end of the tunnel seem to be solidifying. Yet, I am uneasy that we will relax too soon. The daily death tolls (*national*) are still >800 but several other, on balance, more sad than happy, things happened today. Great virtual 'Teams" teaching on the positive side. Lots of praise for our rotas, handover, communication etc.*

I then go on to agonise over a colleague whose mental health 'spring' I feared, we/I had stretched too far and how they needed professional psychiatric help. I describe how, not realizing the seriousness of this situation, I initially *"applied a Band-Aid to the gaping wound"* and worried about their ultimate outcome.

I reflect:

"I truly hope it (the spring) can get back to its original shape! Too sad for me and I know such folk can come down as fast and hard as they go up."

Here, I reflect on the 'dark side' of leadership that can be summarized in the words of Shakespeare in Henry the IV "uneasy lies the head that wears a crown" or in the more contemporary words of grime artist Stormzy (2019) "…Heavy is the head that wears the crown…" as he "…searches every corner of his mind to get the answers…" https://stormzy.link.to/crown.

Yet, reading my documents closely I see that several times, there was a pragmatic need to adopt 'operational mode' a positioning that trumped my more 'natural' conciliatory preferences. A good example of this was the redeployment of the non-consultant hospital workforce within a very short timeframe during the first COVID-19 wave. The imperative to rapidly redeploy 400+ trainees, to cope with the expected influx of patients required stern, hard thinking and authoritative action that proved unpopular with many senior colleagues. Thus, my lived experience illustrates further the need for adaptive leadership strategies, appropriate to the task 'in the moment'

and the urgency of the situation as discussed by Randall, (2007). For this task, I traded off expediency for a more compassionate and collaborative approach.

Yet, from March to June 2020, I experienced the worst of times and the best of times in my long medical career. I knew I was placing trainees in "harm's way" without adequate protection, and I stood by while some became seriously sick. I now realize that this experience hardened me to some extent. As the COVID situation defervesced I behaved differently towards some TELs. I ended two contracts. I do not regret the 'sackings' and was surprised that once done I did not feel bad. The crisis removed the scales from my eyes. I had to acknowledge that invisible TELs were never likely to improve trainee experiences and that some were best replaced. The pragmatic leader was trumping the softer one! However, the senior team also redesigned senior PME activity to enable, better induction and increased contact challenging TELs to participate more actively in exchange for belonging to the PME faculty, support, trust, and autonomy.

5B 4.1.3 Leadership reflections after action: Complex Relationships

Several of the COVID PME trainee taskforce e-mailed me their reflections after the team had been disbanded. This data was given voluntarily, and I subsequently received permission to use quotes specifically for this EdD thesis.

Despite the difficult situation most were grateful for the experience that they recognised would stand them in good stead for their future careers. Some have told me that they miss the intense relationships, the sense of commitment and purpose as well as the camaraderie, change agency and excitement that characterized those heady months.

The following quotes confirm the trainee appreciation of the opportunity to gain leadership experience, their feelings of belonging and being valued during the crisis. Eagerness to point out what worked well and not so well and a readiness to pursue leadership roles in future is also evident. Further comments are available in Appendix X.

Trainee A

> *"Overall, I felt as if I was able to make a small but significant contribution to the Trust's response to COVID-19. It was a silver lining to have an opportunity*

> *to learn more management and leadership skills. I learnt about the workings of the hospital management team and now appreciate the planning required to keep even a single service running…."*

Trainee B commented:

> *"The COVID effort mobilised everyone with a singular goal, and made people feel part of a team. This happened both on a larger level, with handovers, and on a smaller level with the firm system. … (In Future)- a firm system could be replicated in day-to-day ward medicine and on-calls, allowing people to build trust, friendship and a sense of belonging with colleagues…"*

Analysing these comments, I considered their content, how trainees recalled and articulated their perspectives on our shared experiences. The topics they chose to write about, and the evidence of engagement, commitment, and enthusiasm took me aback. I felt personal and professional pride (Eudaemony) in these trainees. Privately, in my FW, I took some modest credit for having orchestrated this unique leadership exposure. I reflected how I encouraged everyone to write papers describing and analysing this extraordinary time. I resisted the urge to take control. My contribution as senior author was as a catalyst and final editor only (Appendix IX). The trainee comments (Appendix X) confirmed that my leadership style had adapted to meet the 'service' needs of the crisis but had not neglected trainees, attending to how their learning could be enhanced even during the unscripted crisis. These doctors showed clear evidence of reflection after action and deep learning that I predict will assist them in their future professional careers. Many refer to teamwork and positive interpersonal relationships. Creating a positive, enabling and trusting organisational culture made a difference. It was clear to me that all healthcare organisations would benefit from taping into the wonderful reserves of energy and intellect that postgraduate trainees possess.

Further, I realized how complex my relationship was with myself. As I contemplated what leadership qualities I demonstrated or were deficient in these COVID anecdotes, I theorized how resilient people behave in a crisis. My response was to step into an active role recognising that with 'others' depending on me, their wellbeing was hugely important to me and I had to work out, and fight for, what we needed. Once again, on a deeper level, my own survival strategy was linked to doing something for 'others'.

My leadership was not perfect but the feeling of empowerment and agency I experienced comes across strongly in many data extracts.

28/3/20 FW 10.54pm

> "*I feel energetic. Each day I seem to extend to a new challenge I would never have thought I had space for".*

For me, stepping into action was not a choice it was a necessity. At this distance, I recall one colleague remarking that I appeared to be 'enjoying' the COVID-19 crisis. Thus, the examples demonstrate this double-edged sword of worry and reward and the feelings of fulfilment that accompany leadership roles. I can now acknowledge that for much of the COVID crisis I resided at the top of Maslow's (1943) pyramid. I experienced the coveted self-actualization and creativity talked about as well as the esteem of colleagues one of whom wrote the following.

7/2/20 e-mail from a TEL (used with permission)

> "*From my perspective I think you do a great job as DME and very much appreciate the support and promotion of * training in the Trust"*

Another e-mail from a senior management colleague leaving the organisation went as follows:

> 21/4/21 e-mail
>
> *"you have been a great pleasure to work with. Your drive, tenacity, care and compassion are unparalleled…"*

I was understandably buoyed by these comments and the intense and often warm relationships that developed especially during the CAR project and the COVID-19 pandemic. More importantly, however, I think I began to forgive myself for my shortcomings. I was following West's (2017) and Brown's (2020) lead that compassionate leadership begins with my relationship with my own self.

5B 4.1.4 Leadership reflections after action: Self-actualization as a leader

With these green shoots peeping through, I realized how far my leadership journey had taken me. As my understanding and style changed, I came to appreciate the need for structure, scaffold, and processes in PME, but I also understood why I often found myself conflicted, mistrusted, and criticized in the HEE hierarchy. Yet, my belief that that HEE was disconnected from what was happening in my world strengthened.

I cite, here, a diary entry made during the height of the pandemic when DMEs throughout the country were especially busy judiciously redeploying their trainees into acute areas (harm's way) while simultaneously trying to support their physical and mental wellbeing as well as their professional development and training.

12/4/20 Diary (no time recorded)

"Then HEE sent an e-mail piling more pressure on DMEs and trainees talking about going ahead with ARCPs (annual record of completion of placement). I think they (ARCPs) should be boycotted. We are trusted as trainees, trainers and ESs to care for their (HEE employee) family members and they don't trust us to say whether a trainee who has put themselves in harm's way, to help patients, should be signed through… NONSENSE."

I used Socratic questioning to drill down on the history and origins of my 'old' leadership style. I recognized that my past performance of largely hierarchical approaches (aligns most closely to authoritarian style; illustrated unintentionally in Figure 2.2, had engineered my 'troubled' situation to a significant extent. I also noticed, that as a 'follower' within the HEE organisation, I was led and controlled in a similar top-down way with little emphasis on trust and DME agency. The extract above demonstrated that this authoritarian approach was destructive and inappropriate in this situation.

I yearned for HEE to understand the intense pressure DMEs and hospitals were under and to suspend the bureaucracy, allow DMEs to exercise more autonomy and to trust and help us (trainees, supervisors and DMEs) to do the best we could in uncharted territory. This realization struck home even more forcefully during my analysis when I considered my supervisors response to the 'letters live' ReadALetter- piece aired on radio (Appendix VIII). Our WhatsApp conversation went as follows: The underlined question had a powerful impact on me.

10/4/20 CF to AB (10:36pm)

> *"…Wow Aine... lovely to see you and to hear you reading your letter … your smile and sense of hope at the end is what has captured my thoughts... the space or wriggle room you have facilitated for your young fledglings to experiment and challenge the complications of the virus is what is proving to offer liberation. In theorising about this you will find how in the moment of crisis such things as trust and belief have borne fruit as these younger doctors from what you suggest, are stepping up. Indeed, that gave me hope too. <u>What do you hope to achieve in response from the body you have addressed your letter to?"</u>*

10/4/20 AB to CF (11:37pm)

> *"You always hit the nail on the head! I addressed my letter to HEE not quite realising why! No one else has asked me.*
>
> *I think I wanted HEE to take notice & to harness the brilliance & youth of our post graduate doctors instead of strangling them with infantile tick box competency demonstrations that have de-professionalised a generation. HEE, to me, see it as protecting them (trainees) from the realities of medical life until they are ready… Trust is the essence of our profession & if it is not modelled from above* (including regulatory bodies*) it sets a tone so that no one trusts them, so they lose heart & leave the profession!*
>
> *At least in my Hospital, for now, we have given them back a sense that they are worth trusting & as I said they have not disappointed. … We have achieved more in a few weeks than we have in the previous half-decade! I am in awe!*
>
> *Thank you for forcing me to articulate some of my subconscious intent!*
>
> *I think my SS, in a bizarre way, has enabled me to see this & facilitate accordingly. We are enacting real CAR to deal with this crisis! It has given us the agility to move fast and to adapt!"*

SS research had forced me to realise that my well-intentioned hierarchical control was steering my improvement efforts off course. Thus, as time progressed, I endeavoured to heed my own advice and create a culture of trust and autonomy amongst my TELs and ESs. I admit that on many occasions, this approach has felt alien. The insistent voice in my head whispers, *"if you want a job done well, do it yourself".* I must figuratively step back and often listen and hold my tongue. I have come to realize that I am at my most powerful as a leader when I give my power away, when I am the 'invisible' leader Hickman (2013) describes, the oil and glue behind the scenes and my leadership goes un-noticed.

Armed with these new insights, I became determined to move to a more inclusive, distributive and importantly collaborative leadership style that the evidence suggested was more engaging for and supportive of TELs, trainees and supervisors. Further, the talent and skills that have been unearthed since adopting this strategy has amazed me. Daffodil for example brought unexpected spread sheet expertise to the rota problem. Another TEL who herself was trained outside the UK has created a popular "hidden meaning" communications skills course for new doctors who join us from abroad. A senior faculty member, in collaboration with a group of registrars, are championing the 'civility saves lives' campaign in our hospital, while another TEL has collaborated

with some enthusiastic trainees to set up afternoon TED (Tea (cake) and discussion) sessions for foundation doctors to share challenging experiences.

The success of empowering trainees did not go unnoticed. Two trainees were asked to speak at a senior leader's hospital event. One of the COVID taskforce has become a 'chief registrar' and has redesigned admissions pathways for acute medical patients and working schedules for medical trainees have been changed to privilege small tight team working with much more trainee involvement although staff shortages continue to make this intention extremely challenging.

Acknowledging the success of the "PME COVID taskforce" and the enormous value of the trainee input, the hospital CEO has decided to support a plan to convert registrar posts to incorporate two days per week of leadership apprentice type training scaffolded on an RCP London 'chief registrar' programme.

This final extract from my FW, exemplifies how SS was a useful methodology in transforming my PME environment. I use it here to illustrate how my SS linked theory and practice and brought a new deep richness to my DME role. Furthermore, serendipitously, I believe this research helped me and others survive a peculiar and particular crisis 'moment in history'.

18/2/20 FW

Medicine is a socially constructed profession founded on an enormous cannon of ***explicit knowledge*** *(growing and evolving at a tremendous rate) but is largely enacted through procedural or* ***tacit knowledge****. Such knowledge cannot simply be applied in a rule-governed way to guide practice. Schon believed that professionals generate their own "theories-in-use or personal epistemology of practice, which in turn enables them to ground and validate curriculum theory through their own practice." (referenced in Zwozdiak, 2018, chapter 3). This third dimension or* ***'cultural knowledge'*** *wherein theory is linked to practice is pivotal in healthcare…"*

I conclude finally that this latter statement is especially true when healthcare, training and leadership cohabit.

On a grander scale I still believe that HEE is losing the battle in improving standards and retaining trainees with their current approach. I propose that it is time for change and considering my work I propose that it is time to re-imagine the DME role.

5.5 Reimagining the DME role

This leadership journey was a difficult one for me but one that has transformed my understanding of my DME and other complex leadership roles. I conclude that it is time the DME role was re-imagined. I propose the beginnings of a mechanism for this re-imagining by addressing the four interconnected areas identified in my study analysis (context, tensions and emotions, relationships, and self-actualization of leadership). The context in which a DME leads could be overhauled by purposefully and deliberately reducing complexity and bureaucracy. Many of the frustrations for trainees and their supervisors could be removed by downscaling the various portfolios and trusting supervisors to assess competence. In our current manpower crisis this would release many potentially patient facing hours. Regained time could also be devoted to nurturing and developing trainees 'apprenticeship style' while assuring the quality of clinical supervision given to trainees in the act of caring for patients. This change would importantly also directly benefit patient care. Empowering DMEs to make supported local decisions or encouraging PME peer group decision making would help to reduce complexity and regain confidence in local leaders. DMEs should also have a meaningful role in their local Trust senior management team and report to the hospital board where their voice could be heard.

I suggest that the second contextual area to concentrate on would be enhanced administrative support and IT upgrades/connectivity together with uplifted staffing. The rota and employment issues need IT support but also additional manpower at both medical, nursing, AHP and administrative levels. The current situation is, I believe, not sustainable and may be encouraging an exodus of highly trained excellent doctors from the profession. It is my belief that we ignore this situation at our peril. Even the most committed individuals' loose heart when everyday issues are so unnecessarily challenging.

Supporting the emotional tensions that inevitably arise in healthcare work more deliberately is equally important. Trust, respect, civility, compassion, and autonomy are important components of this approach and need to be role modelled from top to bottom in the NHS and from the GMC. Both West (ABC) and Kanter's (3M)' elements of contentment and retention at work need to be enabled and fore-fronted. The work environment, the physical and mental health of staff and their wellbeing need to receive more resource and privilege. I have illustrated the beginnings of what this this might look like in Figure 5.13 below.

