UNDERSTANDING LEADERSHIP DEVELOPMENT WITHIN NEW MEDICAL SCHOOLS IN AFRICA

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PLAGIARISM DECLARATION

I, Quenton Bester Wessels, hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Signed by candidate

Quenton Bester Wessels

December 2021

DEDICATION

To Rhona, the love of my life

Sine qua non

To my mother, Marianna Rautenbach,

for your perpetual support, unfathomable love and sacrifice.

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EXTENDED ABSTRACT

The transient and multifaceted nature of leadership in Health Professions Education has changed over time. Programme directors associated with medicine, pharmacy, nursing, allied health and those involved in a clinical setting typically serve as managers and leaders concurrently. Furthermore, managers in modern organisations are expected to fulfil leadership roles. Leader and leadership development are inter-reliant phenomena. Moreover, the growth of leaders, the mutual development within a group and the consequent development of an organisation in the context of health professions education HPE require framing. This is especially true when leaders are faced with an array of constraints in low- and middle-income countries. In order to appreciate leader development, we need to ask "what qualities do we need to develop in our leaders?" and for leadership development "what qualities do we need to develop in our organisation?". Thus, within the context of the current study we essentially ask: "What qualities have developed in our leaders, organisation and the consortium?" The current study sought to understand leadership development of appointed and emergent leaders in new medical schools in Africa.

A mixed-methods approach was employed and the data collection instruments included: a Likert scale survey, a multiple case study approach and a qualitative document analysis (QDA). A total of 29 surveys (64.5% response rate) were returned and 10 successful interviews were conducted after ethical approval and obtaining consent. Many of the participants fulfilled multiple roles as lecturer (linked to the basic medical sciences), departmental head and/or a clinical teaching position in the hospital. Their academic positions and seniority as leaders included deans, a deputy dean, a programme director, heads of departments (HODs), medical educationalists and lecturers. Any additional biographical information was excluded in the study in order to ensure anonymity of the participants. Finally, the QDA relied on a four-step Scott method and considered a total of 58 documents that ranged from meeting agendas and reports, scholarly works, book chapters, newsletters, external reports, conference proceedings, and the CONSAMS (Consortium of New Sub-Sahara African Medical Schools) constitution.

Findings from the current study led to the development of a framework to navigate the complex nature of leadership development in new medical schools in Africa. The three-tier framework views leadership development of the individual, the institution and within the context of

collaboration such as a consortium. Leadership development at an individual level is dependent on the interplay between an institutional climate, contextual forces and resultant responses of leaders. Five archetypes of leadership development were identified at an individual level: the *leader in front*, the *strategist*, the *silenced leader*, *becoming a leader* and the *leader as manager*. The archetypes are the result of biographical, programmatic, institutional and contextual forces. The leader subsequently interprets these forces in order to negotiate their roles, position and course of action. Leadership development at an institutional level occurs within a hierarchical system and can sometimes occur in isolation. Development is often hampered by day-to-day activities that are reactive in nature in a bid to negotiate the various forces. The formation of teams and coalitions are hampered by climate factors such as ineffective engagement of colleagues, poor bilateral communication, perceived misalignment of the values and unsuccessful collaboration. The formation of networks and alliances, as in the case of CONSAMS, drives the leadership development at a collaborative level. Within this context, leadership development is largely dependent on effective communication and feedback. Within a consortium, each participant contributes from the position of their dominant archetype, but are also temporarily freed from institutional constraints to think more strategically. The consortium generates a unique climate where the heterogeneity of leaders through their archetypes can be challenged, tested and strengthened. Interaction within the consortium permits freedom, more so than within the domain of an institution.

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LIST OF ACRONYMS AND ABBREVIATIONS

AFREhealth	African Forum for Research and Education in Health
CBUSOM	Copperbelt University School of Medicine
CCHL	Canadian College of Health Leaders
COBES	Community Based Education and Service
CONSAMS	Consortium of New Sub-Sahara African Medical Schools (formerly known as Consortium of New Southern African Medical Schools)
COVID-19	Coronavirus Disease 2019
DME	Department of Medical Education
F	Female
GHETS	Global Health through Education, Training and Service
HOD	Head of Departments
HPE	Health Professions Education
HRH	Human Resources for Health
ICF	International Classification of Functioning
ICI	Institutional Cooperation Instrument
GHETS	Global Health through Education, Training and Service
HIV	Human Immunodeficiency Virus
LD	Leadership Development
LMICs	Low- and Middle-Income Countries
M	Male
MEPI	Medical Education Partnership Initiative
min	Minutes
MoHSS	Ministry of Health and Social Services
MEC	Medical Education Committee
MU	Mulungushi University
No	Number
QDA	Qualitative Document Analysis

QW	Quenton Wessels
qty	Quantity
PAR	Participatory Action Research
PBL	Problem-based learning
PD	Programme Director
SA	South Africa
SAMSS	Sub-Saharan African Medical School Study
SoM	School of Medicine
SR	Steve Reid
SSA	Sub-Saharan Africa
TA	Thematic Analysis
UB	University of Botswana
UBSOM	University of Botswana School of Medicine
UK	United Kingdom
UL	Universidade Lúrio (Lúrio University)
UM	University of Malawi
UN	University of Namibia
UT	University of Turku
UNAM	University of Namibia
USA	United States of America
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND

Local and global health organisations are increasingly recognising the pivotal role that competent healthcare providers play in order to ensure health equity and equality in sub-Saharan Africa (SSA) (Chen *et al.*, 2014). Health professions educators similarly have an important role to obtain these outcomes (Greysen *et al.*, 2011). The critical need for more doctors in Africa is driving efforts to establish new medical schools and increase the enrolment of students (Mullan *et al.*, 2011). Shortages in academic staff as well as inadequacies in the existing physical infrastructure have been identified as the major barriers in SSA medical schools (Mullan *et al.*, 2011; Chen *et al.*, 2014). The enrolment of more students taxes the existing resources of many medical schools in SSA (Chen *et al.*, 2014). The effect of this on the leadership strategies within these institutions remains unknown. The transient and multifaceted nature of leadership in health professions education (HPE), which has changed over time, justifies further investigation (Davies *et al.*, 2001; Dinh *et al*, 2014; Lieff and Yammarino, 2017).

Lieff and Albert (2010), in their study on the mind-sets of medical education leaders, state that future research would benefit from discussions and direct observations of the activities of leaders (Lieff and Albert, 2010). Medical education has advanced over time and the same holds true for its environment. Many clinicians serving in academia also hold leadership positions within a clinical setting. These roles are typically transitional in nature and are appointed on a rotation basis (Bordage *et al.*, 2000; Davies *et al.*, 2001; Black, 2015). Academic staff, in general, fulfils the roles of an educator, scholar, teacher, researcher and organisational citizen (Astin and Astin, 2000). Each of these aspects requires a form of leadership and this ultimately determines the success or failures of an organisation (March and Weil, 2005). Yet, the complexity of leadership roles is underappreciated; more so when setting up a new medical school. The paucity of literature on leadership in medical schools necessitates further investigation (McKimm and Lieff, 2013; Lieff and Yammarino, 2017). Moreover, the growth of leaders, the mutual development within a group and the consequent development of an organisation in the context of health professions education HPE require framing. This is especially true when leaders are faced with an array of constraints in low- and middle-income countries (LMICs).

