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What, if Anything, has Replaced the 'Firm' Model of Leadership in Surgical Teams?

A Leadership-As-Practice Study

Track 13

Leadership and leadership development

Introduction

The doctors, nurses and allied healthcare professionals who work in surgical teams have traditionally operated under a hierarchical model of 'firm leadership'. With some local and speciality-based variants, firms were typically led by a single (often male) senior surgeon and were characterised by distinctive followership behaviours, including the very long working hours of junior doctors. The firm model has been increasingly challenged by successive reports of leadership shortcomings in surgical failure reports, legal restrictions placed on the working hours of junior doctors, and revised medical training practices. While studies of leadership in other fields have reported shifts towards more distributed models, little is known about what, if any, change has occurred to the traditional 'firm' leadership model in surgical teams.

This paper introduces a study that adopts a Leadership-As-Practice (L-A-P) approach to embrace Parry's proposition to set aside the word *leader* to compel us to consider "what is causing and doing the leading and the leadership effect that follows" (Kempster and Parry, 2018: 65).   The conceptual aim of the study is to elaborate the L-A-P approach through its first application in the context of National Health Service (NHS) surgical teams. The primary empirical goal of the study is to identify and explain current approaches to leadership in surgical terms, whether they be the traditional firm model, or alternatives such as transformational or distributed leadership. This paper outlines the study's conceptual framework, empirical context, method, and research themes.

Conceptual Framework

Although leadership is a "far from stable and enduring timeless form" (Wilson, 2018: 12), studies have tended to concentrate on individual leaders and top-down dynamics. In contrast, the emergent L-A-P perspective builds on ideas of relational leadership to concentrate on the process of leadership as it emerges through everyday experiences (Carroll, 2016; Raelin, 2016). It considers leadership as the consequence of, rather than instigating, teams' actions (Sergi, 2016). With roots in the strategy-as-practice tradition (Whittington, 2006), L-A-P relates to the relational shaping of new spaces of action, rather than mobilization towards an organized future (Crevani and Endrissat, 2016; Kempster and Gregory, 2017). The resulting examination of day-to-day processes may include materiality as well as human actors. Whilst objects themselves are not considered capable of providing leadership, leadership is seen to emerge from the contextual association between objects and human-actors (Sergi, 2018).

L-A-P aims to address suggestions that earlier perspectives of non-hierarchical leadership focus on positive, context-free and normative views, and do not address concerns such as the potential for imposing managerialism through devolved leadership. In contrast, L-A-P considers often ignored issues, such as conflict and tension within leadership practices (Chreim, 2015; Youngs, 2017). Despite these objectives, some concerns have been voiced

about the limited development of criticality, and concern for power, within the L-A-P literature to date (Collinson, 2018; Raelin *et al.* 2018). The L-A-P approach may provide insight into the interplay of "soft" and "hard" power (Raelin *et al.* 2018) and the emergence of hybrid models of leadership including combinations of individual, heroic or post-heroic and distributed forms (Gronn, 2015; Raelin *et al,.* 2018).Alternatively, in the context being explored here, we may find that the 'firm' leadership model remains dominant, with the possibility of some modifications to incorporate the regulatory and training practice changes described above and the adoption of new technology.

As leadership may include such objects, may be located in 'unexpected places,' and comprise processes as well as individuals, the L-A-P approach is well suited, because L-A-P studies aim to explore leadership with an expansive lens (Ospina, 2018). In general terms, the L-A-P perspective directs exploration of four main themes: (1) *what* they do, (2) *how* they do their work (3) socio-emotional aspects, and (4) the process for the leadership effect to happen. The **socio-emotional aspect** of the L-A-P approach requires consideration of organizational culture. Previous studies suggest that this research will be conducted within the context of a work environment that has moved from relatively static teams, to teams that can change on a daily basis or even during the course of the day. In these circumstances, that Clegg and Pina e Cunha (2018) describe as a 'Shift from solid to liquid dynamics of modernity', the research will investigate whether teams have developed the capacity to form what Clegg and Pina e Cunha term 'swift trust' (2018: 177–181), which switches as the teams change or disperse and reform. Following Raelin, this issue would be explored through consideration of the processes of 'reflecting', 'unleashing' and 'inviting'. In turn, these components are identified by the existence of certain markers, which are considered to indicate different forms of leadership (Figure 1) such as: (a) the heroic form of leadership, (b) a combination with a more distributed form of leadership, or (c) a distributed form of leadership. It is also postulated that the pattern of activities and type of leadership may differ in different contexts, for example between emergency and non-emergency surgery.