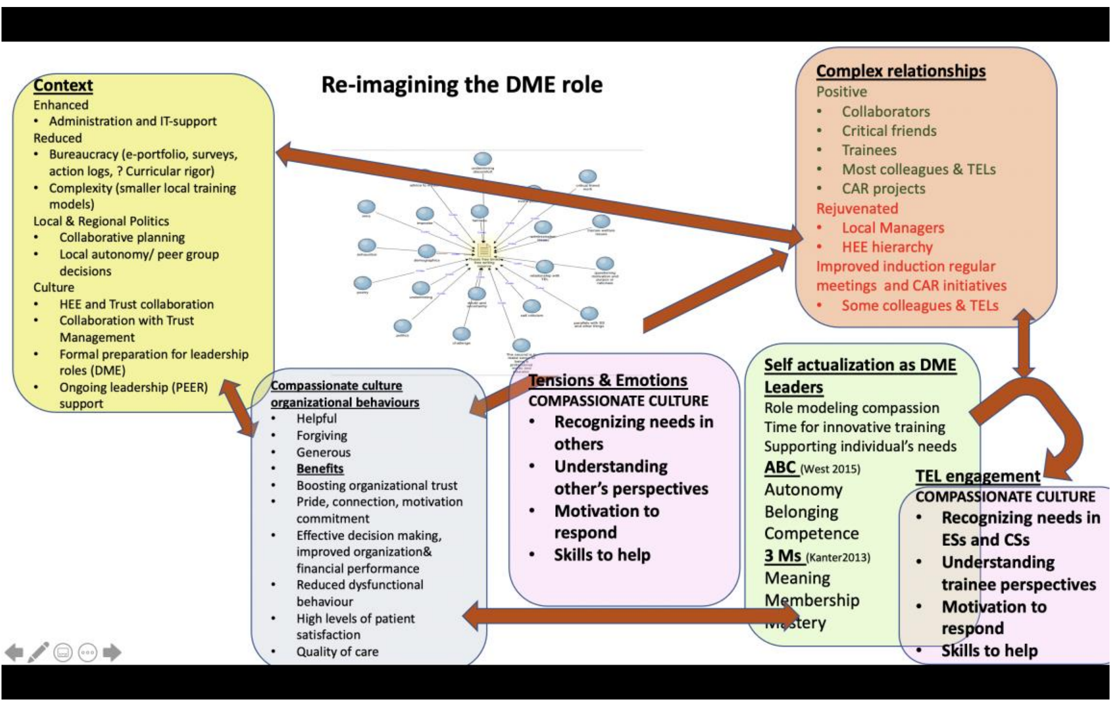

Figure 5.13 illustrates how the key themes identified might help to reimagine the DME role.

Although, my study has attested to the resilience of NHS staff and I am clear that if they are supported with compassion, they will not disappoint. Yet, there is much evidence that many are tired and frustrated and the future of healthcare in this country and perhaps across the world is in the balance. A more compassionate and collaborative approach would I posit result from these changes and in turn would benefit the complex relationships needed to care for sick people competently holistically and safely.

With trust and autonomy starting in early careers and growing under the caring and watchful eyes of trained, supportive, and supported CSs, ESs and DMEs, a facilitatory culture of learning and improvement would I posit result. Further, a strong new cadre of effective leaders would develop and be better positioned to serve the many healthcare demands of the future.

I end this chapter with a quote from Seamus Heaney's "The Cure at Troy"

History says, Don't hope
On this side of the grave,
But then, once in a lifetime
The longed-for tidal wave

Of justice can rise up
And hope and history rhyme.

I feel that "hope and history" rhymed in the ethos underpinning, the chance timing of, conduct, and output from this work. Perhaps this is the opportunity to enact change.

Chapter 6

Returning to the research questions

Q1 How can I as DME enhance/optimise the postgraduate medical training experienced by doctors in my Trust?

To address this question, I chose the novel methodology of SS that had not been used in postgraduate medical education previously but was increasingly popular in teacher educational practices. This strategy afforded me the tools and space to focus, in detail, on 'myself in practice' and on my performance as DME. This is an important leadership role that can determine the careers of the trainees and by implication the care they deliver to the patients for whom they are responsible both immediately and in future. Thus, the core premise underpinning the work was that the experience of trainees reflects the leadership skills of the DME and the functionality of the senior education faculty. Through this and the previous EdD projects, I came to understand that the key to success was not in the transactional adherence to hierarchical rules and operational rigour, imposed by 'powers' outside my control, but in developing and encouraging positive and compassionate relationships at home in my own 'murky' pond.

Extensive diary entries, FW, literature analysis, as well as memos and other varied qualitative data backed up by, what turned out to be, a 'pilot' CAR project formed the research material. All the while, this qualitative data fed the 'in real time' critical analysis that I used in sequential improvement attempts that I then, framed and reframed within their new context.

The planned project appeared to be going well and I felt bolstered by initial fledgling insights. In March 2020, in the middle of the planned project timeline, I found myself engulfed by the COVID-19 pandemic. I was tasked with leading the trainee doctor workforce who would provide the bulk of medical care for the incoming patients. I asked myself whether the lessons I had learned to date could be adapted to assist in this major challenge and what further leadership and relationship lessons I could discover. Encouraged and emboldened by my prior CAR 'pilot' and my readings in relation to SS and leadership, I orchestrated the formation of the PME COVID collaborative taskforce. This group, made up of a mixture of trainees and senior education faculty, emerged and grew organically. The force worked tirelessly to

achieve the best possible outcome for patients, staff and the Trust given the size and speed of the crisis. Special attention was paid to flattening hierarchical arrangements, empowering, and entrusting trainees as well as to staff wellbeing and continuing structured learning. The emergent CAR project grew organically and provided rich material for continuing my SS. My new leadership approach was tested in the most stringent circumstances.

While it is impossible to know whether trainee experience was optimized during this time, I learned how valuable putting trust in trainees and colleagues while divesting oneself of the responsibility of finding every solution is both painful and liberating. Yet, most of all, this approach proved highly productive and fits with the notion that we are at our more powerful when we give power. By the end of the study period, I was enacting a form of collaborative/distributive/adaptive/compassionate and authentic leadership that was personally much more satisfying and had an agility, I posit, to fit most situations.

Q2 What can be learnt about leadership in DME roles through SS and my own critical reflexivity and reflectivity?

My EdD journey originated from a desire to better my practice in my DME role. While I chose SS for this final thesis portion, the other elements of the EdD also skirted and explored this novel (for me) research paradigm.

Much of the writings were internal dialogues recounting my experiences, actions, fears, reasoning, uncertainties and occasionally triumphs. For me personally, through SS I came to see that the narratives reflected intense professionalism and a dogged commitment to improvement. I recognized similar qualities in other DMEs and senior faculty members. Further, Chapter 5B charts the evolution of my leadership style. SS enabled this change as the need for new approaches became obvious when by examining my data, I was confronted with the 'lived contradictions' in my work. I learned that much of what DMEs are expected to achieve is outside their control and they experience 'professional injury' that can be confusing and disheartening. But although DMEs cannot fix everything they have a better chance of enjoying a more satisfying and fruitful time by acknowledging this and engaging others in collaborative work to co-create solutions. Further, through SS I identified an opportunity for DMEs to model and promote compassionate leadership as well as

trust in and autonomy for trainees and colleagues. I also learned how this strategy eases some of the inevitable discomfort that co-exists with the responsibility of the role.

Q3 How could collaborative inquiry with a sample of TELs illuminate the challenges I faced in supporting trainee experience?

I was already aware of how difficult it was to access resources to make small changes in leaning environments, but the extent of the frustration and the draining of enthusiasm, I witnessed, in the CAR study surprised me. Consequently, I have been spurred on to expose these issues more publicly and to use any influence I have, to highlight the importance of leaning environments both in improving the acquisition of knowledge and skills but also in maintaining TEL/ trainer enthusiasm and engagement in the improvement mission.

By working closely with the two TELs in the CAR project and the COVID taskforce team I learned not only the details of what individual TELs and trainees were experiencing but more importantly I learnt how the real challenge of my DME role was how to create trusting and enjoyable relationships and how to work together to support trainee experiences. Through the CAR work, both in normal and crisis times, I experienced a fresh leadership style that rejected overt hierarchy and leaned more to 'noiseless' enablement. It is one where a leader is both the glue and the oil, visible yet invisible, seeing 'everything', judiciously ignoring most things to enable others to grow and develop and be their best selves. This style orchestrates the collective towards shared goals. It supports professionalism rather than dependence. The art of this method is that it conceals itself. The lesson for me and for other DMEs is that leading from within, in this way, is a more fruitful and satisfying custom. Collaborative enquiry demonstrated how DMEs can create opportunity to enjoy the triumphs trainees and colleagues deliver.

Throughout the COVID-19 crisis this leadership style proved to be agile and effective, created bonds of friendship and respect, and stimulated young professional minds to fulfil their broader clinical and local leadership potential. Several trainees who experienced and were key to the PME COVID taskforce response have declared an intention to continue in management and leadership roles.

Q4 – How could SS be a useful approach in researching and/or transforming the PME environment during a critical event: the COVID-19 crisis?

Unexpectedly this SS research provided a blueprint for my hospital to use real time, to deal with training and other clinical issues consequent on the major COVID-19 healthcare crisis (Khelrapal, 2021). This blueprint was used in other hospitals across the world and could be adapted for future crises. This evidenced the potential value of SS and particularly the CAR methodology in a major crisis.

The co-incident timing of the COVID-19 crisis and the resulting new emergency DME responsibilities and this SS (in particular the TEL CAR component) backed up by the reading I had done in preparation, felt like one of Bakhtin's (1998, referenced in Pinnegar, 2017) zones of maximum contact where past, present and future come together and can he believed be shaped and transformed." (I look back and Heaney's (1991) words *"The longed-for tidal wave of justice (can rise) rose up and hope and history rhyme(d)"* came to mind. Although, I am certain that my DME leadership during COVID remained flawed, I am adamant that without the EdD background we/I would have had a considerably rougher ride. While this statement might appear overly dramatic, my diaries and FW attest to my living these experiences at the time and I have evidenced much of what we achieved.

My leadership role felt like that of a conductor in an orchestra. I forced myself to listen attentively and while that sounds simplistic, I was delighted to be a spectator to wonderfully energetic, collaborative, and innovative thinking, theorising with determined agency of my PME COVID taskforce.

Despite this positivity, it would be naive to suggest that abdicating control fully (Laisse-faire style) or that stepping completely into the CAR circle is the only way forward in PME. Yet, my data would suggest that a watchful compassionate and collaborative approach to PME leadership is worthwhile and rewarding. For success I believe there needs to be regular CAR type meetings. By involving the whole team, as often as possible, individuals had the opportunity to gravitate organically to solving problems that are suited to their skill set and personality and progress on previous

action plans can be reviewed. Wins were celebrated real-time, or plans adjusted insightfully. Time and again, I witnessed trainees volunteer to lead on tasks that emerged throughout the crisis. Hidden talents and previous expertise or experience, outside medicine, surfaced that proved highly valuable in the overall effort.

Q5 – How can an understanding of compassionate leadership shape/change the DME role?

This research signposted a fifth emergent question not identified in the original drafts. In the final chapter, I attempt to address this question as, I contend, it is key and falls more naturally into the discussion and concluding remarks.

Chapter 7

Discussion

My research confirmed many previously known and vexed challenges that face modern healthcare leaders. It showed how rapidly changing workforce needs, to deliver increasingly complex, team-based yet simultaneously, safe, person-centred care, makes effective training and education difficult. Further, I evidenced that the expectations of the accountable bodies, and of trainees have changed faster than the systems that support them have evolved. The study showed the importance of organizational culture and how, on the ground, professed philosophies of corporate care often fell short of ideals. Sadly, it added to evidence that undermining behaviours are prevalent both between individuals and at an organizational level in the NHS. The study found that civility and kindness were present but were often trumped by the hurt that unsavoury behaviours caused. Many authors understand suffering as a reality of organisational life and my work would support that notion. I argue that changing my leadership style from hierarchical towards collaborative and compassionate, impacted positively on my leadership relationships, boosting trust, pride, connection, motivation, commitment, and trainee experience. Thus, the work endorses the hope that enacting strategic compassionate leadership across healthcare organisations will enhances patient experience, quality of care and trainee experience.

Yet, as well as revisiting familiar territory, this work is unique, and the insights are original for several reasons. Firstly, PME has been viewed and analysed through the lens of a DME journeying real-time through a leadership transformation voyage, embarked upon to improve trainee experience. Many of the lessons from this journey are new and generalizable. Secondly, SS provided a novel (in PME arenas) vehicle to explore this world. Thirdly, and perhaps most importantly, the work adds to a considerable literature around emotional capital expended in healthcare and a much lesser literature around such labour in leadership and PME roles. The work further points to a rationale for co-constructing solutions to the wicked problems we face, championing EI, kindness and wellbeing starting with ourselves as clinicians, supervisors, role models and leaders. It shows how compassion and collaboration can be woven effectively into education leadership roles. Fourthly, the work exposes how personal, local, regional, national, and global contexts contribute to the everyday tensions and emotions experienced by DMEs. It demonstrates how excess scrutiny, lack of trust and a dearth of DME autonomy, reflecting historical hierarchical

leadership modes contribute to the stresses DMEs, clinical colleagues and trainees experience. It suggests that the attrition of doctors from the NHS has in part resulted from this situation and could be worsened if these issues are not addressed. That is not to say the profession should not abide by any rules, checks or balances but my work indicates that a lighter touch is needed and timely.

The absence of literature on the lived experience of DMEs further strengthens the case for this work. There are no personal accounts, researched perspectives, or comparisons with directors from other educational fields. If trainee experiences are to be enhanced those responsible for their education must surely be the subject of useful study. Thus, my SS was opportune and delivers, I argue, much needed new perspectives on this important role as lived both in relatively certain and in less certain times.

The unconventional bricolage of diary, FW, transcribed CAR meetings, conversations with literature, reflections and reflexions, questioning, e-mails, and artefacts provided a rich and varied tapestry of data for analysis. They four key themes (context, tensions and emotions, complex relationships, and self-actualization as a leader) that emerged became the vehicle for examining and documenting the autoethnographic leadership journey. Veiled hierarchical approaches dominated my early leadership style with little evidence of distributive leadership and an over reliance on heroic norms. The data exposed how this approach led to feelings of isolation, anxiety, inadequacy, and dissatisfaction. Through the CAR pilot the pleasures and advantages of collaborative enquiry and problem solving began to emerge. As the analysis and journey continued it was increasingly clear that the emotional capital expended in the leadership tasks could not be ignored. Almost daily, the role demanded attention to weighty matters that could make or break trainee's futures and wellbeing. Trainee anxiety and mental health issues surfaced repeatedly and fitted with evidence from the literature that such matters are an increasing problem among NHS staff. Not surprisingly contemplation and worry about these situations took its emotional toll on me and on the entire PME team. Thus, in addition to collaboration and distribution to tackle leadership tasks more effectively and despite a deep commitment to trainee development, I realized I needed to add compassion to my approach.

