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ARE ALL ROLE MODELS LEADERS?

LEADER IDENTITY CONSTRUCTION AND ROLE MODELLING IN NURSING

This presentation explores a study that critically examined role modelling and leadership in nursing in the National Health Service (NHS) in the United Kingdom. Contemporary policy drivers call for inclusive, compassionate, collective and shared approaches to leadership in order to meet ongoing health service demands and reforms. Part of this could be achieved by harnessing and capitalising on the role modelling aspect of leadership, allowing all potential leaders to develop.

A constructivist case study methodology enabled role models and leaders to be identified, alongside individual perceptions, opinions, experiences and ideas associated with role modelling and leadership amid everyday practice. Data was collected through nonparticipant observation and semi structured interviews. Both inductive and deductive approaches were used in data analysis within and across the cases using a socially constructed lens. Rigour was assured through robust reflexive strategies and triangulation of methods, data sources and theory. The fourfold leadership typology of Grint (2010), 'position, person, process and results' was utilised as a heuristic frame.

The social collective element of leadership is rooted in the notion of leaders and followers, roles which can be interchangeable and dependent on any given time and space (Ladkin 2010, Haslam et al. 2011, Barr and Dowding 2016). A role model is followed in the most basic sense if, as Bandura (1977) reports, the modelled behaviour has relevance and captures the attention of the observer. The critical element is influence through communication, intentional or otherwise. Essentially, acting as a role model can be seen as leading in the sense of leading by example. This is the first connection to leadership. The second connection is when being a role model is perceived as an expectation of being a leader.

The study offered a means to explore a space in the leadership rhetoric and exposes role modelling as a leadership behaviour, contributing to enhanced understanding of the interface between role modelling and leadership, and the exchange of follower and leader roles. Overarching factors emerged: the act and impact of learning from a role model is evident in the nursing team; being seen as a role model is within the gift of anyone at any positional level, essentially constituting being 'followed'; and at some point in their developmental trajectory, an individual begins to recognise themselves as a role model and this can happen when they become formal leaders.

The path of nurse/leader development in each of the cases displayed an increasing awareness of individual everyday operational leadership, to the wider strategic perspective demonstrated by the established nurse leader. This represents a movement from Grint's (2010) 'person' individual level explanation, to the wider 'position' level, with accompanying 'results' and 'process'. Expecting to 'lead' on a relatively formal incremental trajectory contributed to the participants ongoing professional role identity within their social groups. This provides a new insight into how awareness of self as role model can occur and corresponds with growing leader identity construction in formal roles.

Developing self-awareness and purposeful attention to role modelling and its associated behaviours can be useful as a means of distinguishing areas for leadership development. At some point, in their growing self-awareness, an individual recognises that they are a role model; being able to capture that moment could assist with purposeful development, role identity and leader identity. The juncture where being a role model and being a leader connects could be that time. The provision of guidance and support in the form of organisational processes specific to role modelling as a leader could increase understanding and drive positive performance.

Discussion points - How can we explore and critically reflect on the underlying concepts associated with role modelling and leadership?

• By identifying individuals who are seen as personal role models, whether in a professional capacity or otherwise, consensual or not.
• Recognising self as role model and leader, crucial for expanding leadership capacity across teams and organisations.
• Employing being a role model as a conscious strategy in the drive for shared, collective, inclusive leadership: firstly, to assist with appreciating the impact on those around as a cornerstone of leadership behaviour: and secondly to harness the impact of a role model through direct application
• Contributing to the provision of guidance and support in the form of organisational processes specific to role modelling as a leader in order to increase understanding and drive positive performance.