1.2 PROBLEM STATEMENT AND RATIONALE

The much-needed scaling up of HPE can be achieved through the efforts of knowledgeable and committed leaders (WHO, 2017). Little empirical data exists on the leadership practices and leadership development within the realm of HPE (Lieff and Albert, 2012), more so when considering the challenges faced by medical schools in SSA. There is an existing need to strengthen the leadership and governance capacity within medical schools in Africa. The challenges faced by these institutions appear to be over simplified and require a deeper understanding and conceptualisation of the roles of and interplay between educators, their institutions, local governments, professional bodies, students and the communities they serve. These interactions play a major role in the leadership development of educators and senior managers within new medical schools in Africa. There is also a need to frame the dynamic and evolving roles of deans, academic chairs, programme directors, and educators as leaders within an African context. Bleakley *et al.* (2011) stated that:

> "…medical educational strategies cannot be cooked up in [Western] Universities and then exported. They must be context specific and fit the purpose, formulated in the heat of practice" (Bleakley *et al.*, 2011).

The same holds true for leadership practices. The data from this study and the resulting insights will help to conceptualise the leadership roles that accompany the establishment of medical schools in low- and middle-income countries. This understanding in turn has the potential to facilitate the much-needed scaling up of HPE and human resources for health (HRH). In addition, academics often have mixed feelings regarding leadership roles and are recruited for their research and programme development abilities. They are typically not employed based on their leadership potential (Hill, 2005).

1.3 PURPOSE AND OBJECTIVES

The ultimate purpose of the study is to enhance or facilitate pedagogical leadership and governance capacity within the Consortium of New Sub-Sahara African Medical Schools (CONSAMS). The consortium, CONSAMS, was founded in 2011 with the aim to promote the establishment and sustainable growth of new medical schools in Southern Africa. To date, the members of the consortium include: University of Namibia School of Medicine (Namibia), Copperbelt University School of Medicine (Zambia), Mulungushi University School of Medicine (Zambia), Lúrio University School of Medicine (Mozambique), University of Botswana School of Medicine (Botswana), and Masinde Muliro University of Science and Technology School of Medicine (Kenya). Six international partners have been working alongside the above-mentioned institutions and include: University of Turku (Finland),

Vanderbilt University (USA), McMaster University (Canada), Georgetown University (USA), the Global Education in Medicine Services, and the African Forum for Research and Education in Health (AFREhealth).

The aim is to conceptualise the role and development of leaders and leadership capacity while pursuing joint and individual projects by each medical school within CONSAMS. Joint projects in this study refer to CONSAMS, whilst individual projects relate to the efforts of individual medical schools. CONSAMS, through representation of each of their respective medical schools, has launched various initiatives to steer medical education and capacity development activities. CONSAMS is representative of collaborative and participatory efforts towards the capacitation of health systems (Eichbaum *et al.*, 2015a). Furthermore, it has the potential to serve as a model for the evaluation of the collective growth and development of leaders. The researcher will examine pedagogical leadership of the consortium's activities as well as the pedagogical leadership within new medical schools in SSA. In so doing, the researcher will determine whether there are any emerging themes relating to pedagogical leadership.

The objectives of this study are as follows:

1. To describe pedagogical leadership (leadership in the support of teaching and learning) at each medical school to date.
2. To jointly plan the next steps of collaboration within CONSAMS through participatory action research.
3. To monitor and document the process of implementation of the plan.
4. To reflect upon and build a collective understanding of pedagogical leadership development within CONSAMS.

1.4 RESEARCH QUESTIONS

The following research questions were identified when considering the objectives of the project:

1. What are the pedagogical leadership roles and/or experiences (collective and individual) within each institution in the consortium (CONSAMS)?
2. How do appointed and emergent leaders conceptualise and address anticipated challenges?
3. How is the nature of leadership development (collective and individual) experienced in response to these challenges?
4. How is leadership development perceived and conceptualised, collectively, within CONSAMS?

1.5 CONCEPTUAL AND THEORETICAL FRAMEWORKS

How do leaders in new medical schools in Africa develop their leadership skills amid numerous challenges and transient roles? To answer this overarching question, I will make use of the Force Field Model of Teacher Development (Samuel, 2008). This conceptual framework was proposed by Samuel in 2008 to describe the factors or forces, i.e. push and pull, that impacted the professional development of novice school teachers and their identity in South Africa (Samuel, 2008). Samuel proposed that professional identity formation rested upon the interaction of four major forces. Samuel's forces at play will be viewed in conjunction with the framework of Lieff and Albert (2012). Lieff and Albert developed a four-domain framework that not only relates to the practices of appointed leaders but also captures their learning. These four domains along with Samuel's forces will be considered as outlined below and depicted in Fig. 1.1 (Samuel, 2008; Lieff and Albert, 2012):

- Biographical: These are individual or personal factors corresponding to the leader attributes of Lieff and Albert (2012). According to Samuel (2008), these factors include the cultural, racial, ethnic and religious background of the individual.
- Programmatic: The interpersonal domain, according to Lieff and Albert (2012), reflects the interaction of leaders with groups and individuals. According to Samuel (2008), this relates to the aspects of the curriculum (non-formal, hidden and formal) and the direction of the pedagogy based on the everyday practices of educators.
- Institutional: The homologous domain based on the work of Lieff and Albert (2012) is organisational. The authors state that the leadership practices of educational leaders are aimed at creating a shared vision, implementing strategies and bringing about organisational change. Samuel (2008) states that these forces include the values, expectations and goals of the institution and a functional group.
- Contextual: This corresponds to the systemic domain of Lieff and Albert (2012), and according to Samuel (2008) is the macro-environment and includes aspects of educational policies, theories and practices. Lieff and Albert state that the leadership practices within this domain are aimed at strategic navigation and the establishment of networks. Furthermore, this relates to the interactions of a leader with the outside world.