Although the COVID pandemic disrupted the original research plan it created a unique opportunity to research and test my newfound leadership style as I purposefully continued my autoethnographic SS research during the crisis. The more collaborative and compassionate leadership style appeared to be effective helping the Trust to cope during the crisis. This was an extraordinary time of fear. Some of the pre-existing tensions and undermining behaviours became magnified and certainly I experienced unprecedented emotional and physical challenges. However, I felt a eudemonic pride when our trainees stepped up into responsible leadership roles and delivered extraordinary results that have led to several publications (Appendix IX). The trainees valued being trusted and included and by and large reported positive experiences. Thus, this component of the work suggests that instead of being protected during training, these doctors' brilliance, energy, and commitment could be usefully harnessed if they are given more incremental responsibility through longitudinal and meaningful leadership exposure and experience.

The work has also shown how the local, regional, and national 'context' in which a DME works impacts the 'real world' DME relationships that can be both enablers and barriers to training. There was evidence that the DME role was largely unsupported in terms of administration, to cope with the myriad of operational problems encountered and thus highlights a major area needing change. Either the administrative support needs to be greatly enhanced or the bureaucratic burdens reduced. The insistent problems were often magnified by an overreliance on surveys, action plans, portfolios, and having to submit written assurances that we could fix the unfixable, despite no increase in investment, increasing workforce shortages and service demand. As DME I lived in fear of worsening patient care and greater service pressures with trainee experience spiralling downwards if the ever-present threat to remove trainees from poorly performing areas was enacted. I evidenced that the processes designed to quality assure training often added to the administrative burden and sewed cynicism and dissent amongst the very colleagues I was trying to engage meaningfully as trainers. Thus, a reimagined DME role would look very different with more trust and autonomy (within education and trust management circles), less bureaucracy and more administrative help to overcome the rota and staffing problems creatively.

My writings also attest to my poor formal preparation for the DME role, as well as very little continuing supervision or emotional support. This observation is in line with other evidence that leaders in the NHS are left 'sink or swim'. I categorized this deficiency as 'organisational cruelty' that was sadly pervasive. Yet, I was embarrassed to have to acknowledge that I too had become an instrument of torture as despite being held to account, in my role, for championing supervision and support for trainees, I found I was poorly supported myself and in turn presided over systematic poor support for my education faculty. Thus, I was repeatedly reminded of Whitehead's "lived contradictions": the gap between what I thought I was doing and reality. SS exposed this truth and I realized that I needed to take steps to put this right.

My work concurs with Dewey's (1974) philosophy. DMEs are human and want to do meaningful work and to belong. SS provided a vehicle for me to examine and expose the 'real life' 'difficult to get at' lived experience of an education leader in a large teaching hospital. I was frequently positioned in an impossible, equivocal, liminal position on the margins of Trust management, regional HEE structures, and college activities. In my position I was also occasionally rebuked even shunned by clinical colleagues. I was able to demonstrate the unintended but nevertheless deep professional and personal injury this situation caused me and thus raise awareness that further change in this area is needed. I was expected to deliver on directives from many powerful stakeholders while sometimes feeling overlooked as these initiatives were devised and discussed by others and although, I often did not agree with them, I had to encourage my faculty to enact them. By acknowledging and enduring this personal dissonance, I now seek out, recognize, and try to address when colleagues are experiencing similar torment. At times, I learned that I possess the skills and power to help but at others sharing the pain is all there is available to help.

The lessons regarding 'insider /outsider' positioning, belonging and membership of tribes, parallel and align with much recent literature on retention of valuable staff in healthcare and medicine. They further attest to the importance of West's (2014-19) and Shale's (2019) work and suggests that the problems that troubled me are real and are coming to light in other areas of healthcare. West has become a prominent voice advocating autonomy, belonging and competence as part of a campaign to care for doctors caring for patients in the NHS. Working on behalf of the GMC and the King's fund 'think-tank' he has promoted compassionate leadership to address the

suffering and needs of healthcare workers in distress. This work suggests that such an approach would usefully underpin how the DME role could be refocussed. This thinking led to the final emergent question addressed in this research.

Scrutiny of my documented complex interpersonal and organizational relationships brought me closer to a new more satisfying self-actualization as a leader and signposted how this learning could help others in similar leadership positions. Not surprisingly then, the work proposes a need for a new and more effective DME model in line with modern leadership practices, healthcare needs and trainee expectations. The analytical framework that mapped my leadership journey is proposed as a scaffold to begin to enable this change. This is discussed in Chapter 3.5 and illustrated in Figure 5.13. It suggests that the context in which the DME works needs a complete overhaul privileging less hierarchical scrutiny, more trust and autonomy with local decisions being supported rather than challenged or blocked. This approach needs to come from the top down i.e., NHS, government, and the regulatory bodies. That is not to say that there would be no accountability or scrutiny but other measures such as signs of compassion, patient and employee satisfaction, trainee autonomy, as well as evidence that workers feel safe, secure, and are supported to envision and enact solutions to local problems could showcase success. Standard measures of mortality that considers the age, social demographic and clinical context of patients would continue in my proposal and examine whether as the culture changed outcomes improved. In this way, significant amounts of time would be freed up to care for patients and trainees and to problem solve and innovate collaboratively.

If training is to be truly valued senior leaders in education must have a seat at higher Trust tables and boards so that they 'belong' and are significant contributors to the strategy and operational development and understand why and how decisions are made. These contextual changes can only be effective if the staffing and service issues are addressed so that educators are not constantly side-tracked desperately trying to ensure minimum staffing levels and patient safety. Posts need to be overrecruited to accommodate the 'known unknown' of sickness, bereavement, less than fulltime working, parental and annual leave. The benefits to locum expenditure as well as staff wellbeing seem obvious. Many businesses and industries currently follow this practice as standard.

Other DMEs too, likely experience high levels of tension and emotional/ professional injury and this needs to be addressed. My ‘lived experience’ demonstrated how, for a caring profession, there was a distinct lack of compassion, although, clearly, additional COVID stresses played out here.

Sadly, an insistent culture of undermining was exposed, and I came to believe that I could no longer stand by while this remained hidden “under what Myers (2019) refers to as “a cloak of collegiality” (p. 12). The accusatory context in which we work contributes negatively to the emotions and tensions DMEs endure. It follows then that addressing the ‘context’ should help reduce the negative emotional impact and the tensions experienced by trainees and other healthcare workers.

Training to identify and understand the commonly encountered mental health issues such as anxiety, depression and burnout as well as knowing when and how to access professional help would be part of the proposed change in this area. Further, support with complex relationships by freeing up time for regular peer group meetings and the administrative support to back this up would help break down barriers and make educators develop their PME identity. Help lines and mentoring for difficult collaborations, emotional intelligence enhancement events and opportunities to share good practice without adding to workload heft would all be important.

Formal preparation for the leadership role is vital ideally with periods of shadowing, management, administration, finance, and IT training as well as continuing support and mentoring throughout the tenure in role.

Attending to DME wellbeing is also a key component of the change I envision. For me, reengaging with art and poetry was restorative and DMEs should be encouraged and expected to attend to their own wellbeing and be given the space to do this. Similarly, reflection especially on wins needs time and privileging to digest. Thus, self-actualization as a leader the fourth theme exposed would I believe be realized.

Throughout, this EdD, I experienced great highs, but these were equally balanced by frustrations and tired, low ebbs. This account is personal, brave, and honest. Although, the oscillations were lived in my personal space they could not be separated entirely from my professional and organisational worlds. At times, I did not

know which space I occupied: whether I was poacher or gamekeeper, friend or advocate, leader or follower, bully or bullied, self or other. The emotional capital I expended was caught up in these ever changing yet intersecting/overlapping circles whose boundaries blurred and misted. I see now, that, as professionals in medical education, we attempt to compartmentalise roles and feel we must solve our own problems. This research has forced me to see how futile this strategy is and to accept boundary crossings and insecurity as normal and necessary. Acknowledging vulnerability and guarding against undermining behaviours should, I hope, help me and others in future PME endeavours. These insights, I contend, answer the final research question: How can an understanding of compassionate leadership shape/change the DME role?

Unique contribution of this work

This work has showcased, for the first time, the potential SS research paradigms in healthcare education. Uniquely, it described and theorised the lived experience of a DME, as an insider during normal and crisis times. Tensions between the 'clean' systematizing of training versus the 'messy' business of nurturing professionals was exposed. The legacy of insights can be used to enhance PME leadership induction and continued support. They could stimulate useful discussion amongst educators as well as highlight some cautions for those wishing to engage in SS. It challenges the profession to consider a more nurturing and trusting approach to PME as a way of retaining and energising doctors in the profession and education leaders in the field. It extends the understanding of literature around leadership in medical education and exposed a need to acknowledge the emotional capital expended.

Although this work benefited my own personal development and practice, I already perceive that my changed attitudes towards colleagues and my altered leadership style has emancipated many members of my team. Inevitably, I sometimes fall back into old ways, but I will strive to live the benefits of trusting and collaborating honestly that I exposed so clearly in this work. Not surprisingly too, the organizational advantages have yet to become obvious, I hope that the work has sown the seeds of a better education culture in my organization. My relationships upwards with HEE colleagues has matured so that, rather than fume inwardly, I am now more assured in my belief and articulation that bureaucratic processes need to be minimized as they can lead to the deadening of even the liveliest spirits. I now promote freeing

colleagues by trusting their professional judgement. I will continue to promote and advocate for this position.

Strengths and weaknesses of the work

Overall, SS proved a useful tool to drill down into the PME world and to theorize about my work, stepping back to look objectively at practice, relationships, and outcomes. It enabled me to expose patterns of behaviour (my own and others) that enlightened and transformed my own leadership style and pointed to ways PME, and NHS leadership could improve. Thus, it has great potential, I believe, particularly in healthcare education research and development. The variety of tools and flexibility of the paradigm is particularly apt for this rapidly changing area. The privileging of group work has great potential as the multi-disciplinary team moves forward. The real time benefits of CAR fit with the need for flexibility, and responsive change.

Individual lived experiences are difficult and controversial areas of research. Emotions and tensions too are generally hard to expose. The ethnographic approach scripted using deliberately evocative writing style could be seen as a strength or a weakness. The intensity of self-scrutiny and the ‘nakedness’ of SS does not suit everyone and can be distressing. I have exposed uncomfortable secrets about myself and my organizations and SSists need to be prepared for this risk.

No doubt, issues concerning virtue and trustworthiness of findings will continue to be debated in SS and are valid criticisms of this work. Is a single person account ever generalizable? Further, the inherent biases of insider research can cast doubt on findings as can occupying dual positions of both researcher and researched. These are legitimate concerns. Yet, for me and for those wishing to better an area of their practice, my work would suggest SS holds great promise. I conclude that the strength of SS is the ownership the researcher has over the troubling addressed, the methods used and how the insights gained are applied and further analysed. The SSist’s motivation to examine their own practice honestly (and dispassionately) with the aim of bettering their praxis is exactly what every healthcare professional could sign up to with pride.

Transcribing the CAR conversations, myself, closely listening and re-listening to every word and pause capturing nuances and hidden understandings, proved invaluable for me but was very time consuming and frankly exhausting.

It is hard to reconcile the central yet apparently polar SS notions of solipsism and generalizability. Clearly, despite its name, there is a requirement to involve others in SS and to seek perspectives actively and deliberately outside one's own. In my case, I involved many varied individuals, an extensive and varied literature, and several CFs. The latter group proved invaluable sounding boards for my thinking and validated much of my written records of events. The two TELs who participated in the formal CAR component of the research, too, opened their own new avenues for thought and action. I was surprised and disturbed by Tulip's fear of having his/her identity or that of the department revealed. Some of the other research methods exposed analogous tensions and as discussed evidenced bullying and undermining. I found this very hurtful and unprofessional when directed at me personally but was also outraged on behalf of my trainees, my ESs and my TELs. Prior to this study, my positioning was one of obedience and always giving the benefit of the doubt when such issues poked through. Being forced to confront clear evidence of poor behaviour and the harm that results as well as the unfairness of those actions being condoned either directly or indirectly has emboldened me to speak up and I commend others to do so too.

Out of the blue, a new and deadly virus transformed this environment in a way that very few people could have imagined. I am convinced that SS prepared me for my leadership role in responding to this disaster in my teaching hospital, for a time the UK epicentre of the pandemic.

The work produced an organizational blueprint for leadership during uncertain and volatile times that can be adapted for future crises (Khelrapal, 2021). I believe that the success of this latter scheme was evident during the COVID-19 spring 2020 crisis when lives that might otherwise have been lost were saved.

Yet, I am also aware that harnessing this capital was relatively easy in this crisis as the whole world asked what could be done. Extrapolating forwards, it may be that time and service constraints will limit how feasible it is to continue to exploit these talents in ordinary times.

Looking back from this distance the TEL collaborative research seemed to give those TELs new belief that they could make a difference. Daffodil continues to work a pace and I believe has truly embraced an “educator” identity. I notice also that he/she has recruited trainees to share solutions to some of the improvement tasks and managed to increase staffing with the addition of two new PAs to help in ward areas. Tulip has left the trust for unrelated personal reasons. I have begun to work in intensive collaboration with Tulip’s successor although many problems remain. The senior faculty has designed a package of induction for new TELs and now offer CAR opportunities to them. Theorising about the provenance of this action, I have, I contend, completed the circle as I am using my organisational influence to enable the professional development of TEL colleagues. My personal insights have fuelled this innovation.

A common criticism of SS is its narrow focus and apparent lack of applicability elsewhere. I have shown how shining a spotlight on my own leadership style allowed me to pivot, at a crucial moment in time, to apparent good effect. I contend that SS has also given me powerful new knowledge to bring to future roles in medical education. I also now feel equipped to help others both in SS and leadership endeavours.

It is true that the parochial nature of my work makes generalizability of my insights uncertain. My study was not part of a larger regional or national research program and to some extent stands alone. This research was unconventional especially emanating as it does from a world where positivist outcomes are highly valued. Thus, it risks being dismissed by peers who herald more conventional methods. Whether this is a limitation, or a strength might appear unsettled but having conducted research, spanning the full breath of bench to bedside, throughout my 30-year career, I found the freedoms SS offered refreshing although the work took a greater personal toll and was, I contend intellectually more difficult than my previous positivist work.