The framework used to analyse surgical teams' experiences in this study is developed from L-A-P activities described by Raelin (2016). The unit of analysis shifts from the individual leader to the 'intersubjective interaction among parties to the practice' (Raelin, 2016). The main structure of the framework takes shape from the 7 leadership activities Raelin proposes are indicative of the relationality and actions of leadership. In addition to these, it is supplemented by the "HOW" of practice proposed by Endrissat and von Arx (2013) and the elements recommended by Kempster and Parry, to support Raelin's, with an Input, Process, Output (I-P-O) perspective (2018). The Output in this context is understood as the 'Leadership effect'. The socio-emotional activities Raelin proposes are enhanced by Edmondson's psychological safety contributions (1999) (figure 1).

Inspired, motivated, self-efficiency, clear direction, confident, sense of purpose, psychological safety

Output

Designing

Who is doing who

Responsibilities for design

Leading discussion & decision

Organization, Department/specialism, Team, Team- component (e.g. role-type), Elective / emergency

Context

Scanning

Identifying resources to start / develop the activity/project

Uninspired, Demotivated, Directionless, Purposeless Low self-efficiency, Unconfident

Agency: primary

Mobilising

Redirection of people's attention

Power, Networks, Role, Expectations, Ethics, Experiences

Agency: corporate

Weaving

Create interactions for trust/mutual activities

Practices, Ideas, Assumptions, Relationships, Technologies, Materialities, Histories

Inputs

Process | How

Stabilising

Feedback to evaluate & & lead to change

Socio-Emotional | What

Encourage participation especially of reticent team-members

Reflecting

Understanding

How to do things

Ensure all who want to contribute without fear of repercussion may

Unleashing

Rules observed

Explicit

Inviting

Teleoaffective structure

Inviting open challenge of current assumptions, leading to: Learning to meet mutual needs and interests