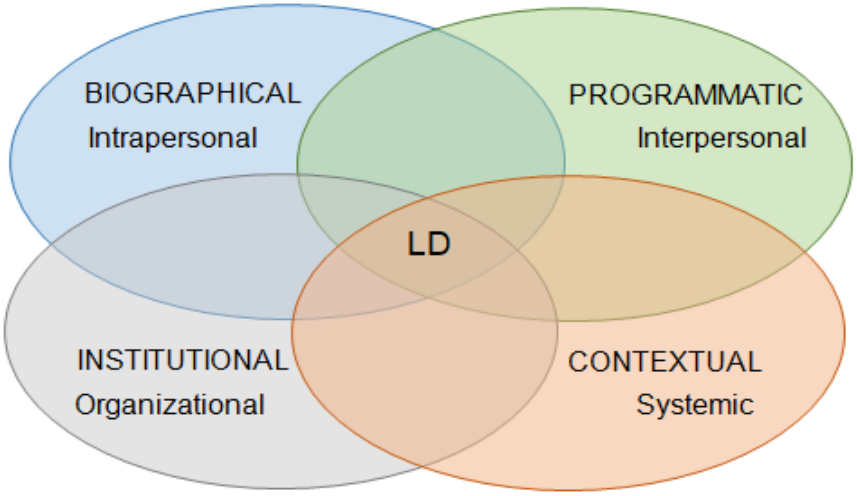

Fig. 1.1. The conceptual framework. The Force Field Model of Teacher Development proposed by Samuel (2008) will be employed as a conceptual framework to study the leadership development (LD) of leaders within new medical schools. In parallel, the four-domain theoretical framework of leadership practices is superimposed on Samuel's model (Samuel, 2008; Lieff and Albert, 2012).

The premise within the current study is that any occurrence or event is the result of numerous factors (Lewin, 1943). Similarly, leadership and its development are influenced by a multitude of factors or forces. The forces proposed by Samuel (2008) appear to complement the four-domain framework presented by Lieff and Albert (2012) (Fig. 1.1).

How then do leaders in new medical schools in Africa develop or grow their leadership skills? I will draw upon Samuel's Force Field Model of Teacher Development as well as the work of Male and Palaiologou (2015) to consider the drivers, retainers and equilibrium effects of the factors driving leadership development within CONSAMS. An excerpt from the work of Olapade-Olaopa *et al.* (2017) serves as an example of the possible forces that are at play within new medical schools in SSA:

> "…it must be remembered that efforts at restructuring Africa's health-workforce can only succeed if there are concomitant efforts at improving the socio-economic, educational, and technological infrastructure of the individual countries as these are the pillars on which health systems are built" (Olapade-Olaopa *et al.*, 2017).

Leadership, according to Male and Palaiologou (2015), should rather conceptualise the relationship between pedagogy and the endogenous and exogenous social axes. The internal social axis represents endogenous factors such as culture, religion, customs, values, beliefs, and the local economy related to the learners, educators, families and the community at large. The external axis relates to exogenous elements that influence the community where pedagogy takes place. The external factors include climate, global economy, information and communication technologies, and social networking (Male and Palaiologou, 2015).

Three frameworks are at play. The first draws heavily on the work of Samuel (2008) and focuses on the complex factors – biographical, contextual, institutional and programmatic – which influenced teachers' identities. Samuel argues that teachers' professional growth could flourish amidst an understanding of these four forces. Samuel contends that these four forces could align themselves within the discursive space. Similarly, the investigator argues that the theoretical lens of Samuel's Force Field Model could provide an understanding of the alignment of these forces and their influences on leadership development. For instance, Samuel (2008) states that teachers are not homogenous (implying teachers have various levels of expectations and expertise) and therefore they require different kinds of interventions in order to restart or involve their professional practice. Similarly, health professions educators possess varying levels of experience and expectations.

The Force Field Model of Teacher Development therefore has the potential to interpret the pedagogical context, and related leadership activities, as a "potentially vibrant space that can be activated by a variety of charges" (Samuel, 2008). An understanding of the dynamic context of pedagogy has the potential to shape their leadership in turn. By viewing the aspects of pedagogical leadership within CONSAMS through Samuel's lens, it is believed that new insights can be gained in a similar fashion. The second conceptual framework, by Male and Palaiologou (2015), is in line with the work of Samuel (2008) in that it captures external and internal axes that are at play. Male and Palaiologou found that pedagogy and the concerns of pedagogical leaders were dependent on the interactions between pupils, teachers, ecology and the community along these axes (Male and Palaiologou, 2015). The internal axis, according to the authors, aligns with the social-cultural, beliefs, customs, values and local economy of that influence pedagogy. The external axes, in turn, relate to the national curriculum, global economy and societal values. The two axes are not depicted in Figure 1.1., but they span across the four domains and the forces that are at play. In addition, the attributes of Lieff and Albert (2012) (the third lens of the proposed study) refer to the individual or personal factors of pedagogical leaders and can be viewed in light of Male and Palaiologou's (2015) element of the "teacher". The premise, according to Male and Palaiologou, is that "if an educational organisation exists then leaders within must subscribe to pedagogy and, therefore, are pedagogical leaders" (Male and Palaiologou, 2015).

Leadership is complex and dependent on the interactions of leaders within their respective organisational and socio-cultural environments (Porter and McLaughlin, 2006). The theoretical and conceptual frameworks described above will be employed to determine the social realities and constraints of leadership development within new medical schools in SSA. Leader and leadership development are co-dependent and should be incorporated into a new leadership strategy with an organisation (Dalakoura, 2010). This study hopes to shed light on the nature and possible intricacies of leadership within each institution's social reality.

1.6 SIGNIFICANCE OF THE STUDY

Existing leadership theories, whether focusing on trait theory or practice, might not fully capture the true nature of leadership practices in the here and now (Smith, 2001). Trait theory within the context of leadership refers to the feelings, thoughts and behaviours of leaders. Lieff and Albert (2010) aptly recommend that further research would profit from the direct observation of and dialogue with medical education leaders (Lieff and Albert, 2010). It is believed that this study will elucidate the growth and development of leadership in new medical schools in Africa. In so doing, the findings might shed light on the nature and possible intricacies of leadership within each institution's social reality and the collective efforts to upscale the existing shortage of HRH.

The resulting insights will help conceptualise the leadership roles that accompany the establishment of medical schools in low- and middle-income countries. The study also has the potential to further direct and influence leadership efforts within Africa. In so doing, the findings have the potential to plan the next steps of collaboration within CONSAMS. Ultimately, the study has the potential to facilitate pedagogical leadership and governance capacity within new medical schools on the continent. The findings could be of particular interest to various stakeholders, particularly funders, and might also guide the development of context-driven leadership development programmes.

Finally, the results and recommendations will be disseminated via international peer-reviewed scientific journals and conferences. It is also believed that the interviews will promote reflective practice of the participants on their respective leadership roles and development as leaders.