Recommendations for future work

As the importance of preparing doctors for leadership in clinical medicine continues to be acknowledged and prioritized, leadership in PME has arguably fallen behind. The unique contribution of this work to the PME leadership literature is its

autoethnographic nature and its exploration of lived experiences. There is much opportunity to research other PME leadership roles both to validate this work and to study other areas.

Reassessing my hospital culture in the future will be useful to research the effects of my approach and my work. Yet, the complexity and changing nature of our contexts may make comparison futile. Similarly, whether the insights that emerged and the call to reimagine the DME role are listened to is open to further study. The opportunities for promoting SS in healthcare education are legion and could effect a whole new cannon of work as it has in the teacher S-STEP literature. If so, I propose we call it Self-Study of Healthcare Education (S-SHEP) to align with S-STEP teacher education terminology.

From a position where I enjoyed a reasonably strong research pedigree prior to commencing this EdD and this thesis, I was blown sideways by the liberation SS brought to my thinking concerning medical and education research and leadership. The freedom to examine any scenario in depth, selecting from a plethora of qualitative tools, not by prior guessing, but real-time and in a pragmatic but rigorous fashion, has been eye-opening. I will advocate for and build on this. Further, I feel I am now able to guide and assist others in SS journeys whether they are involved in PME or aiming to better other aspects of their work. The caveat that I will need to alert would be researchers to, as discussed, are the personal and organizational risks of emotional trauma and “uncomfortable truths”exposure.

Although the COVID taskforce group has published several papers (Appendix IX) I have not yet finished a thesis manuscript. Having completed this submission, I now feel ready to progress this task.

My private journey exposed by this narrative might seem unimportant. Yet, I contend that it is a unique, brave, and powerful contribution to the body of leadership knowledge and has advanced understanding of PME roles. Further, from analysis of my private personal ‘lived’ experiences I conclude that a restoration/endorsement of trust and autonomy in doctors and their educators is urgently needed to reduce the emotional capital DMEs and other PME supervisors expend. Further, I propose that there is an urgent need to reduce unnecessary paperwork and bureaucracy and create a

new more durable DME model. If this could be achieved, I believe that DMEs, ESs and CSs, trainees and ultimately patients could enjoy more meaningful relationships and a more companionable, compassionate, and safer culture would likely result.

The End

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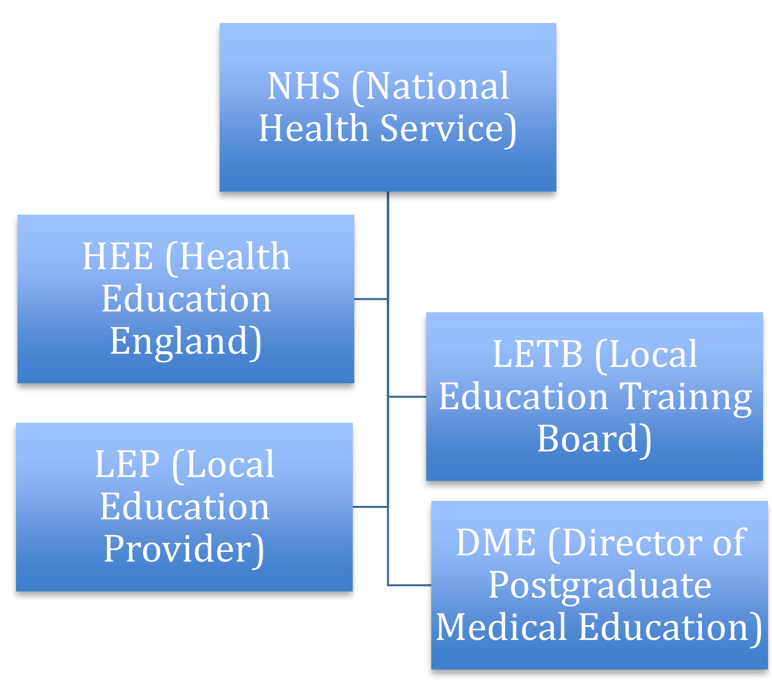
Appendix I
Postgraduate medical education in the UK (PME in the UK, Job description for DME role and notes on education supervision)

Following graduation, all doctors[36] require additional training and supervision commensurate with their career plans, level of expertise and experience. Some join competitive training programmes after 2-years period of mandatory foundation training. Others do not follow a defined pathway, either because they failed to be selected or are seeking specific experiences or training to help them decide on or advance their preferred careers. In the NHS, postgraduate departments, based in various healthcare settings, are contracted by health education England (HEE) through local education providers (LEPs) and regional local education training boards (LETBs) to deliver this. Each PME department is led by a DME (a senior clinical consultant from within the LEP organization see Appendix I for roles and responsibilities) is. Figure 2.1 illustrates this structure.



[36] As a result of my misgivings about nomenclature, throughout this thesis, I favour the terms postgraduate training doctor or trainee. However, there are subtle differences as one can be a postgraduate doctor without following a defined training pathway. While strictly speaking, my DME responsibilities cover, only so called 'numbered' trainees (those competitively selected and assigned to approved and regulated training programs), our trust has equal numbers of non-numbered, non-consultant hospital doctor posts. In practice the training faculty tries not to make a distinction and applies the same expectations for supervision and training to all non-consultant hospital doctors.

Figure 2.1 The broad structure of PME in England.

Trainee postgraduate doctors follow GMC approved curricula to become GPs, surgeons, paediatricians, radiologists etc. Their progress is monitored rigorously until they are awarded a certificate of completion of training (CCT). There are 76 competitive specialty training entry points available to doctors after successful completion of the two-year foundation programme.

During the foundation period, newly qualified doctors rotate through six deliberately diverse specialties spending 4 months in each area. For many medical and surgical specialties, a further 2-3 years of core training is required before competitive selection into higher specialty training. These core years are focused on broad areas of specialism training e.g., hospital medicine or surgery. Throughout all training years, the doctors undergo mandatory annual record of clinical progression (ARCP) assessments. Success in these milestones is based on reports from supervisors, attendance at teaching events, postgraduate examination success, 360-degree appraisals, portfolio-captured reflections, and workplace-based assessments.

HEE reimburses Trusts 50% of the basic salary for these medics as well as a supplement to support training. In addition to the regulatory role of the GMC, most specialties are also governed by their individual royal colleges who are largely responsible for the shape of training, curriculum design, higher exam matters https://www.hee.nhs.uk/.

JOB DESCRIPTION & PERSON SPEFICATIONS: Director of Medical Education (DME)

The Director of Medical Education is responsible to the Chief Executive for the Business of Medical Education and Training within the organisation and for ensuring the delivery of the Deanery Educational Contract. They will have a close professional relationship with the Dean/Deanery to ensure quality control of programmes, develop and deliver the wider educational agenda and for supporting and developing tutors as educators.

The DME should be a senior officer in the Health Organisation, with a seat on or access to the senior decision-making structures within the organisation to ensure that medical education is fully integrated with the delivery and future requirements of the service both operationally and strategically. Recent changes to the way junior doctors are trained, as part of Modernising Medical Careers (MMC), and restrictions imposed by the Working Time Directive pose challenges to both the educational and service environments. The explicit specialty curricula and assessments of competence

detailed in MMC have changed the type of educational provision required within Trusts. Increasingly knowledge and skills training are being dealt with in the workplace. This requires a co-ordinated, cross-specialty approach with educational support readily available for those charged with implementing the curricula and carrying out assessments. “Transition” from the current postgraduate medical training arrangements to those envisaged under MMC will take a minimum of 5 years and will require careful management to ensure that neither education and training nor service suffers.

Education is a core NHS responsibility, on a par with clinical activity, and as such requires robust governance policies and procedures. PMETB has the responsibility in the UK for quality assuring specialty training at a national level. At a local level it is essential that quality assurance takes place outside scheduled PMETB inspections and this requires local leadership. Education is increasingly seen as an integrated, inter-professional activity and appropriate linkages need to be developed at the local level.

Quality assured, competency based, time limited and seamless medical training is key to Government’s commitment to a high quality. Consultant based service. Central to this is quality assured postgraduate medical education and training. Trusts will need to create and develop a first class “educational environment” if they are to attract and retain approved training posts. There will be a need to develop and enhance the teaching and training skills of existing medical staff.

The need for educational governance is recognised by all key education stakeholders – National Association of Clinical Tutors, MMC, PMETB and Royal Colleges – as is the need for a dedicated medical educational lead at Trust level.

Following failures of educational supervision (e.g., Southampton University Hospitals Trust) the NHS Litigation Authority in England now views educational governance as a key component of overall corporate governance.

General Responsibilities

- Take responsibility for the organisation achieving defined standards of postgraduate (and in some places undergraduate) medical education.
- Provide professional leadership and vision for the organisation on medical education issues
- Produce, implement and monitor a strategy for the provision of medical education and training
- Align medical training and education with the service objectives as defined by the Trust Board

  or equivalent

- Represent the organisation on medical education issues, both externally and internally.

  In order to deliver these, the DME will

- Identify a structure for the local delivery of medical education, ensuring that all those involved

have clear roles and responsibilities and are accountable for these educational roles

- Lead, direct & develop all involved in medical education and be involved in their appointment
- Manage resources and budgets devolved by the organisation to medical education & training
- Manage data collection and reporting processes necessary both for internal quality control

  and training service development

- Liaise with other educational leaders towards the development of multi-professional learning

  as appropriate

Key Result Areas

  - Provide evidence of robust systems for educational governance required by statute for the GMC & PMETB QA processes, and other external bodies as required
  - Ensure that trainers and trainees are fit for purpose within the organisation
  - Report to Trust Board, or equivalent, as appropriate to ensure awareness of the impact of

    changes in medical education on the organisation

  - Implement, monitor and improve medical training programmes
  - Provide an annual financial report and business plan

The wider role of Directors of PGME involves participating in Deanery meetings, Dean's monitoring visits and representing the Deanery at appointments committees.

Procedure for appointment

Post should be widely advertised within the Trust. Applicants should be formally interviewed by a panel which should include the Postgraduate Dean (on behalf of the University and the NHS), the Chief Executive, Medical Director and the NACT UK Deanery representative.
Annual review of the role will take place through the appraisal and job planning processes.

To ensure professional development within this role DMEs must join NACT UK (National Association of Clinical Tutors) and attend regional and national meetings of an educational nature.

Requirements

The duties will normally require 3-5 PAs of protected time. Goods & Services – mileage, laptop & mobile internet access Administrative support (1 Grade 5 WTE)
Office space

PERSONNEL SPECIFICATION

JOB TITLE: LOCATION:

FACTOR

Director of Medical Education

ESSENTIAL

CRITERIA

HOW INFORMATION WILL BE OBTAINED

DESIRABLE

1. ATTAINMENTS (General and Higher Education, Professional/Management Training, Relevant Experience etc.)	1. GMC Full Registration 2. Name on Specialist Register of GMC London 3. Minimum of 5 years experience as a Consultant 4. Minimum of 5 years experience in a senior medical education role, e.g. Postgraduate Clinical Tutor, Royal College Advisor, Specialty Tutor 5. Consultant with a minimum of 5 PA clinical contract with the organisation.	Postgraduate qualification in Education	Application Form
2. KNOWLEDGE AND INTERESTS	Knowledge of management structures in medical education and awareness of recent changes in the delivery of medical education, nationally and locally. Interest & enthusiasm for improving delivery of medical training and Continuing Professional Development Knowledge of assessment methods	Evidence of relevant research and/or publications. Evidence of experience at strategic level of national and/or international education organisations	Interview/ Presentation Interview

1. SPECIAL APTITUDES (Dexterity, numeracy, computer literacy, ability to drive, communication, etc.)	Evidence of ability to work in a team and to organise and manage the work of the Department. Effective leadership & communication skills. Applicants may be required to make a presentation to the panel as part of the selection process. Evidence of delivering well evaluated teaching sessions / tutorials. Approachability. Good interpersonal skills Ability to manage change Ability to meet the travel requirements of the post, including access to a car on appointment. Evidence of personal development in medical education	Evidence of supporting trainees and trainers Evidence of motivating and developing others Understand use of IT in education Evidence of working with other specialties & professions Evidence of audit/research in medical education	Interview Interview/ Presentation Interview Interview Interview / Portfolio
4. PHYSICAL REQUIREMENTS (General Health, Eyesight, Build and Cleanliness, etc.)	Health Standards applicable:- (a) Doctor Acceptable attendance record.		Occupational Health Assessment Application Form/ Interview/Referee / Report

APPLICANTS PLEASE NOTE: Shortlisting will be carried out on a basis of the Shortlisting criteria set out above, using the information given on the application form. You should therefore address the requirements of the specification when completing the application form, as failure to do so may result in you not being short listed.
Appointments are subject to verification of appropriate qualifications

Notes on Educational supervision

The roles and responsibilities documented in Appendix 1 outline how DMEs are held accountable for education supervision of trainees. I have found that enhancing the quality of this supervision, consistently and reliably, is difficult. Following on the

above discussions, several organisational and cultural factors are likely to be relevant to both supervisor commitment and trainee experience.

Ahluwalia (2020) cites evidence that engagement with GP training is associated with improved patient outcomes for those registered in training as opposed to non-training practices. His EdD thesis explored the reasons for these benefits. He analysed recorded interviews with 11 GP educators. His findings resonated with my PME purpose and how other postgraduate medical educators, in particular education supervisors, might be motivated. Patients registered with GP training practices reported greater satisfaction in consultations compared to patients in non-training practices. He cites evidence of higher satisfaction in the domains of access, communication, and overall experience, counterbalanced (not surprisingly) by lower levels of satisfaction relating to continuity of care. Further, these patients were more likely to have higher cancer detection and referral rates and be prescribed fewer antibiotics overall (an acknowledged measure of good practice). Admittedly, the size of these benefits was modest compared with the influence of deprivation, disease burden, demographics, and ethnicity. However, although Ahluwalia (ibid) cites work to suggest that the learning environment may influence patient care, he recognizes that this does not explain how this occurs. Hence, he set out to discover how GP trainers perceived engagement with educating future GPs, influenced patient care. Before embarking on his work, he also considered theoretical models that might have some “explanatory power”. He contemplated how clinical education could touch a whole organisation and influence the quality of care that all parts of an organisation provide. He also explored ideas of how students entering a practice can change it and how distinctions between learning and working are artificial. His two main findings are both interesting and relevant to my situation. He concluded that the designated GP trainers[37] were beacons modelling good practice and promoting new ideas and methods. The learning, he found, was felt to be bi-directional with the trainee registrars bringing updated information and practice from their hospital placements and their GP trainers exchanging with them the ‘softer skills’ of communication and clinical decision-making. The up skilling was not confined to the GP trainers but the whole practice team benefited as all were engaged in teaching seminars, audits and quality improvement projects through collective learning events. Updating procedures

[37] Not all GPs in a training practice are “designated” trainers.

and practice to get accreditation was also felt to have an important positive influence on patient care.