References

Bandura, A. (1977) Social Learning Theory. London. Prentice-Hall

Barr, J and Dowding, L. (2016) Leadership in Healthcare 3rd Edition. London. Sage

Grint, K. (2010) Leadership A very short introduction. Oxford. Oxford University Press

Haslam, S. A. Reicher, S.D. Platow, M. J. (2011) The New Psychology of Leadership – Identity, Influence and Power. Hove. Psychology Press

Ladkin, D. (2010) Rethinking Leadership – A new look at old leadership questions. Cheltenham. Edward Elgar

Submission to the 21st International Studying Leadership Conference
The Leadership Dynamics of Systems Change

There are no sharks in this tank: The role of trust in the early development stages of a collaborative research project in the healthcare sector

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"The optimistic view of things is that we are complementary. I think people are sufficiently intelligent and there are no sharks in this group. There isn't one person who's trying to dominate. I mean, everybody's ambitious, everybody wants to do well. But there are no sharks or people who are trying to dominate". (Lead2)

In order to tackle more efficiently important societal, economic and environmental issues we are witnessing an increasing number of different types of collaborations among organizational and institutional actors, within or across different industries. These strategic partnerships consist of "a cross-sector, inter-organizational group, working together under some form of recognized governance, towards common goals which would be extremely difficult, if not impossible, to achieve if tackled by any single organization" (Armistead et al., 2007: 212). Within this complex and at times ambiguous context, single-organization traditional forms of leadership do not apply, and are often replaced by collective organizing efforts with networks of interacting dynamics. Leadership hence becomes a "plural" phenomenon (Denis et al., 2012; Mailhot et al., 2016), where alternative forms of leadership such as collaborative agency (Raelin, 2016; Robinson and Renshaw, 2022) and distributive leadership can be essential to the success of major collaborative projects (Mailhot et al., 2016).

Such partnerships create a number of challenges for involved leaders as they have to manage different tensions that arise within the partnership and navigate power dynamics that shape the emergence of collective leadership (Foldy & Ospina, 2022). These include contextual challenges such as power imbalances and scale mismatch between the different partners (Dolzier & Burbach, 2020), and tensions such as the tension of value creation vs value capture and that of mutual value vs individual value (Oskam et al. 2020). We therefore ask the following research question: *How do leaders navigate tensions in the early development stages of a collaborative research project?*

To answer this question, we examine the case of a research consortium working on personalized treatments for cancer patients at the metastatic stage. The consortium consists of highly competitive academic and industrial experts including a cancer medical center, European leader in cancer-research, three public research institutions, two biotech companies, one major European pharmaceutical company, and a renowned French university. The consortium was selected for funding by the French National Research Agency as part of the 5th call for projects for the University Hospital Research in Health (RHU) action within the Investments for the Future program.

This paper focuses on the initial stages of the collaboration, and is part of an ongoing inquiry with the consortium, adopting an interepretivist epistemological lens. The data collection includes observations (attending the regular consortium and operational meetings), semi-structured interviews with Work Package Leads, from the different partner institutions, and archival data such as the proposal, monthly newsletters, meeting notes, etc. The first phase of data collection used for this paper, took place over a period of 10 months, between September 2023 and Jun 2024. For the data analysis, we use the qualitative data analysis software atlas.ti for coding and category development, and we adopt an iterative process of coding and theorizing.

Our preliminary findings first highlight a number of tensions experienced by the leaders during the initial stages of the project. They are: (i) visibility tensions (partial vs. full visibility on the progress of the activities of the different partners related to the project); (ii) communication tensions (academic vs. commercial language within the communication); (iii) operational tensions (well-established, stable, but bureaucratic institutions vs. developing, agile and quick start-ups); (iv) outcome tensions (looking for in-depth results of one experiment vs. a large number of repeated tests and results). These tensions do not only exist at the intra-individual level between the leaders, but also at the inter-individual and inter-project levels.

Next, we identify inter-personal trust among the leaders as a key factor ensuring the inter-connectedness (at the motivation level, at the operational level, at the outcome level). The foundations of trust in our findings lie on different premises: (i) previous working relationships/experiences between some of the partners; (ii) clear communication clarifying individual objectives as opposed to project objectives; (iii) professional reputation (partners who haven't worked together but who are familiar with and admire each other's work); (iv) complementarity of the partners within the project; and (v) extra-project relationships (creating opportunities to socialize outside of the strict professional interactions). Yet, as the project moves from the initial formation phase to a more stable operational phase, we notice that certain (individual) objectives start shifting and new types of tensions are emerging. We accordingly wonder whether trust will remain key within the collective leadership and whether is will be impacted by the observed changes.

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References

Armistead, C., Pettigrew, P., & Aves, S. (2007). Exploring leadership in multi-sectoral partnerships. *Leadership*, *3*(2), 211-230.