1.7 SUMMARY

The critical need for more doctors in Africa drives the establishment of new medical schools. The successes and failures of leaders rely heavily on the efforts of those in leadership positions. This study aims to understand the roles of leaders within the milieu of medical education. Leaders of new and developing medical schools face numerous challenges within their individual and social realities. It is believed that these challenges drive the growth of leaders. By framing the interplay between the forces at work and their effects on leaders and leadership, the study has the potential to streamline individual and collective efforts.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The health and well-being of individuals and populations within any country is dependent on the efficacy of its health system. Such an effective system requires unison between six building blocks (as proposed by the World Health Organisation), namely: governance, human resources for health (HRH), the provision of funds, service delivery, information systems, and medicine and pharmaceutical technology (WHO, 2010). HRH is by far the most important of the building blocks as it forms a golden thread that binds all the others together. The human resources element includes both the clinical complement of medical and paramedical professionals, as well as administrative and support staff (WHO, 2010).

The global shortage of HRH, according to the third Global Forum on Human Resources for Health, will reach an estimate of 12.9 million by 2035. The shortfall stood at 7.2 million healthcare workers in 2013 (WHO, 2013a and 2013b). Data have shown that the shortage in developed countries, such as the United States of America (USA) and the United Kingdom (UK), can be ascribed to an increase in chronic diseases, so-called brain drain, and the tendency of healthcare workers to accumulate in urban areas (Bhatt *et al.*, 2008). However, the greatest HRH burden is associated with low-income countries, particularly in Asia and sub-Saharan Africa (SSA) (Miseda *et al.*, 2017). The Malaysian government, for instance, forecasted in 2008 that the country would have a deficit of 3,306 doctors by 2020 (Barling *et al.*, 2008). In 2006, the World Health Organisation (WHO) reported that Africa represented 40% of the global deficit (WHO, 2006). The majority of countries in dire need of more HRH were in SSA. The region, in 2006, had a 24% disease burden and 11% of the world's population at the time (WHO, 2006). To make matters worse, the emergence of chronic, non-communicable diseases is on the increase in the region (Chen *et al.*, 2004; WHO, 2008). Since the WHO's report in 2006, there is still a lack of up-to-date data on the state of HRH in Africa (Willcox *et al.*, 2015).

Adequate numbers of healthcare professionals are essential for any effective healthcare system to work (Mokone *et al.*, 2014). It is for this reason that various governments initiated a drive to establish new medical schools to address the ever-growing shortfall in HRH. England announced, in 2018, that five new medical schools would be established in order to increase the number of "home grown" doctors (Rimmer, 2018). Similarly, many African countries are establishing new medical schools whilst others are urged to train more healthcare professionals and improve the training of community health workers.

The regional office of the WHO states that there are only 168 medical schools in Africa. Twenty-four countries, including Botswana and Namibia, only have one medical school, and an estimate of 11 countries have no medical school at all (WHO, 2017).

Health professions education plays a key role in addressing the existing shortages of qualified doctors in Africa, especially in light of the global disparities in doctor-to-patient ratios (Gukas, 2007; Greysen *et al.*, 2011). Estimates from the WHO in 2006 highlight the shortage in health professionals, and data indicate that Egypt and Sudan have 54 and 22 physicians per 100,000 individuals, respectively. The ratio for Tanzania and Ethiopia, however, epitomises the existing disparity with 2 and 3 physicians per 100,000 people, respectively. The WHO's yardstick in their report was the UK that boasted around 230 physicians per 100,000 individuals (World Health Statistics, 2010). A total of 137 medical schools served 900 million individuals on the African continent by 2006 (Boulet *et al.*, 2007). Countries such as Namibia and Botswana did not have their own medical schools at the time of the report and both countries established their first medical schools in 2009 (Wessels *et al.*, 2012; Mokone *et al.*, 2014). The current public health burden as well as the projected life expectancy of the elderly are some of the major stressors to the existing public health systems in Namibia. Data from the WHO state that Namibia has one doctor for every 2,952 of the country's citizens (World Health Statistics, 2010). More recent figures suggest this ratio to be as low as 1:7,500. This is considerably lower compared to that of South Africa (2:3,000) which faces dire shortages in health professionals as well. Furthermore, the low representation of care providers in Namibia extends beyond that of medical doctors. Additional ratios include 1: 10,039 for pharmacists, 1: 13,519 for social workers and 1:704 for registered nurses. Namibia has around 248 clinics, 37 health centres and 37 hospitals within the public sector. The quality of care among these facilities varies tremendously as a result of the allocation of resources, the performance and competence of care providers, and the specific needs within the communities. The projected increase in urbanisation within developing countries, in particular Namibia, will further adversely affect the public health sector. As an example, Namibia purportedly saw an increase in urban settlement from 28% in 1991 to 43% in 2011 (Ministry of Health and Social Services, 2014).

The establishment of new medical schools in Africa holds the key, in part, to addressing the ever-growing shortage of HRH. The following sections in this chapter will consider the challenges and opportunities of new medical schools in Africa. The chapter will also explore the perceived roles of leaders in medical schools and within the domain of medical education.

2.2 THE CHALLENGES WITHIN NEW MEDICAL SCHOOLS IN AFRICA

Various African countries are prioritising the advancement of medical education in a bid to strengthen their respective health sectors and address the growing deficit in HRH (Mullan, 2011). The past two decades saw the establishment of 58 new medical schools on the African continent. Furthermore, this growth in the number of training institutions coincided with an overall increase in student enrolments (Chen *et al.*, 2014). Ethiopia alone saw the addition of 20 new medical schools since 2004 (Girma *et al.*, 2016). Estimates point towards a total of 100 new medical schools that will be established in Africa within the next decade. These projected new medical schools, like those currently within SSA, face intimidating challenges. Yet, they are also presented with some exceptional opportunities (Eichbaum *et al.*, 2015a). Four categories of challenges have been identified for institutions that hope to establish new medical schools (Whitcomb, 2009). The first is to sell the idea to the various stakeholders (including but not limited to government officials), existing university, university faculty, university trustees, and community leaders. Secondly, the necessary funding needs to be secured in order to finance the initial planning process. Funding is also required to prepare for the actions pertaining to the establishment and implementation of the school's education programme and to recruit administrative staff for the faculty. Thirdly, the institution must develop a project plan for the development of the administrative and instructional spaces (both formal and informal). Finally, the institution is required to secure clinical attachment arrangements with various healthcare organisations in order to provide appropriate patient-centred education (Whitcomb, 2009).

An extensive and fairly recent publication by Mullan and colleagues (2011) addresses the existing challenges of medical schools in SSA (Mullan *et al.*, 2011). The authors surveyed a total of 105 medical schools within the region and found that these institutions, like the rest of Africa, are prioritising medical education in order to strengthen the health systems within their respective countries. Accreditation of their educational programmes as well as the certification of their graduates has become a major priority. Their pivotal health policy publication, the culmination of the Sub-Saharan African Medical School Study (SAMSS), also identified various challenges (Mullan *et al.*, 2011). The authors found that doctor migration (so-called "brain drain") is in part ascribed to the current state of the health systems in many countries. This comes amidst existing staff shortages, curricular issues and resource constraints. An additional challenge is the variability in secondary school quality which creates challenges in medical school admissions. The authors also found that coordination among the various stakeholders, such as ministries of education and ministries of health, will improve medical schools' ability to increase health workforce capacity (Mullan *et al.*, 2011).