Drawing parallels with hospitals and my situated environment, it is difficult to demonstrate the beneficial effect of trainee presence on patient outcomes as all NHS hospitals are designated teaching hospitals allied to university medical schools and LETBs. Yet, I envied the positive influence the GP trainers appeared to have and wondered how I could ensure that my TELs and ESs had similar influence. One striking difference between the hospital and community education environments was that many of the GP trainers had initiated the bid for practice 'training status' and were seen by their non-trainer colleagues as having special status and knowledge. Another, area of possible difference was the acknowledgement, by the GPs, that trainees contributed to their (the GPs) own learning. I pondered whether I could create a similar culture in hospital environments where, already, service, research, academia, power and competing commitments vie for precious time. Drawing on this study, I wonder if trainers feel they are the purveyors of the specialist knowledge the trainee seeks and if there is less perceived room for up learning.

Work based supervision requires leadership skills and this topic also features in the teacher education literature with some contending that it has low status (Beck, 2002; Cuenca, 2012). Arguably, a similar dismissive culture prevails in PME in hospital environments (Shaw, 2011, p. 37). In recent years, in both hospital medicine and general practice, educational supervision has been officially recognized as important and every ES is required to show evidence of training for the role. A plethora of literature (Cooper, 2009) and courses have been developed (Hallewell, 2020; Enhancing supervision for postgraduate doctors in training (2021). Yet, many wicked problems remain to be named and solved and I hoped my research would uncover and illuminate some of them.

A further thorny issue relates to evidencing capability. In order to 'support' ESs in documenting competency attainment [38], hefty portfolios listing 'workplace-based assessments' (WBA) often involving 'multiple consultant reports' and input from

[38] These are specified and curriculum based. E.g., for ARCP 'sign-off', over a single year, FY2 doctors need proof that a minimum of 23 workplace-based assessments have been signed off evidencing 15 core competencies that have been 'mapped' to their curriculum.

'supervision placement groups' have been developed. Much data upholds the interpretation that this systemization has not achieved the desired privileging and betterment of supervision. Lloyd (2007), for example, point out that both trainees and consultants often consider educational supervision as currently practiced to be an undesirable and administrative obligation rather than a valuable process. This rigid view is further shared by trainees and educational supervisors, who criticize the e-portfolio for its inflexibility and lack of specificity (Beard, 2005).

Most studies recognize vastly increased supervisory expectations with limited investment in this area (summarised in Patel, 2016). Yet, the 'Gold Guide' [39] for postgraduate specialty training in the UK, recommends that educational supervisors should be trained in understanding educational philosophies and practical educational methods. While desirable, evidence indicates that this aspiration has not yet been realized (Cooper, 2009) and in the context of other pressures, this situation is not likely to change.

As a leader in PME, I have worried that an unwanted side effect of 'professionalizing' and systematizing education supervision may also be the loss of senior ESs as a result of and the reliance on portfolio electronic box ticking and may be contributing to the burnout and early retirement intentions of NHS consultants (Khan, 2018).

Previous studies have also identified complex and multi-faceted tensions that medical undergraduate faculty encounter in their education roles (Sethi, 2017). Translational work against the status quo as well as juggling educational and clinical work and lower prestige. It is likely that those with postgraduate responsibilities face additional tensions especially when trying to enact translational work against at the intersection between cash strapped healthcare service and training.

Work by Dillon (2017), Martin (2017), Thomas (2017), Forgasz (2017) and Arndt (2016) all address the issue of teacher guidance and the need for a 'support space' to produce better supervision practices in general. Clearly, PME supervisors are not alone in their frustrations and provision gaps. Yet, Beck (2002) acknowledge the

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[39] The gold guide is a reference guide for postgraduate foundation and specialty training in the UK. The guide is maintained by the Conference of Postgraduate Medical Deans (CoPMeD), on behalf of the four UK health departments. It is applicable to all trainees in GMC approved programmes. An 8th edition has just been published https://www.copmed.org.uk.

potential cost/organisational consequences of intervening to expressly privilege supervisory activity within an educational institution. Balancing these priorities need to be considered as institutions struggle to achieve fiscal rectitude during changing and challenging times.

Appendix II
Examples of previous attempt to engage TELs (2017-2018) with examples of very poor attendance at the meetings organized for April and October 2017.

<u>Planned activity</u>
Community of learning

- Enhancing the support for trainers – 19th March 2018
- Issues of mental wellbeing amongst trainees – 18th July 2018 –
- Supporting quality improvement projects – 28th January 2019

Faculty development workshops

- New junior doctors' contract briefing session – 20th March 2017 & 30th March 2017
- Enhancing learning through feedback – 13th February 2018 & 17th April 2018
- Coaching skills for supervisors – 25th May 2018 & 13th June 2018
- On the job teaching – 14th September 2018
- Not just a tick box exercise: Making supervisor meetings and reports meaningful --14th December 2018

Education leads' meetings

- Joint education committee – 28th April 2017 & 6th October 2017 –

Sample attendance

October 2017	**April 2017**
Library Manager RFH	
Medical Education Service Manager – RFH	Associate DME
DME	Lead for Quality
Medical Education Manager	DME
TEL - Obstetrics and Gynaecology BH	Gastro/HEP ST Education Lead
TEL - Anaesthetics RFH	Resp Education Lead
Head of Quality (PGME)	Oncology Education Lead
TEL - Radiotherapy & Oncology RFH	T&O Education Lead
Medical Education Service Manager - BH	GMC Regional Liaison Adviser
TEL - Acute Medicine RFH	PGME Service Manager
FY3 Academic Trainee	
TEL for Paediatrics BH	
DME BH	
DME BH	
TEL - Anaesthetics BH	
TEL - Anaesthetics BH	
Paeds (Observer)	

Appendix III
Ethical approval letter

Project title	"Researching beyond reflection in healthcare education and training: using self-study (SS) methodology to purposefully unpack the personal, professional and structural elements of a postgraduate medical education director's practice" Aine Burns 16081400 ***UCL Data Protection Registration Number** No Z6364106/2020/01/93 Date issued 15/1/20
Reviewer 1	
Supervisor	Dr d'Reen Struthers
Do you foresee any ethical difficulties with this research?	Ethical issues all covered in detail
Supervisor/first reviewer signature	
Date	15th January 2020
Reviewer 2	
Second reviewer name	Prof Jeff Bezemer
Do you foresee any ethical difficulties with this research?	The ethical issues are appropriately described and dealt with.
Supervisor/second reviewer signature	
Date	27 Jan 2020
Decision on behalf of reviews	
Decision	Approved ☒ Approved subject to the following additional measures ☐ Not approved for the reasons given below ☐ Referred to REC for review ☐
Points to be noted by other reviewers and in report to REC	
Comments from reviewers for the applicant	

Once it is approved by both reviewers, students should submit their ethics application form to the Centre for Doctoral Education team: IOE.CDE@ucl.ac.uk.

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Appendix IV

Additional notes on SS and ethical considerations

Key theories underpinning SS research

The field of SS research is framed and underpinned by epistemological, pedagogical, moral, ethical, and political concepts. Pinnegar (1998), (cited in LaBoskey 2004b) describes it as "*a methodology for studying professional practice settings*" where the professional takes responsibility for transforming his or her own practice (p 817). This way of thinking and the inherent agency suited my purpose perfectly given the situated and specific nature of my professional practice problem and my desire to better my leadership practice for ultimate patient benefit. Thus, this SS is rooted and constructed in a healthcare societal world and my moral and ethical positioning. My interpretation does not, however, use 'grounded theory' as one might initially expect given the constructivist leanings of SS. The SSist believes that this is neither possible nor appropriate but invites the whole of their past experiences and their 'present moments' to bear, in the hope and expectation of identifying better ways of progressing forward.

Most SSies are conducted within education and the objective of the research is to gain new knowledge; therefore, the epistemological theories underpinning knowledge and learning are relevant. The definitions of knowledge and the thinking about how people know what they know are complex. Extensive discussion is beyond the scope of this thesis but, from my perspective, the debate favours knowledge as temporary, evolutionary, settlements made up of understandings that are born out of prior experiences, new facts, and information, as well as reflections. Whether knowledge is formal or practical, whether we know *that* or we know *how* is important but so, LaBoskey (2004b) reports is the narrative or paradigmatic thinking that underpins it (pp. 821-826). In developing and refining my research questions, I favoured wanting to know *how* I could improve my practice. I also understood that the new knowledge, I sought, would only become accessible by capturing, examining, and reflecting on my real life, current narratives, constructed out of my stories. Here, I am minded of Winter's (1988, 1998) articles and Bruner's (1986) comments that "*we do not store experience we story it*" (p 235). I knew that to progress I needed to examine my problem honestly, engage in reflexive and reflective practice, question taken for granted assumptions and see my practice through different lenses to gain the deeper

learning and agency I sought. Only then I reckoned could I extrapolate lessons to others in similar roles. In line with SS the tools I employed were largely qualitative. Diarizing events, thoughts, and feelings, tapping into unconscious anxieties and bias, gathering field notes, e-mails as well as other artefacts would I understood provide me with rich data to mine.

SS, particularly, privileges the varied views of 'others' in creating new knowledge. The theory professed by Loughran (1998) is that 'divergent' rather than 'convergent' learning outcomes should be sought through the 'alternative' view. Formal reflective practice, critical friends and literature can all contribute to these different perspectives. With this approach, captured reflexivity can, the theory claims, be framed and reframed in successive sequences and be responded to by creating new knowledge and innovative interventions. So, for this work, I concluded that SS, should provide me with an opportunity to become my own agent of change, so that I could push reflection past defensiveness into transformative learning and action. Importantly, I also predicted that by taking this approach, I would uncover new insights from which to draw more generalizable lessons for other leaders in healthcare education.

By following this path, SSists can recognise and experience moments (variously referred to as 'now', 'present' or 'nodal' moments) of intense lucidity. [40] Such moments bring about clarity of purpose and action that enable the researcher to, then, make worthwhile progress towards their improvement goal. The kernel of the idea is that SS is "at its heart about studying and changing practice in the moment of practice" (Pinnegar, 2009b p. 23).

Yet, however steeped in the moment of action, the SSist is also conscious that his or her own identity and actions are rooted in past experiences and that the purpose of the teaching endeavour is very much focussed on improving future performance (their own and/or their students'). Stern (2004a, 2004b) glorifies 'now' moments when an individual can bring past, present and future together in their thinking while impacting on all three.

[40] The theory underpinning the importance of 'the present moment' was articulated, originally, by Stern (2004b) and applied in psychotherapy.

Common motivations

The SSist is usually stirred by a 'troubling' related to their own work landscape and sets out to understand his or her personal, interpersonal, professional and structural or organizational practice more fully (Pinnegar, 2009a, p. 47) as the basis for making effective improvements and relating their own history to more generalizable issues. Louie (2003) identified three dominant themes in SS research: 'teacher identity', the 'relationship between teaching beliefs and practice'; what Whitehead (1996) referred to as 'living contradictions', and 'collegial interaction' or what I have come to think of as relational professionalism. I believed that my prior experience of SS touched on all three of these themes and that all three were relevant to this current problem. My troubling related to my identity and sense of inadequacy as a leader in postgraduate medical education and my relationships with other members of the PME faculty. Hence SS seemed an appropriate methodology to use again in this work.

Additionally, SS is often driven by perceived social or political injustices (Cochran, 1999; Griffiths, 2000; Hamilton, 2002; Kemmis, 1998). Yet, Bullough (2001) cautions that the aim of SS is to "provoke, challenge and illuminate rather than conform or settle" (2001, p. 20). Thus, the purpose of this research was to achieve the 'justness' of improved experience for the trainees under my care and by implication for the patients they would in turn care for. While I recognised that perfect solutions were unrealistic, I hoped SS research would improve my understanding of my praxis and point to a more satisfying and successful leadership experience.

Controversies in Self-Study research

There has been much criticism of SS for reasons rehearsed by Vanassche (2015) both from within and without, what Samaras (2010) calls the 'SS learning community' (Ch 3). Much of the disapproval focuses on features that are not unique to SS with fundamental dissonance between positivist and interpretivist research stances surfacing. Few doubt that SS research provides a method for personal and professional development. Shulman (2004) criticises SS because he believes it fails to build sufficiently on previous work in the field and does not fit into more comprehensive research programs (Cochran, 2005; Zeichner, 2007). Likewise, Zeichner calls for the SSs of teacher educators to be incorporated into syntheses of research offerings on aspects of teacher education. Others question its potential for

theory development yet Zeichner (2007) believes that SS has the potential to contribute to both improving theoretical understandings and practice.

Much disapproval has also focussed on methodological 'messiness' i.e., the variety, inventiveness, lack of objectivity and 'uncertain' rigour of methods utilized (Feldman, 2003; Loughran, 2010; Wilson, 2002). The validity of self-evaluated findings, insider bias and difficulties, simultaneously, juggling involvement and detachment, familiarity and 'stranger-ness' have all been questioned. Loughran (2007) points to the risk of SS research becoming "a pseudonym for rationalisation or self-justification"(p. 13). This criticism is not unique to SS and has been levelled at many other forms of practitioner or insider research. Yet, although Ybema (2009b) rehearses the complexities of studying 'everyday life' in 'at home' research environments he points to the value of developing key new understandings from within (pp. 11-13) and I favour his view. Other considerations such as an apparent lack of transparency and the parochial or situated nature of SS research have led to anxieties that SS cannot reach generalizable conclusions. While I readily accept the validity of these views, the notion of using the particular to illuminate the universal, the intimate to view the epic, the personal to see the political, is highly prized in literature and poetry and adds rather than detracts from the potential of SS, in my view.

However, studying one's own work within one's own practice evidently removes any distance between the researcher and the researched (Ybema, 2009b) and so conclusions or recommendations could be dismissed as self-serving and unworthy of extrapolation or exploitation (pp. 177-248). In a similar vein, the research practice of SSists viewing their own past actions through a theoretical lens, in order to envision and enable a brighter future could be interpreted as self-indulgent and according to Korthagen (2005) risks "reinvent(ing) the wheel on the basis of a limited theoretical framework" (p. 110).