Implicit routines, not actively reflected on activities that are familiar / apparent to participants activities are observable and learnable
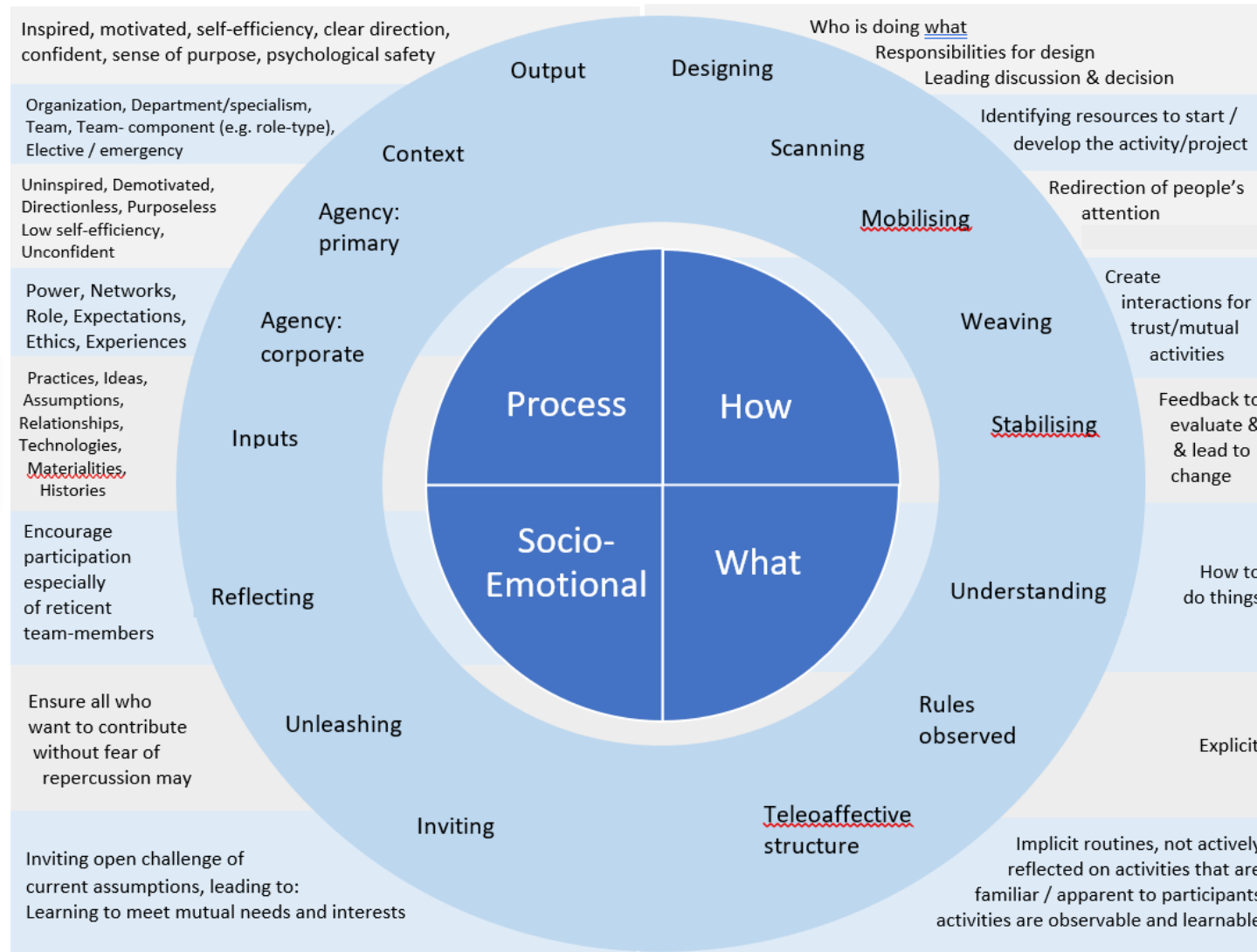
Figure 1: Proposed Framework for L-A-P.
Source: author, with reference to Raelin (2016), Endrissat and von Arx (2013), Kempster and Parry (2019).

Context

The traditional model of hierarchical firm leadership in surgical teams was typically justified as protective of (senior) clinical autonomy, oriented towards quality assurance, and supportive of (junior) professional development. It has, however, increasingly been challenged by the emergence of more distributed leadership approaches in other fields, legal restrictions on the working hours of junior doctors (through the European Working Times Directive) and successive studies of performance failings in NHS hospitals that identify shortcomings in approaches to leadership (Berwick, 2013; Francis, 2013; Kennedy, 2013). It has been shown that the traditional, hierarchical, form of leadership hampers wider participation in leadership activity and stifles the raising of concerns about areas of performance, including patient safety (Edmondson, 1999; Kennedy, 2013; Currie and Spyridonidis, 2016). While these challenges are well documented, little is known about what, if any, change has occurred to the traditional 'firm' leadership model.

Method

Given the exploratory nature of this first L-A-P investigation of surgical teams, it will adopt a qualitative approach, underpinned by a social constructionist epistemology, to enable close-engagement with what is studied using "why" and "how" questions to develop theory. Rich, in depth case studies at two NHS hospital sites will be conducted using multiple sources of data collection including: semi-structured interviews, observations, and documentation review. It is proposed that the case studies will focus on two teams at each site: colorectal (elective and non-elective interventions) and emergency department surgical teams.