The findings of Mullan *et al.* (2011) correspond with the earlier work of Burdick in 2007. Burdick similarly investigated the challenges and issues in health professions education (HPE) in Africa. Burdick identified several key obstacles including physical infrastructure constraints (particularly a consistent electricity supply), student selection criteria in order to address underserved areas, access to information resources, faculty recruitment and retention due to poor salaries and substandard working conditions, and the need for faculty development (Burdick, 2007). Perspectives from the University of Botswana, School of Medicine, paint a similar picture. The work of Mokone *et al.* in 2014 highlights a 30-40% shortfall in the school's academic staffing goal. The authors also noted that foreign academic staff members have the highest attrition rate and outnumber the local staff by 4:1 (Mokone *et al.*, 2014). Additional recruitment and retention challenges arise from the University of Botswana, School of Medicine's organisational culture and the school's subsequent lack of autonomy (Mokone *et al.*, 2014; Wynford-Thomas *et al.*, 2012). This in turn delays recruitment efforts as a result of rigid bureaucratic processes (Mokone *et al.*, 2014). The organisational culture for medical schools in Africa adds an additional facet and Chen *et al.* in 2014 briefly alludes to this. Chen and colleagues, in their detailed follow-up publication to the 2011 SAMSS of Mullan *et al.*, surveyed a total of 146 medical schools in Africa of which 105 schools responded. Their study aimed to assess the baseline dimensions of HPE in Africa, highlight critical barriers in HPE, and recognise innovative strategies to overcome these barriers (Chen *et al.*, 2014). Their study found that 102 of the schools surveyed have existing relationships with external organisations – such as ministries of health, ministries of education, professional councils, international partnerships, community organisations – and alumni. The interactions between the schools and these organisations and alumni varied from minor to significant in terms of establishing the health strategies and policies of their respective countries (Chen *et al.*, 2014). The primary barriers that were identified through the study once again related to resource constraints. The quality and quantity of student and teaching resources, poor remuneration of academic staff and clinical teaching centres were found to be of an adequate or below average standard (Chen *et al.*, 2014). As mentioned before, the development of new training institutions during the past 20 years coincides with an overall increase in student enrolments (Chen *et al.*, 2014). Sadly, evidence points towards a disproportionate growth and many medical schools are not recruiting basic sciences and clinical faculty at the same rate that they are admitting students (Chen *et al.*, 2014; Mkony *et al.*, 2016).

The day-to-day operational demands of young medical schools in SSA are further complicated by the need to transform and scale up medical education as well as HRH (WHO, 2013a and 2013b). The need to change and adapt health professions curricula, in order to meet the needs of the population they wish to serve, has been emphasised by the WHO. This includes the commitment of senior managers and academic leaders, and the mobilisation of resources such as staff time and adequate funding (WHO,

2013a). The recommendations set forth by the WHO include the development of a faculty, curricula, and simulation methods, as well as the direct entry of graduates into programmes, streamlined admission policies, and streamlined educational pathways and ladder programmes. The recommendations continue further to emphasise the need for continuing professional development (CPD) of health professionals and the accreditation of educational programmes by national governments (WHO, 2013a). These guidelines were aimed at providing sound implementation considerations and thus safeguard the provision of equitable health care (WHO, 2013a).

Data thus suggest that resource constraints are the primary limiting factor for most medical schools within Africa (Burdick, 2007; Mullan *et al.*, 2011; Chen *et al.*, 2014; Mokone *et al.*, 2014; Mkony *et al.*, 2016). The strategies employed to overcome the barriers mentioned in the preceding sections include the construction of additional facilities, pursuing donor support, curriculum development, employment of technology, faculty development, and developing institutional relations (Mullan *et al.*, 2011; Chen *et al.*, 2014). One possible solution to address the development of institutional relations and efficiently achieve health care strengthening was proposed by Frenk *et al.* in 2010. The authors recommended collaboration through "networks, alliances, and consortia" in order to strengthen and capacitate health systems by working together (Frenk *et al.*, 2010).

Consortia such as CONSAMS have strengthened their ability to face challenges and succeeded at educational innovation. The following section will highlight some of the challenges and opportunities within CONSAMS (Eichbaum *et al.*, 2014a, 2014b; Eichbaum *et al.*, 2015a). CONSAMS has celebrated many successes through the past few years. The dominant achievement is capacity building among faculty and health workers through various training programmes. The University of Oulu in Finland, initially involved and later replaced by the University of Turku, has facilitated many of these interprofessional and transprofessional training programmes, especially at the University of Namibia, School of Medicine (UNAM SoM) and Lúrio University Medical School. In addition, faculty exchange programmes and working in teams within local communities have proved to be effective (Eichbaum *et al.*, 2014a and 2014b: Eichbaum *et al.*, 2015a). Frenk *et al.* (2010) aptly pointed out that new medical schools have the ability to be more flexible and can adapt to current educational trends as opposed to their established counterparts (Frenk *et al.*, 2010). The challenges and associated opportunities documented from CONSAMS include the following (Eichbaum *et al.*, 2014a and 2014b; Eichbaum *et al.*, 2015a):

- The establishment of appropriate undergraduate medical curricula.
- The establishment of postgraduate medical training programmes.
- Ensuring contextualised accreditation standards for both undergraduate and postgraduate programmes.

- The establishment of equitable admissions policies.
- The development of transformative medical education programmes that enhance health worker retention.
- The development of robust, appropriate and sustainable research programmes.

The majority of the above-mentioned challenges not only correlate with the findings of the SAMSS report and publications but also relate to the fundamental principles of HPE amidst financial pressures and a progressively turbulent healthcare environment (Mullan *et al.*, 2011; Chen *et al.*, 2014). The review presented here highlights the existing challenges within HPE in Africa, particularly SSA. The successful implementation of policies and capacity development appear to be some of the major drivers of change within these medical schools (Mullan, 2011; Chen *et al.*, 2014; Eichbaum *et al.*, 2015a). Curricular challenges, according to Chen *et al.* (2014), relate to the quality of graduates amid the pressure of yielding more graduates (Chen *et al.*, 2014). This pressure is typically addressed through the planning of additional physical resources such as skills laboratories, student residences, computer centres, and research laboratories. In fact, the report by Chen and colleagues (2014) noted more than half of their respondents planned such physical infrastructure expansions in their respective institutions. Such expansions led to further financial constraints and taxed existing medical schools in SSA (Chen *et al.*, 2014). It appears as if a rigid dichotomy exists between medical schools and their major stakeholders, i.e. their ministries and professional councils. This in turn has a detrimental effect on the leadership and management approaches within these institutions. The following section will explore the nature of leadership within medical schools.

2.3 MEDICAL EDUCATION LEADERSHIP

> "Teaching faculty education and assessment methods, as well as management and leadership skills is another challenge for health professions institutions" (Burdick, 2007).