There is much synergy with, insider research (sometimes referred to as endogenous research) defined as research which is undertaken within an organization, group or community where the researcher is also a member (Brannick, 2007) or has 'a priori' intimate or familiar knowledge of the group (Hellawell, 2006). Fleming (2018) points to the advantages of the deep understanding and interpretation as well as the different

perspective that an insider brings compared with someone not deeply embedded and involved. I hypothesize that SS is the ultimate insider research and is aptly placed to examine the lived experience of leaders within organisations. Fleming (ibid) outlines many relevant inherent challenges and ethical dilemmas. These include: the potential for implicit coercion of participants; the desire for positive outcomes; tacit patterns being taken for granted and the conflicted stance of being an academic and a researcher within the same setting. The researcher must therefore work diligently to reassure their peers that such considerations have been carefully addressed in the study design and conduct. Vanassche (2015) concludes that in order to achieve their purposes SSists need to position themselves "always and continuously" between the inherent tensions of relevance and rigour on the one hand and effectiveness and understanding on the other.
Thus, questions of truth and trustworthiness pervade the SS literature (LaBoskey, 2004a, 2004b; Loughran, 2007; Mena, 2017; Pinnegar, 2009a; Whitehead, 2004). Several authors have published guidance to help minimize this disquiet (Craig, 2009; Feldman, 2003; Mena, 2017). Nonetheless, the popularity of SS and its endurance, speak to its value as judged by teacher educators and points to potential in other learning arenas. While SS suggests a single researcher, Samaras, (2010) and others (Louie, 2003; Mena, 2017; Ritter, 2018) champion collaborative inquiry in SS research and maintain that it adds a further rigorous dimension.

In the next section, reflecting the importance of ethical considerations, I dissect the specific moral dimensions of this work in greater detail.

Ethical consideration

General ethical challenges

My study shared ethical risks that are common to all participatory and insider research in education (Brooks, 2014; Burgess, 2005). Gray (2013) divides the salient issues into 'content' and 'character' to distinguish the (former) imposed 'rules' from the (latter) personal behaviour of the researcher in ensuring that their research is conducted in a moral and responsible way (p. 69). I believe, my study design and conduct paid attention to both, but I also faced additional ethical challenges because of my position of 'middle' authority within a healthcare environment. The apparent 'power' hierarchy depicted in Figure 2.2 illustrated a clear risk to consensual

‘volunteering’ and unfettered participation. Yet, I was not on the hospital senior management team and reported up to the medical director and Chief Executive Officer as well as the local HEE deans throughout the study period. Thus, I stood in ‘middle’ ground amidst a larger hierarchy of ‘authority’. Yet, my improvement aims were genuine and I believed that the best way to approach my professional practice problem was using SS, accepting its inevitable insider methodology. My multiple professional roles as well as my longstanding friendships and working relationships within the hospital, risked engendering, confusion, unease or even a desire to please and could be seen to invalidate the knowledge gained. Analogously, my shifting positionality as a colleague, friend, educationalist, administrator, researcher, or manager during the research project was clearly important and presented additional challenge as well as opportunities. Myers, (2019) gives a thorough account of the issues in insider research that I found helpful. I acknowledged too, that to conduct this research, I would, inevitably, move often, and sometimes subconsciously, across boundaries that straddled ‘research’ and ‘daily toil’. I knew I needed to be aware that others might also wonder if I had covert aims and once again would need to demonstrate rigour in study content and character.

Much literature exists on making the familiar strange (and indeed the strange familiar) in insider research (Foley, 1992; Sikes, 2003; Ybema, 2009a). Over familiarity with the research environment and/or a tendency to see and represent intimate events in a positive light, could create bias. Fine and Shulman’s (2009b p.179) notion of a “*kindly Trojan horse taking notes*” as cited by Ybema resonated with my hopes for this work. A variety of tools borrowed from such diverse worlds as sports journalism and critical theory ensured that the advantage of the closeness of ethnography were balanced with the necessary ‘strangerness’ to perform SS research ‘honestly’.

Further, I had to consider the effect of potentially disrupting the status quo in my trust by arriving at conclusions or unearthing previously silenced, unpopular, or disturbing, institutionally delicate facts that could possibly be damaging. I drew from the work of Fine and Shulman again to inform my thinking and practice in this area. (Ch 9 & 10 Ybema, 2009, pp. 175-196).

Similarly, in insider research, sharing as well as disseminating lessons and research publication is fraught with potential conflict that I needed to manage carefully and

sensitively as I articulated my findings and invited further critical review that is so important to the SS ethos.

Positioning self, blurring boundaries, 'othering' and purpose

Balancing and flexing between disparate roles, in my case: senior clinician, teacher, manager, leader, colleague, friend, elected officer in a specialty association, Royal college and university programme director, exemplifies the many ethical challenges posed by applying SS methodology to research in educational leadership roles and is examined in depth by Pinnegar (2009b).

This spikey intersection between inquiry and practice is also discussed extensively (Groundwater, 2007; Mockler, 2014). Whether it is ever ethical to conduct research in parallel with or taking advantage of one's professional working role is controversial. Greene (2014) explores some of the issues and provides some useful insights on how to minimize ethical implications, avoid bias and increase trustworthiness. Nicolini (cited in Ybema, 2009, p. 125) raises the political question of who benefits '*cui prodest*' from the research? "Breen (2007) discusses how such tensions influenced the scope of her research study, her access to informants and her collection and analysis of data. Both she and Mercer (2007) argue persuasively, that rather than a distinct either/or , insider/outsider dichotomy the researcher is positioned in a reverberating continuum moving back and forth across definitional boundaries in a situational dependent manner. This, Breen (2007) claims, can be helpful as it maximizes the advantages, while minimizing the disadvantages of such research. Issues of friendship exploitation were explored by Taylor (2011) and were clearly relevant to my work as a 'happy and fulfilled' insider in my organisation for over three decades.

In action research (AR), however, Eikeland (2006) contends that special rules should apply to insider research as conventional 'condescending ethics' are unfit for AR purposes because of what is described as 'othering- effects' (p. 37). By this he means using one's position to take advantage of others' behaviours and input without necessarily their knowledge or express consent. He champions establishment of peer communities of inquiry to overcome these issues recommending the establishment of 'practitioners-researchers-researched' groups.

Historically, there has also been significant criticism of research conducted e.g., from Western perspectives 'on' people whose worldviews are incommensurable with Anglo-Euro-American discourses and similarly 'on' minority groups by those outside the community. The term "decolonizing epistemology" has been applied to challenging the imperialistic understanding and practice of research (Smith, 2013). Fine and Weis (cited in Myers, 2019) talk of "Social scientific voyeurism " and the phrase "poverty porn" (p. 10) highlights how research can be taken advantage of for fundraising in NGO contexts. These notions are relevant in first world research and Bhattacharya (2009) argues that there can never be a Utopian space where qualitative inquiry can be free of imperialistic ways of knowing and documenting people's lived experiences. However, she alludes to the advantages of auto ethnography to take some account of this imbalance. Nonetheless, it is hard to argue that SSists do not take some advantage of their interactions with 'others' for their research, commonly, without the 'other' being aware. Clearly, making all 'others' fully aware would be impossible in a study such as this and the relationships being studied might be altered. SSists, therefore, need to be minded of this possibility and take every opportunity to promote the improvement-aims of the research while simultaneously minimizing judgements and maintaining objectivity.

Groundwater (2007) highlight key ethical concerns in this area. Quality of evidence is underpinned by ethical principles such as informed consent, but it also involves a desire to be authentic in engaging with the research process, such that evidence is collected with the intent not merely of celebrating what is to be celebrated but acknowledging and understanding what is problematic. They point to evidence collected under duress; evidence collected covertly, evidence that is not validated by triangulation and evidence that has not been debated as evidence that is invalid (p. 207).

Equally, the questions being asked, and the evidence being gathered should emanate from the genuine and authentic concerns of the researcher. Groundwater and colleagues (2007) assert that practitioner research fails the 'quality of purpose' test when it is implemented in a 'top down' way. They warn that as the role of insider practitioner inquiry is to "problematise practice" and that an important outcome "is that the knowledge that has been developed is acted upon". They warn that acquired knowledge must be put to good use (p. 208).

Power and influence

The reference to "*wielding a double edged sword*" in the title of Mercer's (2007) paper draws attention to the many dangers of the insider research. The 'simple' task of seeking volunteers for collaborative inquiry research, for example, risks drawing on the goodwill and friendship of colleagues, rather than on their unfettered commitment to the project. Perceptions of power and/or career advancement opportunities, too, could clearly influence participation. There is added complexity if the researcher (as in my case) could be viewed as part of the management establishment as participants could worry that disclosures arising during the study could compromise future promotion or working partnerships. Thus, aspect of this research would inevitably address the culture of power. As DME I was in a position of power and my study would examine my relationships 'downwards' with TELs, ES, and Trainees as well as power upwards in relation to hospital management, LETBs, HEE and the GMC. I take some consolation however, from Nader (1975) cited by Myers (2019) who considers that insider research should not consist only of 'studying up' or 'studying down' but both should take place. In my situation I expected to study horizontally, too, as part of examined and triangulated work with senior faculty and colleagues.

Political and institutional sensitivity

Trainee, patient, and colleague welfare is central to my role as DME. Although this research was designed to improve trainee experiences the hope was that patients and colleagues' experiences would also be bettered. Disrupting existing arrangements and, potentially power balances by changing procedures, or enacting plans deriving from the SS carried unknown risk. Even more seriously, my insider research findings had the potential to raise sensitive previously hidden 'guilty knowledge' within a department or the institution. Myers (2019) for example, was greatly troubled by identifying the existence of a considerable number of 'uncomfortable experiences' her students interviewees experienced with some senior staff, in her South African University. Her findings not only raised ethical dilemmas of reporting her findings but also influenced the conduct of her study. Myers highlighted the danger of hiding unpalatable findings under the "cloak of collegiality" as well as her obligation not to harm participants (both students and colleagues).

SS outcomes may be or appear to be critical of people, organisations, or systems. Similarly, the findings may not align with, departmental, institutional, or public policy. Vanassche (2015) analysed and reported how "micro-political tensions" around educational views "negatively interfered with and almost jeopardized the quality" of SS projects (p. 11). The personal and departmental cost of such tensions contaminating the workplace, in insider research, can prove significant. I was minded that diplomatic navigation was needed to protect my co-researchers and myself and to ensure that the possible beneficial outcomes could be trialled or enacted regardless of such controversy.
Further, in my situation, concentrating on one specialty area could disadvantage another. So, I had to ensure that I did not neglect other areas of my work especially during the CAR project. Clearly, the COVID-19 experiences destabilized everything, and raised many clinical ethical issues. I have described this experience in the body of the thesis.

Discomfort and potential harm

Throughout this project I subjected others, and myself, to intense study that carried potential for discomfort, even harm. Scrutiny particularly when intense or even a perception of being watched, judged, or evaluated can make colleagues feel uncomfortable, even threatened and, as such, posed a further ethical dilemma. According to Gray (2013) research studies need to be conducted in a "responsible and morally defensible way" (p, 69) using "behaviours appropriate for the subjects of the research" (p, 68). This he believes involves both the rules imposed on researchers by institutions and regulatory bodies as well as the 'character' of the individual researcher.

Confidentiality

Insider research carries a greater risk that colleagues or bystanders could inadvertently read or listen to confidential material by accessing shared equipment, computers, and storage areas or by overhearing conversations.

With these risks in mind, I arranged for CAR meetings to be held in private rooms, I personally typed the recorded material, verbatim, using codes to de-identify individuals. Once collaborators had been given the opportunity to read, amend or redact transcript content, the original recordings were deleted. Secretaries and

administrative colleagues, for example, did not have access to any data. In my own writings, I made sure to de-identify all individuals and departments. Disclosures were only made with the expressed agreement of individual participants and CFs. All recognizable information regarding other staff members or departments remained strictly within the CAR study group and were rendered anonymous as soon as possible. CFs only accessed segments of the data as required, in the context of the work. On a few occasions, I needed to alter and censor some transcribed dialogue so that the specialty department referred to could not be recognized in the final manuscript.

Self-Study potential in healthcare education and leadership research

As discussed earlier some methodologies used within SS, such as action research (AR) and reflective practice (RP) have already been widely adopted and endorsed in healthcare education and research (Meyer, 2000; Munhall, 2012; Taylor, 2010). In AR the focus is on changes in an area of study, whereas in SS the 'self' is the focus aiming to reframe understanding of one's role and it's impact on others and the AR component complements this (Feldman, 2004; LaBoskey, 2004b). Supporters hold that RP is one tool that can help health workers to develop core skills, attitudes and behaviors that maintain their human side despite the arduous multidimensional challenges they face (Goodell, 2006; Mann, 2009; Sandars, 2009; Tidwell, 2010). However, controversies shroud universal RP with some critics decrying how RP has become "mechanically instrumental" (Clark, 2011; Macaulay, 2012). This was not always so, perhaps for legitimate reasons. Fadiman (2010) details how "*the failure of reflection does an excellent job of removing medical students of their emotions*" (cited by Ryan in Lyons, p. 102). Others proclaim RP as transformative and insist that it forms a critical element in all professional healthcare education from undergraduate beginnings to the praxis of seasoned clinicians (see Lyons, 2010 Ch 1 & 6). Ryan (op cit) rehearses how expert clinicians (whether they know it or not) use the components of RI[41] to enact and hone their metacognitive skills. He points to evidence that reflective reasoning (the 'so what?) is superior to analytical reasoning (the 'what') in complex medical situations and may reduce medical error. He reasons, too, that its value also lies in its ability to prepare the clinician for the "*knowledge dilemma, increasing health system complexity, medical uncertainty, medical error and*

[41] Ryan refers to reflective inquiry (RI) as opposed to practice. Here, I prefer Ryan's terminology as it implies delving into the unknown.

escalating disillusionment within the profession"(see Lyons, 2010 Ch 1 & 6). Ryan rehearses the 4 components of RI in medical practice: reflection before action, knowledge in action, reflection in action and reflection on action (in Lyons, 2010, p. 125). The fourth, reflection on action i.e., looking back on the past to change future action, links obviously to the ethos professed by SSists. Yet, Loughran (2005) contends, that SS out-performs RP in that it is "*an extension of reflection on practice with aspirations that go(es) beyond professional development"* (p 7) with a deliberate and purposeful improvement intent.