Denis, J. L., Langley, A., & Sergi, V. (2012). Leadership in the plural. *Academy of Management Annals*, *6*(1), 211-283.

Delozier, J. L., & Burbach, M. E. (2021). Boundary spanning: Its role in trust development between stakeholders in integrated water resource management. *Current Research in Environmental Sustainability*, *3*, 100027.

Foldy, E. G., & Ospina, S. M. (2022). 'Contestation, negotiation, and resolution': The relationship between power and collective leadership. *International Journal of Management Reviews*.

Mailhot, C., Gagnon, S., Langley, A., & Binette, L. F. (2016). Distributing leadership across people and objects in a collaborative research project. *Leadership*, *12*(1), 53-85.

Oskam, I., Bossink, B., & de Man, A. P. (2021). Valuing value in innovation ecosystems: How cross-sector actors overcome tensions in collaborative sustainable business model development. *Business & society*, *60*(5), 1059-1091.

Raelin, J. A. (2016). Imagine there are no leaders: Reframing leadership as collaborative agency. *Leadership*, *12*(2), 131-158.

Robinson, J. L., & Renshaw, P. S. J. (2022). Place–The final frontier: Exploring the outer reaches of collaborative agency using the Japanese concept of Ba. *Leadership*, *18*(1), 13-39.

Disruption, relational activities, and moral injury: A study of command leadership in healthcare

Background

In previous conceptualisations of collective leadership authors' focus appears to be predominantly uni-directional, emphasising the movement towards, and growth in the use of, collective leadership. We lack empirical studies and theoretical consideration which explore the possibility of a shift back to a 'top-down' form of leadership after collective leadership has been embedded in an organization, what the effect of this would be, and what steps are needed to accommodate the (temporary) reversal. We consider a systems approach to inform the development of an alternative model of leadership to support such a shift. We propose this consideration is required because such a reversal occurred during the COVID-19 pandemic, but as yet we are without a theoretical proposition to explain how to address consequential detrimental effects experienced by the workforce.

In conflict with the UK National Health Service's (NHS) contemporary practice since the 1990s, which advocates the use of collective leadership across the organization, command leadership was operated by senior leaders for a prolonged period during the pandemic. Command is often characterised as autocratic, with the exercise of a directive, centralised power that may help or hurt team-members. The prolonged use of the NHS' model of command leadership, enshrined in an NHS policy, is reported to have contributed to a demoralised workforce, with rule-breaking by staff, staff absences, elevated levels of resignations and early retirements.

Research design:

This is a qualitative case study, underpinned by a social constructionist epistemology. It comprises data collected predominantly from interviewing 60 clinicians[1] and non-clinical participants working in or with NHS surgical teams, supported by virtual observations of hybrid online/in-person meetings.

[1] Clinician denotes a health care professional who is involved in the treatment and care of patients.

Findings:

We provided empirical data of bundles of visible and less visible activities which are integral to the production and reproduction of leadership. We show that physical and relational aspects of leadership changed because of the disruption of different leadership activities.

The paper provides insight into the exercise and effects of command leadership which was operationalised during the COVID-19 pandemic. We show how a 'war zone' atmosphere came to permeate the health service which was sustained by senior leaders even as the crisis abated. In doing so, hospital leaders prolonged the command regime of centralised power and control. This impeded clinicians' ability to make decisions and to act autonomously, eroding morale, causing moral injury, and driving employee turnover.

Conclusions:

This paper proposes the pursuit of a systems approach to inform the development of an alternative model of command leadership. It addresses the potential need to exercise command leadership more frequently, in light of the scientific prediction of increased instances of new, highly transmissible viral variants, producing large numbers of hospital admissions. As opposed to the current homogenous command system, we advocate for plurality in organizational leadership policy and systems, even in times of crisis. We present this as required to accommodate differentiated demands on teams with distinct specialisms.

We draw on two key concepts from outside the field of leadership. First, on the concept of 'disruption' from the technology field, we theorise about how changes occurred to the leadership model during the pandemic. We propose that by building an understanding of potential disruptions, a strategic systems approach may be developed. This may provide the means to enable pre-emptive action that prevents or reduces the effect of disruptive events on the workforce.