Many countries face deficits or an imbalance in their respective health workforce (Frenk, *et al.*, 2010). HPE is an essential resource to their individual health systems. HPE also needs to adjust to the growing competencies of healthcare professionals (Celletti, *et al.*, 2011). This, according to the WHO, can be achieved by the efforts of knowledgeable and committed leaders (WHO, 2013a). The WHO's road map for scaling-up HRH identified poor leadership, leadership governance and uncoordinated partnerships as some of the major threats to health systems in Africa. In addition, the report states that additional

factors such as inadequacies in the deployment, performance and retention of human resources remains problematic (WHO, 2013b).

In terms of HPE, only one of the publications cited thus far, i.e. Burdick (2007), alludes to the need for the development of leadership and management skills specifically within African medical schools (Burdick, 2007). It appears that the challenges at a national level are similar to those at an educational level. Faculty members are required to take up leadership roles that relate to education design, reform and development (Mcleod *et al.*, 2003). These responsibilities require various activities, such as the engagement of human resources in order to set an educational course; staff recruitment, support and development; the design and management of the required infrastructure; the discussion and arrangement of resources; and the fostering of a positive learning culture (Lieff and Albert, 2010). A recent publication by Girma *et al.* (2016) refers to a lack of poorly defined responsibilities amongst stakeholders, poor strategic planning by stakeholders, and poor administrative and leadership support as the hurdles associated with the establishment of new medical schools (Girma *et al.*, 2016). These findings might be more insightful when viewed within the context of leadership versus management practices. Long (2011), like others, delineates the different characteristics between management and leadership (Bennis and Nanus, 1985; Northouse, 2004; Long, 2011). The approaches of both management and leadership are different in style, response to objectives, and the outcomes obtained.

Management activities aspire to provide stability rather than change, are reactive rather than proactive, focus on objectives rather than a vision, and are driven by financial desires and results rather than excellence (Long, 2011). Critical reflection on the work of Mullan (2011), Chen *et al.* (2014), and others points towards proposed solutions that are steered by management approaches. These include securing financial support, setting objectives, managing workload of academic staff, and creating reactive responses; all aimed at achieving stability within the respective institutions (Burdick, 2007; Mullan *et al.*, 2011; Chen *et al.*, 2014; Mokone *et al.*, 2014; Mkony *et al.*, 2016). The following question, however, remains when considering the true nature of leadership (Long, 2011): What are the long-term, proactive, change-facilitating, vision-driven solutions required to scale-up HSE and HRH? In other words, what does it really mean to lead a medical school?

The etymological root of "leadership" is derived from the old English term *Lithan*, which translates to "travel", and *Leid* (old Norse) which translates to "find a way at sea". Leadership, within this context, thus aims to direct or to set a specific and desired course. Yet, embedded within this very simplified view of leadership are four empirical facets or approaches. Grint in 2010 captured these four approaches of leadership as: a position ("where" leaders operate), a person ("who" leaders are), a result ("what" leaders achieve) and a process ("how" leaders operate) (Grint, 2010). The heuretic approach of Grint

(2010) captures the enormous amount of literature on leadership and leadership theories within the public and private sector, most of which focus on the biographical attributes of leaders. A more contemporary approach, where leaders are required to manage and *vice versa*, will be followed rather than differentiating between leadership and management (McKimm and Lieff, 2013). A further motivation results from the nature of leadership in education. Programme directors associated with medicine, pharmacy, nursing, allied health and those involved in a clinical setting typically serve as managers and leaders concurrently (Bordage *et al.*, 2000). Furthermore, managers in modern organisations are expected to fulfil leadership roles (McCauley, 2008).

The sections that follow will address what leadership involves in the context of medical education, the domains of leadership practices and how leaders develop or grow. Leadership development in these sections will encompass the development of those in managerial positions as well. The author will not make a pointed distinction between managerial development and leadership development (McCauley, 2008). Leadership development literature typically encompasses the development of individuals within managerial roles (McCauley, 2008). Thus, an approach will be followed where pedagogical management is subsumed under leadership. Leadership development will be viewed within the context of Grint's four-way approach to leadership as well as the work of others, particularly that of Lieff and colleagues (Grint, 2010; Grint *et al.*, 2016; Lieff and Albert, 2010 and 2012; McKimm and Lieff, 2013).

2.3.1 The Who and Where of Medical Education Leadership

> "Organizational leaders must have a sense of vision and mission, and change with an eye toward the future […] to bridge the current and future state, taking the organization forward to grasp opportunities" (Lehmann, 1997).

Leadership as a person ("who" leaders are), according to Grint (2010), reverberates with the leader's character or personality (Grint, 2010 and 2016). The work of Bordage *et al.* (2000) found that the desirable traits and competencies of prospective programme directors in education include: flexibility, value-driven, open-mindedness and trustworthiness (Bordage *et al.*, 2000). These findings were corroborated by McKimm in 2004, and the author found additional complementary traits such as: self-awareness, self-management and time management, contextual awareness (including the ability to describe the roles of others), and having strategic and analytical skills (McKimm, 2004). Many of these traits embody an emotional intelligence approach to leadership (Goleman, 2000). Academic leadership roles of deans or heads of a school or department tend to be transitional in nature and Bordage *et al.* (2000) stated that programme directors "wear many hats" and fulfil multiple roles (Bordage *et al.*, 2000).

Such roles rely on a rotation basis and are sometimes awarded *primus inter pares* [1] (Davies *et al.*, 2001; Black, 2015). Academic personnel in general fulfil the roles of scholar, teacher, organisational citizen and researcher (Astin and Astin, 2000).

The central role that leaders, through their individual leadership capacity, play in any organisation's success or failure is widely accepted (March and Weil, 2005). The general supposition is that if an educational organisation exists then the leaders should subscribe to pedagogy, and these leaders are subsequently pedagogical leaders (Sergiovanni, 1996). Yet, academics are known to be hesitant to take up leadership roles (Hill, 2005). The leadership roles of academic personnel in higher education often do not form part of their professional identity which is typically field-based or discipline-based. This discipline-based expertise is usually accompanied by an extensive understanding of the current trends and advances in pedagogy and research (Ruben *et al.*, 2018). The same level of understanding is sometimes lacking when considering an in-depth appreciation of their respective institution and higher education on a national level (Ruben *et al.*, 2018). It is for these reasons that leadership and leadership development in higher education tends to be more complicated compared to the corporate or business world (Hill, 2005). The social processes of leadership and management are immersed in uncertainty and choice (Gallos, 2009). Howe (1996) argues that there is an interdisciplinary imperative at the heart of effective leadership and that the solutions to a complex problem are always interdisciplinary in nature (Howe, 1996). The importance of establishing an identity as a leader within a healthcare setting has gained much needed attention during the past few years (Morahan *et al.*, 1998; Arroliga *et al.*, 2014).