A version of reflection on action forms part of annual appraisal and ARCP for all qualified doctors. Leaders in the NHS often undergo separate appraisals for their different roles or have 'whole practice' reviews where each aspect of their work is evidenced and considered separately. However, many believe that the whole process of learning from such reflection has been killed by large-scale mechanisation, so called 'Fordism',[42] and they question the value of what has become, for many, a bureaucratic and 'tick boxing' exercise now required for GMC revalidation (Anon, 2018). In relation to healthcare, Fish (2005) has put forward the suggestion of "aesthetic inquiry" as an alternative that has many similarities to SS. She describes this as a form of research into one's practice as opposed to mere record keeping about one's practice. She encourages capturing experiences, using art and language that create a portrait or portfolio that explores the essence of a doctor's practice in relation to the profession. She also contends that appraisal through self-directed learning and education as well as interrogation of an individual's practice, is potentially more powerful than appraisal through technical evaluation (cited in Lyons, 2010, p. 115). Further overlap with SS is evidenced as aesthetic inquiry has been described as a form of AR that can be conducted by individuals or collaboratively, working through cycles of evolution and development to effect positive change within their practice.

Throughout the conduct of this study, I have considered whether the lure and increasing popularity of SS might, in part, be the result of lack of control or autonomy (Fish, 2005) in the practice of medicine. I contend that there is growing alarm concerning the power of highly complex and large data science over which an individual healthcare worker has little agency. As a clinician for example, I often feel obliged to implement 'evidence based' guidelines, trusting that the evidence is sound.

---

[42] 'Fordism' typically refers to large-scale mechanized mass production.

A recent published example illustrates the dilemma (Reddy, 2019). In this instance, the authors and accompanying editorial (Radenkovic, 2019) remind us that greater knowledge, of computer programming, is needed by doctors to achieve highly efficient, truly "data-driven modern medicine" (p 493). These and similar developments are important in delivering education and the leadership behind this endeavour as they challenge the student and the teacher, as well as conventional teaching methods, to keep up with these fast-moving developments. In this context it is easy to see how old dichotomies between data driven, evidence based, and positivist healthcare outcomes vie with more reflective holistic practices. The emphasis on reflection as a research tool and the sense of control inherent in SS could, I posit, help reconcile some of these tensions.

(Moen, 2016) has recognised the importance of engaging novice healthcare leaders in habitual reflective practice. Acknowledging, however the reluctance of some clinicians to engage in written contemplation and the scepticism described above she proposed a 'patchwork' approach of small e.g., diary contributions to ensure that reflective practice integrated into a portion of her master's in leadership program.

When considering the positive benefits of reflection, it is important to consider the concepts of 'moral injury' and 'burnout' in relation to healthcare, healthcare education and leadership. The former describes the challenge of simultaneously knowing what care a patient needs but being unable to provide it due to constraints that are beyond the clinician's control. The latter appears to blame the doctor and gives them yet another thing to address in their daily life (Shanafelt, 2017). Indeed, there are calls for the term 'moral injury' to replace 'burnout'. (*Doctors are suffering…* 2019). There is no literature on DMEs experiencing burnout or moral injury, but De Oliveira (2011) found that 52% of 100 programme directors in anaesthetics scored in the high or 'at risk' range on the Maslach (1986) burnout inventory scale.

Finally, SS is inexpensive and highly accessible. It can be conducted by individuals and/or in groups. Not surprisingly, then, SS research, has already extended into other disciplines including higher education linguistics (Louie, 2003; Richards, 2019) and technical education (Hawley, 2017; Hosenfeld, 2003). Could SS be about to enter the healthcare arena?

Appendix V
Collaborative Action Research (CAR) letter of invite to TELs

FOR ATTENTION OF ALL TRUST EDUCATION LEADS (TELS)

Date:

Dear colleague,

As a Trust Education Lead (TEL) colleague, I am writing to you to introduce an idea and ask you to consider participating in an education research project.

We have all been working hard here at *** to make the experience of our young colleagues as good and valuable as possible. Clearly, I am aware of the challenges we face. I admit, it sometimes feels like an uphill battle.

Since 2016, I have been studying towards an Educational doctorate (EdD) at the UCL Institute of Education (IOE) and as part of the final thesis component I will be researching an area of my own education practice. I therefore wondered whether I could use this opportunity to try a different approach in the hope of improving our trainee experiences and additionally helping you in your TEL role. To do this, I am seeking 4 TELs to collaborate with me in an action research (AR) type activity. This will involve meeting either individually or in group(s) (as you wish) four or five times, over a 6-month period (likely May – October 2020) for 30-60 minutes, to "trouble and ponder" how to best support our trainees and conduct the TEL role.

At each meeting, we will discuss, reflect on and question educational issues. We will then devise a reasonable action plan that we will aim to enact before, and revisit at, the next meeting. Thus, in spiral fashion, we will hope to understand more clearly what is happening in an area, why things are the way they are and perhaps what small adjustments might make a difference. This is a well-tried research methodology called collaborative action research (CAR).

I propose that this CAR would also form a significant part of my own auto-ethnographic self-study for use towards my EdD thesis.

My research plan is to audio-record the CAR meetings and transcribe them verbatim (carefully making individuals anonymous) *. The purpose of the audio recordings is for me to examine how I interact with you and seek ways to improve. Ultimately, by using these recordings I aim to enhance the support I give all TELs, and thus, to indirectly better the training experience of our JD trainees.

If any participant were also willing to write some thoughts about this process after each CAR meeting, I would use those ideas in my research if they were agreeable.

The research paradigm that involves me examining an aspect of my own practice in this detailed way is known as 'self-study' (SS). It is widely used and valued in teacher education. In SS the researcher formally, deliberately, and critically examines an area of his or her, own practice to see where and how to improve.

Practically, the SS component will involve me listening to the recordings several times, typing them and categorizing the content into my own personal, professional, and structural (operational) themes. I stress the emphasis would be on me rather than on the participant.

Ultimately, I hope that the CAR work and my intense scrutiny of my interactions with a small number of TELs would allow me to come up with some evidenced work that I can share with other healthcare educators in the form of publications, suggestions, guidance, or tips.

Before embarking on this work, I will get ethical approval from UCL/IOE and from the hospital research ethics committee. Participation is entirely voluntary, and participants would be free to withdraw at any time for any specified or unspecified reason without any repercussions.

So, if you, like me, think our profession is brilliant and you hope to encourage and nurture junior colleagues, and you want to think disruptively about trainee experiences in our hospital with an improvement focus, please get in touch for further information or a chat without obligation.

Finally, if (as I hope) I am swamped with volunteers I will purposefully select 4 to represent TEL areas and experience as widely as possible.

Many thanks for taking the time to read this message.

Yours etc.

Appendix VI

5B 1.2.1 Painful reflection, and reflexion

Effective reflective practice requires honesty and insight. SS provides a vehicle to do this, but the process can be painful. The IFS portion of this doctorate described the successful use of SS research in improving training in the struggling emergency department, of an adjacent teaching hospital, to which I was seconded, part-time. I concluded that the unit had lost sight of its purpose and I was able to initiate some effective remedial actions (Burns, 2019). Although, I recognised the power of SS, in line with the SS literature, I first had to examine my own history, biases, and prejudices and had found that process painful. Thus, I knew this current intense self-scrutiny would also cause similar discomfort.

In this section, I detail how, throughout this latest portion of my EdD journey, I held an uncomfortable and sometimes fearful mirror up to my DME practice both literally and metaphorically. I illustrate the power of reflection in SS as an entry point to complex, difficult to research, emotional territory. As a result of the anticipated discomfort, I debated whether to embark on this project at all. The following extracts reflect this dissonance. I begin early in the formal research study period in mid-December 2019.

14/12/19: Diary (4pm)

> ***"Who and what?*** *I just spent a timed 5 minutes looking into a mirror literally creating a self-portrait. The purpose was to hold a mirror (literally) up to myself and see myself as physically flawed as Lucian Freud depicted himself in the images below (Figure 7.1).*
>
> ***Why do this?*** *With SS clearly in my consciousness, I found myself at Lucian Freud's 'self-portraits' exhibition in the Royal Academy of Art, London and later that month in the national gallery in Washington DC, where I viewed Rembrandt's equally 'truthful' self-portrait. I began to consider how a painter could be so honest in his depiction of himself and began to draw parallels with SS. I decided, then, to have a go! Firstly, it was not as hard as I thought as I was concentrating so intently on trying to get the likeness remotely accurate. I was subsumed by the task in hand. An interesting exercise!*
>
> ***So What?*** *Perhaps, if I really concentrate on the art and science of this SS, I won't be so vulnerable to hurt that I risk emerging from being exposed! Hmmm. Glad I did it, not sure it will fit into my thesis, but I would like to add it. Can I make its addition scholarly enough (perhaps I will discuss with *)? It's the honesty and the nakedness (literally and metaphorically) that intrigues me and chimes with SS.*

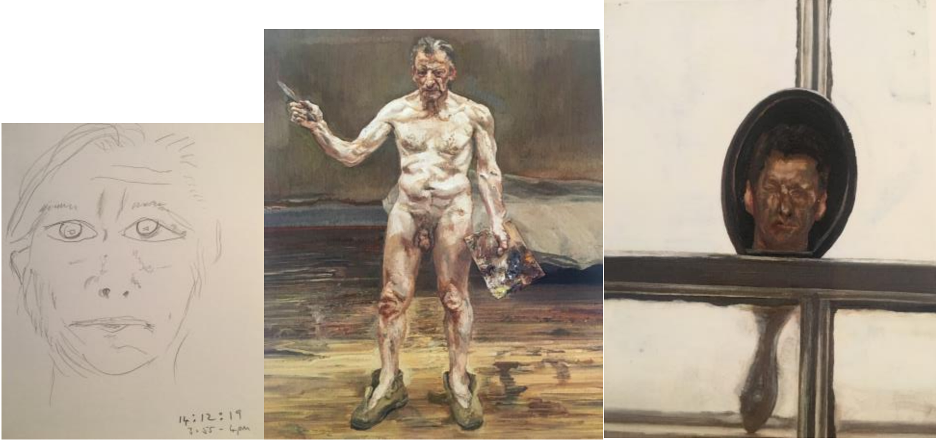


Figure 5.9 Self-portraits

> ***What now?***[43] *Address the discomfort of SS. Probing assumptions: ...*
> *My assumption was that even 5 minutes would be excruciatingly hard, but it was not…*
>
> - *Probing rationale, reasons, and evidence: ... Why did I do this? Was it relevant? This EdD & SS has invaded my inner consciousness. I find myself thinking and living, SS each day.*
> - *Questioning viewpoints and perspectives: ...I'm worried that others reading this thesis might question its relevance or utility and its scholarly application. Yet, I have pulled something useful for me, out of it, in relation to dealing with my anxiety about the nakedness of SS.*
> - *Probing implications and consequences: 'Noli timere' of SS, concentrate on the art or science of it, consider the purpose, the motivation.*
> - *Questioning the question: Have I just identified one of the personal themes that will emerge from my data? How brave do you have to be to do SS?*

Several authors had written about the value of mirrors in SS (Epley, 2008; Freidus, 2005). In relation to the above entry, my previous day's FW entry read as follows:

13/12/19: FW (11.30pm)

> *"I will explore this idea of discomfort and facing discomfort in my thesis. The poet, Seamus Heaney's epithet reads "walk on air against your better judgement" He apparently used this phrase in his Nobel Prize acceptance speech referring to the irresistible pull of poetry but there is an analogy, I think. With SS the reward of 'walking on air' comes with discomfort and pain as we question the very act of questioning our own practice. Do I really want to stare hard into the mirror? See Lucian Freud's self-portraits. I will approach this work with an open mind. "…as open as a trap"*[44]*. Tomorrow, I will spend 5 minutes looking at myself attentively in a mirror and will try to sketch a self-portrait. Perhaps, this is not relevant, but perhaps it is very relevant."*

---

[43] The headings here are adapted from Rolf (2019)

[44] From Seamus Heaney 1975 poem "Whatever You Say, Say Nothing"

From a personal perspective I found many aspects of this SS uncomfortable but was consoled by evidence that I was not alone and that the discomfort came in many forms. Meyer, cited in Ritter (2018), pays attention to how she found" the focus on self is quite hard and often elusive", how her "research gaze had(s) always been outward and to turn it inwards felt foreign." (pp. 63-69). She also admitted doubts about the validity of SS methods and describes how "my comfort with and conceptualization of S-STEP would ebb and flow". Yet, later, she concedes, "In some ways it was not the limitations of the methods but rather my own struggles with focusing inward that challenged and limited the research "(p 67). Likewise, I found the intense scrutiny of my own practice, both in this work and in my IFS, difficult, at times almost unbearable. These anxieties, I concluded, crossed boundaries between personal and professional worries but were rooted in feelings of inadequacy and exposure.

28/01/20: FW (8.20pm)

> *"I think it is time to start analysing my FW and D entries, but somehow I am reluctant afraid perhaps??"*

Yet, I knew that honest reflection and reflexivity was integral to the sincerity of any resulting conclusions, actions or interventions and was, central and necessary to this research and to bettering my DME practice. Overcoming my initial fear and (notably) acknowledging my discomfort, it was important to move forward.

Yet, the DME role involved working within and for many different complex groups, systems, and professions (Figure Figures 5.1 and 5.2). Not surprisingly then, complex relationships emerged as one of the four key themes in this work.

Appendix VII
Extract from CAR transcripts and example action log

Extracts from CAR meeting 2 with Tulip: chosen to demonstrate Tulip's enthusiasm and early achievements. After our first meeting s/he had made changes to how the work rota was organized and arranged anonymous feedback from trainees. We started by discussing enhanced support for ESs.

26/3/2020 venue: Tulip's office.
(field note added) *Atmosphere relaxed with a cup of tea! Tulip goes to trouble to make sure we are alone and will not be interrupted for the entire duration.*

AB: Ya, feedback… we can easily do that …and sometimes we have a session on trainees experiencing difficulty…em…and I think for the other one … we could do a bit about culture (I go on to tell a story about a previously encountered problem in a different department as follows)……there was a terrible culture in a particular area where there were non-medical hierarchy who were more experienced than the junior trainees and it was creating a lot of …sense of undermining and we actually…faced those issues and we talked about them and we so…that was actually really good so again…em…we can tailor it (group sessions for ESs) for what we want to do so …if we make sure we do a "how to give feedback session, and the teaching culture and the one to one teaching*

T: …bridging…

AB: Ya, bridging the divide

T: ***laugh***…we won't call it the divide…***laugh***

AB: OK the little crack…***laugh***+++

T: not the chasm…***Laugh***++

AB: Shall we call it the crack?... but well done! … 'cause you can sense that they are already feeling that they are being cared for …

T: Because I think it was good for me to come in with this rota...try to sort that out and now I can think clearly about the teaching element which is what I regard as my two main domains…but then having L* there has been invaluable because em…

AB: Ya

We go on to talk about formal teaching sessions…

T: She has been here (as a registrar) and she says ...actually there has always been that lacking of the teaching contribution …even before the merger.