Secondly, we apply the concept of 'moral injury'. Whilst this is acknowledged in military studies as an ancient phenomenon, engagement with it in leadership and organizational studies is relatively recent. Limited empirical evidence exists on moral injury in the healthcare context. It is identified as a multidimensional effect from exposure to potentially morally injurious events, resulting in moral emotions, such as anger and guilt, depression and anxiety.

We make two main contributions to the leadership research field. First, we conceptualised the combined effects of greater use of virtual communication and the use of command leadership. We illustrate this may cause disruption to the relational outcomes of leadership which in

'normal' times enable people to collectively achieve goals. We propose the disruption is triggered by (in)action that may be avoided by using pre-emptive relational activities.

Second, we extend the notion of 'moral injury' previously studied in military settings, to the 'war zone atmosphere' experienced by NHS staff during COVID-19. In doing so, we provide a theoretical proposition for why people experienced detrimental effects from the organizational use of command leadership.

References

Adner, R. (2002). When are technologies disruptive? A demand-based view of the emergence of competition. *Strategic Management Journal*, *23*(8), 667–688.

De Hoogh, A. H. B., Greer, L. L., & Den Hartog, D. N. (2015). Diabolical dictators or capable commanders? An investigation of the differential effects of autocratic leadership on team performance. *Leadership Quarterly*, *26*(5), 687–701.

McCauley, C. D., & Palus, C. J. (2021). Developing the theory and practice of leadership development: A relational view. *Leadership Quarterly*, *32*(5).

Nash, W., Marino-Carper, T., Mills, A., Au, T., Goldsmith, A., & Litz, B. (2013). Psychometric Evaluation of the Moral Injury Events Scale. *Military Medicine*, *178*, 646.

NHS England Emergency Preparedness Resilience and Response Unit 2016. *NHS England Emergency Preparedness, Resilience and Response Framework*. Leeds.

Padmanathan Id, P., Lamb, D., Scott, H., Stevelink, S., Greenbergid, N., Hotopf, M., Morriss, R., Raine, R., Rafferty, A. M., Madan, I., Dorrington, S., Wessely, S., & Moran, P. (2023). Suicidal thoughts and behaviour among healthcare workers in England during the COVID-19 pandemic: A longitudinal study. *PLos ONE*, *18*(6), e0286207.

Ritchie, K., D, A. M., Brown, A., Alterman, T., Millman, H., Pichtikova, M., Xue, Y., Altman, M., Beech, I., Karram, M., Hosseiny, F., Rodrigues, S., Schielke, H., Malain, A., McCabe, R. E., Heber, A., Lanius, R. A., & McKinnon, M. C. (2023). The Hidden Crisis: Understanding Potentially Morally Injurious Events Experienced by Healthcare Providers during COVID-19 in Canada. *International Journal of Environmental Research and Public Health*, *20*, 4813.

Sonabend, R., Whittles, L. K., Imai, N., Perez-Guzman, P. N., Knock, E. S., Rawson, T., Gaythorpe, K. A. M., Djaafara, B. A., Hinsley, W., FitzJohn, R. G., Lees, J. A., Kanapram, D. T., Volz, E. M., Ghani, A. C., Ferguson, N. M., Baguelin, M., & Cori, A. (2021). Non-pharmaceutical interventions, vaccination, and the SARS-CoV-2 delta variant in England: a mathematical modelling study. *The Lancet (British Edition)*, *398*(10313), 1825–1835.

White, L., Currie, G., & Lockett, A. (2016). Pluralized leadership in complex organizations: Exploring the cross network effects between formal and informal leadership relations. *Leadership Quarterly*, *27*(2, SI), 280–297.

Influential Others: supporting and developing relational leaders

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Social Care provides an excellent context for studying leadership within complex systems and collaborative practice. This paper presents findings from an empirical study of care sector staff in leadership and non-leadership positions in which we discussed how the acquisition and development of leadership capabilities can best be supported. The Social Care sector in England is characterised by demands for improved leadership to drive various change agendas and a history of attempts to apply transactional and transformational leadership approaches with limited success. This work has always demanded collaboration within and between organisations but the creation of integrated care systems has seen this formalised in new, more extensive, ways. Our research focused on how the practice of leadership can be supported following the publication of a Professional Capabilities Framework that outlines leadership responsibilities at all levels of the profession. We concern ourselves with the question of how (and why) we support the development of relational leaders – not just within this sector but more widely.