Lieff and Albert (2012) suggested four emerging themes in medical education leadership. Their work aimed to determine what medical education leaders really do. Medical education leaders, according to the authors, occupy formal authoritative positions as leaders and managers of educational programmes. A total of 16 leaders were interviewed in order to determine the nature of their work. Four major themes emerged, namely, intrapersonal, interpersonal, organisational and systemic (Lieff and Albert, 2012). The first theme, i.e. intrapersonal, further addresses *who* leaders are. This domain relates to the qualities of the leader and the quality of *knowing self* (thus strengths and weaknesses) and thus relates to the biographical information of the individual. The authors found that the medical education leaders (10 men and 6 women) possessed self-awareness of their strengths and weaknesses, their values and their inherent drive. The leaders also identified the following as important traits: credibility, being an effective communicator, role modelling and the ability to care (Lieff and Albert, 2012).

[1] *Primus inter pares* is a Latin phrase that means "first among equals" and within this context the role of leadership is the result of their seniority in office.

Yet, literature focussing on leadership in medical schools is still in its infancy with insufficient data on academic health science centres (McKimm and Lieff, 2013; Lieff and Yammarino, 2017). The majority of empirical studies focusing on academic leadership within higher education have focused on heads of universities, with little research on academic pedagogical leaders such as academic programme directors (Briggs, 2001; Vikström *et al.*, 2016; Schieffler *et al.*, 2017). Leaders can be found at all levels and therefore leadership extends beyond the roles of deans or principals to the level of medical educators in the classroom and leaders within a community. But what does it mean to lead? Drucker (1996) suggests leaders have followers, are exemplary and accountable, and effectively achieve results through the right actions (Drucker, 1996). Of interest is that Drucker also states that the concepts of a leadership personality, trait or style do not exist.

This then represents, in part, *who* the leaders are, and the *where* is similarly subject to change. Social systems change continually (Dinh *et al.*, 2014). For instance, an academic leader might develop an additional role external to his or her academic setting (Davies *et al.*, 2001). It is common for clinical staff to not only serve an academic institution but also head a clinical unit or department within a clinical setting. Thus, leadership is not only dependent on reciprocal followers but also on the position (*where* leaders lead) held by the leader; consequently, bestowing legitimate power. Position-based leadership is dependent on a formal or informal spatial position within an organisation (Grint, 2010). Two distinctions can be made: leadership-in-charge (a vertical positioning and someone at the top where a hierarchy provides them with resources) and leadership-in-front (this is a horizontal approach and is more informally established such as a military corporal with some degree of authority) (Grint, 2010).

A further dimension to the *where* of leadership is the context or environment. Male and Palaiologou (2015) argue that leadership should be context dependent instead of focused on a particular model (Male and Palaiologou, 2015). Male and Palaiologou assert that the practice of leadership should rather be viewed as praxis (Male and Palaiologou, 2015). Praxis, according to Freire (1994), starts with an abstract theory or a specific experience and progresses through reflection into action. Praxis thus entails both reflection and action (Freire, 1994). The study by Male and Palaiologou suggests that pedagogy extends beyond the purpose of teaching and learning and that pedagogical leadership should aspire to create links between educational outcomes and social realities. Pedagogical leadership should not follow models of effectiveness, such as transformational, learner-centred and situational leadership, but should rather conceptualise the relations of the learning ecology and the endogenous and exogenous social axes. The endogenous axis includes elements such as the values, culture, religion, customs and beliefs within the community that is served. The external or exogenous axis relates to the global economy, values of the society by large, the national curriculum, social networking, and information communication technologies. Ultimately, the goal is to establish educational interactions and relationships (Male and

Palaiologou, 2015). This then, in part, captures some additional aspects of the context of leadership. Earlier work by Barman and colleagues (2014) reinforces this to a degree when they stated that educational leaders should consider the social-cultural perspectives of teaching and learning development. They further stated that the context in which pedagogy takes place should be considered (Barman *et al.*, 2014).

The following sections will consider how leaders function and what they achieve through their actions. The theoretical framework of Grint (2010) will be regarded in light of the existing body of knowledge on leadership practices and behaviours.

2.3.2 The What and How of Medical Education Leadership

"Popularity is not leadership. Results are" (Drucker, 1996).

The result of leadership (*what* leaders achieve) and the process of leadership (*how* leaders operate or what they do), according to the work of Grint (2010), will be discussed in this section. However, this will be done along with the perspective of the leader as a person and the context of where leadership occurs. Drucker (1996) wrote that leaders typically ask two questions. They first ask, "What needs to be done?" Then they ask, "What can and should I do to make a difference?" (Drucker, 1996). These questions are typically posed amidst various challenges. Pedagogical leaders play significant roles in ensuring the design and advancement of quality academic programmes, facilitating academic staff development and steering the learning and teaching outcomes of students (classroom leadership) (Briggs, 2001). These actions typically require some form of leadership.

An extensive review of effective leadership, specifically leadership actions, in higher education has been provided by Bryman in 2007. The primary leadership behaviours, according to the findings of Bryman (2007), can broadly be described as the ability to: provide direction (strategic vision), orchestrate direction within an organisation, be considerate, and treat staff and colleagues fairly and with integrity. Additional attributes include: being trustworthy, having integrity, allowing participation and open communication, communicating goals and direction, advancing the cause of the institution, providing feedback, providing the necessary resources and appointments, and finally, augmenting workloads in order to promote research and scholarship (Bryman, 2007). Ineffective leaders typically undermine collegiality, the opportunity to actively participate and the autonomy of the individuals within the organisation (Bryman, 2007).

Current scholarly works focus on the challenges faced by educators in secondary education as well as leadership models and the characteristics of leaders (e.g. Bottery, 2004; Duignan, 2007). Similarly, the growing body of knowledge on the challenges associated with leadership and management by senior management in higher education exists (e.g. Bright and Richards 2001; Smith *et al.*, 2005). However, few publications zone in on leadership within the context of medical education. The influential work of Lieff and Albert (2012) provides a theoretical framework for the activities of medical education leaders.

The four-domain framework of Lieff and Albert (2012) provides insights into the behaviours of educational leaders within medical schools. The practices of medical educators fall into four domains, as proposed by Lieff and Albert namely; intrapersonal, interpersonal, organisational and systemic (Table 2.1).

Table 2.1. A framework for leadership practices in medical education (Lieff and Albert, 2012).