AB: …from some…from some quarters

T: So she has great ideas planned with the registrar who is in charge of the teaching…'cause she wasn't getting much engagement from consultants when she had to go around with a list …saying can you do this slot? and then they will cancel it at the last moment…so hopefully it is now more structured…

AB: …and she has a registrar with her so the topics…er…?

T: Ya

AB: …agreed with the registrar …that is brilliant!

T: …or we are going to say…this week it is the GI team… please …so someone from the GI team teach… rather than say …a free for all…

AB: Ya, OK and then we will see…and then the secret will be constantly reviewing it to see what is working …building on that and then brilliant…

T: …and then we will collect feedback after the teaching session…which also should go back to the consultant who does part of the teaching as…

AB: Absolutely, absolutely, Ya Ya.

T: …part of their portfolio

Later….
We discuss trainee feedback that Tulip has gathered since the first CAR meeting.

T: (reads a quote from a trainee)
'since taking on the role of TEL, Tulip has transformed the quality of training at the R* from an extremely dysfunctional training post into a good one"

Both laugh…

AB: Well wow that is pretty excellent …did you feel emm…

T: I think I know who that is … ***LAUGH***

AB: Well, it does not matter…even if you know …they would not have said it unless they felt it was true …" there are still improvements to be made but I feel the more severe training problems in the department have been resolved. I feel that Tulip's role is currently very demanding and impacts on her reporting and requires her to stay often after her contracted hours" …em ...ya …so (AB looking at the trainee feedback) there is a little bit about the rota there…

T: Ya, so this has been resolved because I created a shared mail box to stop people e-mailing the rota co-ordinator leave and requests etc. which ...sometimes tend to border … a bit aggressive…why have you put me on …so by the shared in box I have access as well, and so…people think more carefully… more carefully before they say these things ….and…and I stress that you can only send requests…swaps to this address…

AB: OK, and also, I think it is worth a reminder about professional behaviour...amongst people

T: Em, ya … and I think since then the rota co-ordinator has not reported any…

AB: bcause you have made it more transparent for everyone to see it ...

T: Ya

AB: Ya, very good idea…

T: Because this comment came after I instituted the shared e-mail box when the rota co-ordinator had indicated to me was a problem...

AB: OK, so well done!

T: I asked… I fed back to the rota coordinator. Do you still get these inappropriate e-mails from your colleagues...and …he said no that is gone now …

AB: So, in a way you have a before and after …em…laugh

T: Ya… and I think this person used to be subject to some of these as well…so he was aware that there was a problem…

AB: OK, well done! Actually, I like that idea of a shared box for the rota co-ordinator …I might take that and suggest it to other people...

T: Ya because I think we struggle with it

later…….

T: But she is doing it so that we get a nice positive vibe from her area*…

AB: …and that is lovely because she is now part of the family of…and what we want to make sure is that she continues to feel part of the family…

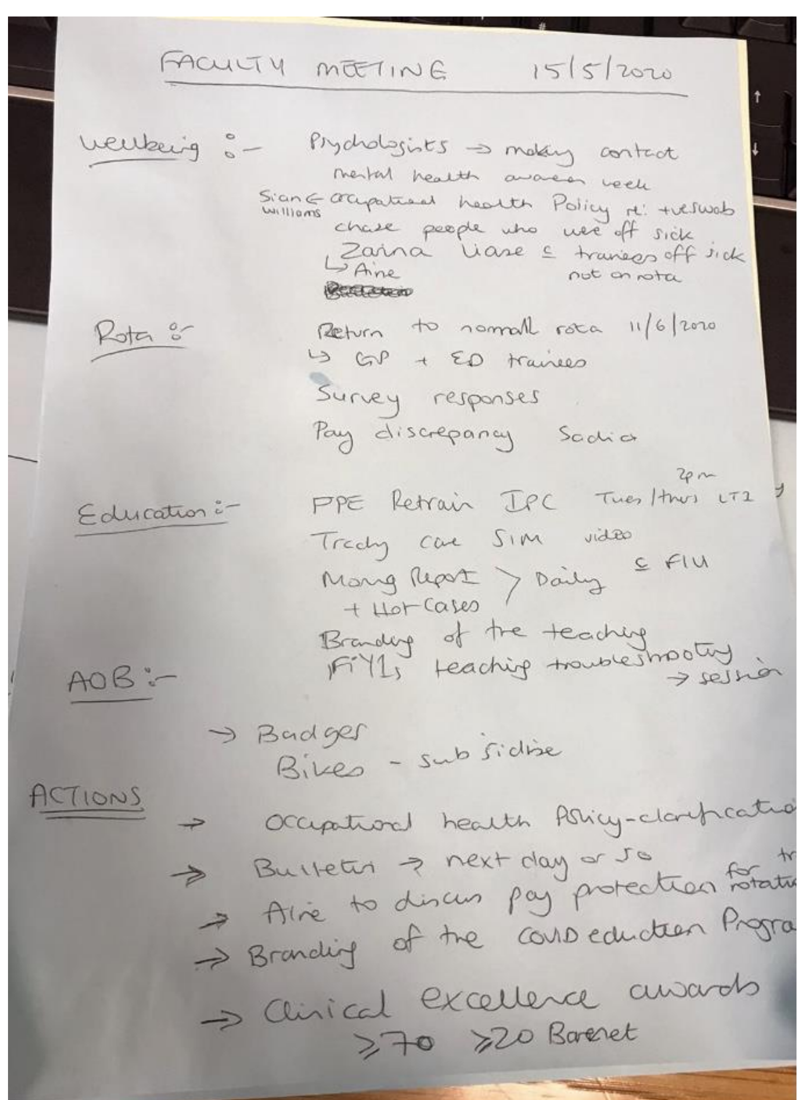
T: That is right yes

Agreed Action plan 20/2/20 with Tulip

1	AB to e-mail CD and arrange a meeting with ops manager to discuss commitment to training…	AB to re-read last HEE report and review GMC survey results over past few years
2	Tulip to meet TPD and discuss the rota balance and training opportunities properly	Informal meeting but
3	Tulip to gather survey monkey anonymous feedback from trainees and fellows re rota pilot	
4	After meeting with CD Tulip and AB to pursue	

	getting defective clinical environment fixed/updated	
5	Tulip to come back to AB re number of hours sorting rota will take and how many hours have already been spent	24/2/20 REPLY

Example of one of the PME COVID-19 taskforce action logs


FACULTY MEETING 15/5/2020

Wellbeing :- Psychologists → making contact
mental health awareness week
Sian Williams ← occupational health Policy re: +ve swab
chase people who were off sick
Zaina liaise c̄ trainees off sick
↳ Aine not on rota

Rota :- Return to normal rota 11/6/2020
↳ GP + ED trainees
Survey responses
Pay discrepancy Sadia

Education :- PPE Retrain IPC Tues/thurs 2pm LT2
Trachy care SIM video
Morning Report + Hot cases > Daily c̄ FIU
Branding of the teaching
FY1s teaching troubleshooting → session

AOB :-
→ Badges
Bikes - subsidise

ACTIONS
→ Occupational health Policy - clarification
→ Bulletin → next day or so
→ Aine to discuss pay protection for rotation
→ Branding of the COVID education Program
→ Clinical excellence awards
≥70 ≥20 Barnet

Appendix VIII

ReadALetter-Aine Burns
www.youtube.com
(2/4/20)

Dear Health Education England,

Today is April 2nd 2020 and I am a few days older than 60 years and it feels like I have lived all of those 60 years in the last 16 days! In Irish we would say the world has turned 'tri na ceile!' (topsy turvy)

My twin sister and I knew we wanted to become doctors, from age 4, when we were charged with keeping a classmate occasional company while the rest of our class played in the 'smallies' yard. Barbara suffered from what we now know to be congenital heart disease. She was blue and breathless with clubbed fingers, short stature, coarse hair and pursed lips- her own version of PEEP (positive end expiratory pressure) ventilation. Fifty-six years later I can feel the same outrage, as she did not have a chance to enjoy break-times or 'sos'.

We prayed for her immortal sole before the year ended.

So, I never doubted what my career would be. I have not become a pediatrician or a cardiologist, but I have found a home looking after people with kidney problems and training and developing qualified doctors to become the best specialists or GPs they can be.

Not 4 weeks ago I was cruising toward my 60th birthday looking forward to celebrations with 'family and friends'. I had no intention of retiring. Life seemed good. I loved the balance of my 50:50 portfolio career. My 5 children were all happy in their work and healthy in mind and body. Three have followed their parents into medicine and I am equally proud of my scientist daughter and my literary son. What could possibly go wrong?

Somehow the pictures from Wuhan and other Asian cities did not seem real. On 9th March I oversaw a 'journal club' focused on modeling predictions of COVID-19 spread. It all seemed very far away. The first patient had been admitted to our hospital the day before. I had dodged the cameras parked outside. It began to dawn on me how poorly prepared we were for mass acute respiratory failure. On Monday March 16th at 7:23 (I checked) I woke with the mental image of a longstanding friend and UK trained respiratory and infectious disease consultant imprinted on my consciousness. I WhatsApped Chris, now based in Hong Kong, to ask some questions about his COVID-19 experience there. He replied immediately. Throughout that day we exchanged countless messages and had a 90-minute telephone call that I recorded. With each exchange my fear and horror at what we were about to experience grew exponentially. I looked around for evidence that the cavalry was on their way. I could see no dust on the horizon!

I was seized by a bad dose of headless panic and a sense of doomed inevitability. I indulged these sentiments long enough to become irritated with myself. I needed to narrow my focus to my sphere of influence and fell into a well-practiced complex problem-solving grid. I was determined that I would look back on this and be able to say, hand on heart, we did our very best. In a frenzy of activity I sent the

recorded call to colleagues and friends in the UK and abroad. I stopped listening to the news apart from a single bulletin each evening. My brain became a manic space churning out ideas, some sensible some clearly ridiculous. Who and what resources or connections did we have to call on? In my role as overseer of post-graduate medical education, in my hospital, I had 450 of the brightest young minds in the country, within earshot. It was clear that they could find solutions. The image of a murmuration of birds settled in my head: together they could take flight with common purpose. With the freedom to find solutions these youthful professionals have not disappointed.

We are now 26 days into this disaster and no doubt there are hundreds more to come. My silver lining has been the pride I feel in my younger colleagues and newfound friends. I can hear our fledgling choir begin to sing. We have created a heady mixture of innovation, fear, excitement, indignation and scholarship bound by single-minded determination to do the very best we can. We sing with a powerful voice and tireless resilience.

I think we will be OK!

Noli timere! Do not be afraid!

ReadALetter- Aine Burns: https://youtu.be/cgAxKqfaLq4. More than 3000 people accessed this soundtrack, and the video has had several thousand more views with countless likes.

Appendix IX
Publications from the COVID-19 PME taskforce.

Khetrapal, P., Skarbek, S., Tapper, L., Mason, C., Davis, S., Henderson, D., ... & Burns, A. (2021). Setting up an emergency medical task force to manage the demands of COVID-19: experiences of a London teaching hospital. *BMJ Leader*, leader-2021.

Henderson, D., Woodcock, H., Mehta, J., Khan, N., Shivji, V., Richardson, C., ... & Burns, A. (2020). Keep calm and carry on learning: using Microsoft teams to deliver a medical education programme during the COVID-19 pandemic. *Future healthcare journal*, *7*(3), e67.

Mehta, J., Yates, T., Smith, P., Henderson, D., Winteringham, G., & Burns, A. (2020). Rapid implementation of Microsoft Teams in response to COVID-19: one acute healthcare organisation's experience. *BMJ health & care informatics*, *27*(3).

Faderani, R., Monks, M., Peprah, D., Colori, A., Allen, L., Amphlett, A., & Edwards, M. (2020). Improving wellbeing among UK doctors redeployed during the COVID-19 pandemic. *Future Healthcare Journal*, *7*(3), e71.

Levene, A., & Dinneen, C. (2020). A letter to the editor: reflection on medical student volunteer role during the coronavirus pandemic. *Medical Education Online*, *25*(1), 1784373.

Appendix X
Further trainee comments see 5B 4.1.3 Leadership reflections after action: Complex Relationships

Trainee C voiced the importance of attending to physical wellbeing to improve trainee experience as follows:

> *"Of late, these physical spaces for doctors have been reducing, as well as simple amenities like coffee, lockers and rest spaces. The presence of these things makes trainees feel valued and are incredibly important for wellbeing and improving training experience."*

Trainee D

> "*…here are some of the things I learnt:" Leadership: some of the most impressive leadership was found from individuals who hadn't necessarily been in positions of leadership before the crisis began. New challenges created new voids of leadership and many junior team members stepped up to fill these positions and did remarkably well. That being said, many existing members of the leadership system fulfilled their responsibilities and went above and beyond the call of duty and the specifications of their role/title, but occasionally seniority/title did not correlate with the most impactful leadership during this time and emphasised the importance of providing opportunities to a variety of people to step into leadership roles especially in times of crisis."*

Trainee E

> *"- Involving trainees in decision making processes and forward planning ensures their voices are heard, and their ideas can be taken into account. It can be helpful to have trainees across the whole spectrum of grades, from foundation doctors to senior registrars."*
>
> *- Often, unrest was the result of poor communication, as opposed to poor decision-making. TELs, CDs and other leaders wanted the best for the trainees at all stages, but often compromises had to be made. The results of this sometimes led to anger amongst trainees - often this anger was quelled once trainees realised the process behind these decisions. Sometimes views were completely flipped from anger to praise, as it was realised that everyone wants the same thing, and people worked together to come to solutions."*

Appendix XI

Camden journal

Camden New Journal Thursday 16 July 2020

The postgraduate medical education Covid-19 taskforce

Hospital thanks 400 trainee docs for help

THE Royal Free has thanked more than 400 trainee doctors who were thrown into action during the coronavirus crisis.

Professor Aine Burns, director of postgraduate medical education at the at the hospital in Hampstead, said: "Sadly, this crisis will be remembered by many people as the worst of times. For me, however, a silver lining was the enormous pride I felt as I watched our trainee doctors step up to the plate, finding and solving problems with brilliance, hard work, ingenuity and good humour."

She added: "I am sure their contributions saved many lives. The future for patients must surely be bright."

Sarah Davis, a trainee doctor in internal medicine, said: "We were thrown in the deep end being asked to redesign medical staffing and organise a rota in 48 hours for 180 doctors.

"It was a fast learning curve but we had a great team working together, and ensured we added a bit of fun to the new rota allocating doctors to Harry Potter houses."

A postgraduate task force helped daily in the operations room, mortuary and bereavement services; oxygen supplies, scrubs and PPE availability; and supporting the physical and mental wellbeing of all staff.

Dogs to sniff out Covid?