A semi-structured interview design will be based on the themes and focus arising out of the conceptual framework (table 1). These aim to explore not only relational aspects, including the capacity to develop 'swift trust' in the context of flexible team arrangements, but also the spaces and processes that give rise to leadership. This includes consideration of the contextual association between objects and human-actors. Observations of the surgical team-members before, during and after surgery will aim to provide additional/alternative evidence of the practice of leadership in their working environment. Documentation will triangulate staff perceptions through considering reports of 'never events'[1], 'near misses'[2], and patient safety reports. NVivo software will be used to interrogate data and code emerging themes. Review interviews with participants will be used to discuss the findings and to confirm or reassess the data.

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[1] Serious incident or error, e.g. of patient harm, that could have been prevented before harm occurred.
[2] Surgical incidents that could have resulted in very serious adverse damage to the patient or their confidence e.g. surgery carried out on the wrong part of the body, but were prevented.

Table 1: Proposed interview question themes, focus and questions

Theme	Area of focus	Examples of Questions
General opening questions exploring the work of a member of a surgical team	• How members of a surgical team experience their work • How it differs according to their role and status • Whether their experience has changed over time due to other features (e.g. changes in working practices / the move away from the 'firm' structure • How they perceive leadership in their work environment	• What does your working day entail? • Has how you work changed over time? • How would you describe leadership usually works in your team?
What surgical team-members do to produce leadership	• Do theatre staff do things according to explicit rules • What do they do that relies on tacit understanding/routines • What implicit routines do theatre staff use • Are these implicit routines apparent i.e. observable and learnable	• What sort of work is done using an understanding of or familiarity with what needs doing rather than because there are specific rules or protocols? • If you use these understandings of what needs doing, rather than specific rules, would someone, who is say new to the team, be able to observe and learn them?
How theatre staff experience (not) generating the leadership effect	• What experience do theatre staff have of how they are producing the leadership effect (Designing, Scanning, Mobilising, Weaving, Stabilising)	• Thinking about different aspects of your working day, what is a common surgical activity that might be carried out? • Is there any equipment, visual aids or technology used to help the discussion or the decision be taken?
Socio-emotional aspects team-members experience regarding the leadership effect	• What experience do theatre staff have of socio-emotional aspects (Inviting, Unleashing, Reflecting)	• What, if anything, is done to make sure anyone who wants to contribute to a discussion or give feedback can do so, without worrying about personal repercussions? • Can you describe whether and how open challenges about current work practices takes place?
The process experienced in (not) producing the leadership effect	• How does their experience differ according to the context of their work • What experience do theatre staff have of the inputs to the process • What experience do they have of corporate agency as an input to the process • What experience do theatre staff have of primary agency as part of the process • How do they describe the outputs of the leadership effect	• Are there any differences in leadership if the operation starts as a routine one but there are complications? • Have you noticed a difference in the way the team is led when there is a change in the surgeon/anaesthetist/senior theatre nurse? • What feeling would you describe might make you decide to try to take the lead, or help others take the lead to get something done?

Contributions

In conceptual terms, this research is designed to extend the emergent L-A-P approach through focused attention on the process of leadership which produces the 'leadership effect' (Kempster and Parry, 2018). Additionally, by drawing on perspectives from the established psychological safety literature, the elaborated framework will develop the socio-emotional theme within L-A-P.

By undertaking the study in the complex NHS surgical environment which, to the best of our knowledge, has not been undertaken before, we aim to provide a rich contextual contribution to the advancement of L-A-P. Whilst it is focused on understanding NHS surgical teams' current leadership practices and their possible leadership effects, the findings are expected to be of relevance to other environments that display extreme and knowledge intensive work. The research based on the proposed conceptual framework may enable the development of theory to inform future research into the practice of leadership in general.

The conceptual and empirical outputs of this study are designed to support policy development and training programmes. For example, future leadership development programmes may be designed to reflect current models and practices, whether they are revealed to be the traditional firm model, or some alternative.

Word count: 1,553

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