Relational leadership shares an ontological position, in which the social experience is understood as being fundamentally inter-subjective (Cunliffe, 2010), with the Ethics of Care, a normative ethical theory that presents obligations with respect to caring relationships (e.g. Kittay, 1999). In this view, leadership is understood as being a way-of-being in relationship-to-others (Cunliffe and Erikson, 2011). Following the work of Ospina *et al* (2020) this paper makes use of relational leadership as a lens to explore and analyse the data. In doing so we recognise the synergies between the relational nature of work in the care sector; the value of relational leadership theory in informing discussions about both the work of effective relational leaders and the nature of effective professional relationships; and the content of our data which was characterised by a focus on the value of relationships.

Nicholson and Kurucz (2019) call for relational leadership development that engages more explicitly with the ethical underpinnings of practice. They posit that understanding *who to be* helps us to understand *what to do* (Shotter and Cunliffe, 2002) and suggest a four component approach to leadership development that draws on the work of Noddings (2002) with respect to a caring pedagogy. Whilst valuable, these ideas focus attention on the individual and fail to address the shared responsibility to attend to the quality of relational space. The application of relational leadership as a lens for the analysis of empirical data helps to adds a third heuristic, namely '*why we do*' which encourages leaders to consider the collaborative space, the relationship itself, as well as their own role and actions.

Our paper will first present the four components of the Nicholson and Kurucz (2019) model: modelling, dialogue, practice and confirmation. We show that whilst this model outlines approaches which, in the right context, may support the development of relational leaders it also describes an approach which risks reinforcing rather than challenging the existing status quo within organisations. One example drawn from our data concerns the process (often a lack of process) of 'talent-spotting' – who is identified as a future leader and then mentored or supported. Those who do not fit the existing mould are passed over. No matter how enthusiastically future leaders are supported this approach is problematic. First, it fails to recognise the inherent polyphony of relational work (Cunliffe and Erikson, 2011) in which our only hope for learning about the constantly shifting nature of inter-

personal and inter-organisational relationships is by listening to the voices of those we seek to work alongside. Second, rather than working to improve equity of access to development, to challenge the diversity gap in management roles – where, according to Skills for Care (2022) managers are more likely to be white and male than in the rest of the care workforce – this practice reinforces inequitable access. Our contention is that whilst the intentions of leadership or management development are often excellent these problems are caused by a lack of attention to what makes relationships effective.

Our conclusion is that by using relational leadership as a lens through which we can observe and comment on leadership practice within and between organisations we can throw light on the practices which support collaboration, particularly in complex domains or systems. We argue relational leadership development which encourages leaders to consider both who they should be and the nature of effective relationships can then inform a discussion of what effective relational leaders do.

References:

Cunliffe, A. L. (2011). 'Crafting Qualitative Research: Morgan and Smircich 30 Years On'. *Organizational Research Methods*, 14(4), 647–673.

Cunliffe, A. and Eriksen, M. (2011). 'Relational leadership', *Human Relations*, 64(11), pp. 1425-1449.

Kittay, E. F. (1999) *Love's Labor: essays on women, equality, and dependency*. New York: Routledge (Thinking gender).

Nicholson, J., Kurucz, E. (2019). 'Relational Leadership for Sustainability: Building an Ethical Framework from the Moral Theory of 'Ethics of Care'', *Journal of Business Ethics*, 156, 25–43.

Noddings, N. (2002). *Educating moral people: A caring alternative to character education*. New York: Teachers College Press.

Ospina, S.M., Foldy, E.G., Fairhurst, G.T. and Jackson, B. (2020). 'Collective dimensions of leadership: Connecting theory and method', *Human Relations*, 73(4), pp. 441-463.

Shotter, J., and Cunliffe, A.L. (2002) 'Managers as practical authors: Everyday conversations for action'. In Holman, D. and Thorpe, R. eds., *Management and Language: The Manager as a Practical Author*. London: SAGE Publications Ltd.

Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England 2022*. Leeds: Skills for Care.