Intrapersonal
• Role modelling • Communication
Interpersonal
• Value relationships • Petitioning support
Organisational
• Sharing vision • Enabling change
Systemic
• Political navigation • Organisational understanding

Lieff and Albert argue that this framework aligns with the complex nature of leadership within the complex and evolving milieu of medical education (Lieff and Albert, 2010). The first domain, intrapersonal (Table 2.1), overlaps with the practices of what leaders do and how they do things. As mentioned in the previous section, the intrapersonal practices focus on the leaders themselves (Lieff and Albert, 2012). It extends beyond the biographical elements of *who* the leader is through a leader's self-awareness and directly influences their practices. Their leadership behaviour is subsequently modelled

on their self-awareness and in so doing they become role models (Lieff and Albert, 2012). The second domain refers to an interpersonal domain (Table 2.1) and relates to the ability to foster relationships and networks within the organisation and focuses on the individual, as member of a group, and the group itself. The third organisational domain (Table 2.1), according to Lieff and Albert, focuses on a programmatic level. This includes the elements of planning and resource management pertaining to the educational programmes and thus the curriculum (Lieff and Albert, 2012).

The final domain, the systemic domain (Table 2.1), refers to the external factors or the world view of the medical education activities and thus includes the political milieu and any relevant external engagements. This also includes a political awareness of the healthcare environment (Lieff and Albert, 2012). The authors continue to state that the latter aspect is typically neglected in contemporary literature. The findings of Lieff and Albert (2012) suggest that the educational leaders within one large North American medical school typically learn leadership skills from experience (experiential), reflective practice, strategic mentoring (or learning from example) or advanced pedagogy (Lieff and Albert. 2012).

Among the first publications on leadership within the domain of HPE was published by Bland *et al.* in 1999. Their work, on what constitutes effective leadership when aiming to achieve enduring curriculum and student career changes, spanned five years. Their project involved the modification of health professions curricula to: allow for a multidisciplinary approach, accommodate community-based training (rather than being primarily hospital-based), include community members as stakeholders, permit monitoring and evaluation by the primary partner, and bring about change to the national and state-based policies within the USA (Bland *et al.*, 1999). Data collection entailed telephonic interviews, surveys and focus groups, and was aimed at capturing participants' (27 health professions schools) predictions of the project's success. The study also aimed to assess participants' use of 16 traits associated with effective leadership (Bland *et al.*, 1999). Each of these traits was grouped under four major themes, namely: organisational power, coalition-building power/prestige, participative governance and cultural/value influence (Table 2.2).

The study by Bland *et al.* (1999) found that effective leaders use a broad spectrum of behaviours (*how* leaders operate) with participatory efforts, the sharing of a vision and the provision of clear structures appear to dominate. They found that effective leaders frequently used all four leadership categories (Table 2.2.). Data from their study pointed out that project leaders who employed three or four of the leadership categories and their traits were perceived to be most successful. The authors also pointed out that participative-governance (a variant of governance theory) and cultural-influence proved more effective than organisational-power (Table 2.2) (Bland *et al.*, 1999).

Table 2.2. The four leadership categories and sixteen behavioural traits of effective leaders (based on Bland *et al.*, 1999).

Organisational Power
• Uses organisational authority • Provides rewards or allocated resources • Gains control of resources (e.g. human resources and personnel)
Partnership-building Power/Prestige
• Empowers others through building coalitions (internal or external) • Uses professional/discipline expertise as perceived by others • Uses other people's identification of him/her as leader • Espouses and signals high commitment
Participative Governance
• Perceives and attends to the needs of other partnership members • Provides structural mechanisms to accomplish task at hand • Communicates a vision • Actively and consistently seeks input of others • Provides development activities to enable others to accomplish goals • Provides mechanisms for keeping goals visible and communicating progress and activities
Cultural/Value Influence
• Communicates the dominant values of the endeavour • Articulates the stories or symbols that represent the real meaning of the enterprise • Defines, shapes and maintains values

Traditional sources of organisational power can be positional (also known as legitimate power) and is the result of a person's position within the hierarchy of an organisation (Fig. 2.2). Other sources of power include: expert power (rests upon the expertise or knowledge of an individual), referent power (resulting from the interpersonal relationships), coercive power (driven by sanctions or threats), reward power (achieved through the allocation of incentives), and reciprocal power (derived from a shared set of moral values) (Singh, 2009). Power holds a strong relationship with the organisational climate, leadership styles and overall project success. Power, or "the ability to get things done the way one wants to get them to be done", can either be dependent upon formal authority or individual qualities and competencies

as depicted in Fig. 2.1 (Singh, 2009). However, the interplay between power and leadership (as cited above) is also dependent on the power of the "followers". *Followers* within this context is not a term that denotes weakness, nor has it a negative connotation. Followers, as Zogjani *et al.* (2014) aptly point out, "… is a prerequisite that allows leadership to exist" (Zogjani *et al.*, 2014). Followers thus have an equally important role to play, and a mutual influence exists between leaders and followers (Hollander, 1992). This might account for the successes associated with participative-governance and cultural-influence reported by Bland and colleagues (Bland *et al.*, 1999).

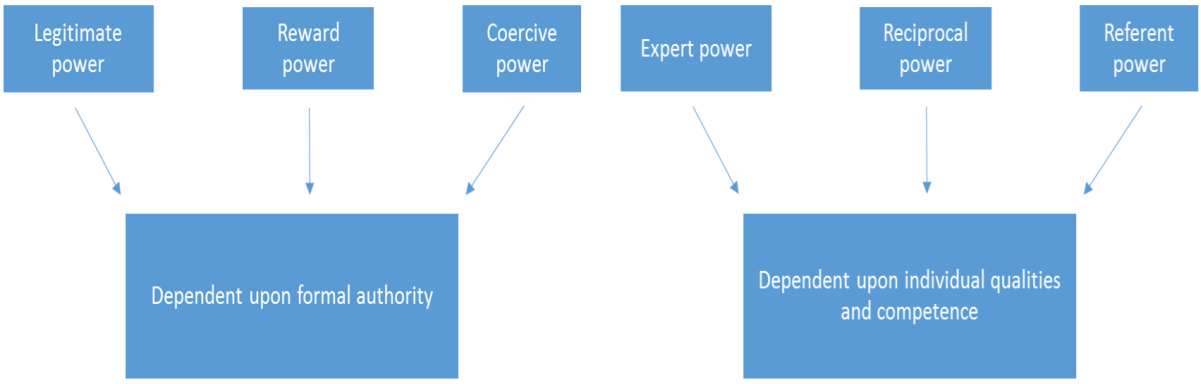

Fig. 2.1. Sources of organisational power and their dependencies (adapted from Singh, 2009).

The purpose of leadership is to obtain a result ("what" a leader aims to achieve), a desired project outcome or meet a target. The outcome can be traced back to the actions or attributes of a leader. Some psychological studies suggest that what leaders achieve (i.e. the leadership result) can be measured, but is refuted by some in the field of sociology (Grint, 2010). Results-based leadership typically focuses on the result, and in some instances the method or process involved might be considered irrelevant by some. This view of leadership can exemplify the efforts of a leader with a charismatic persona or even a social engineer. Regardless, what was achieved and reaching a target or goal becomes the primary approach (Grint, 2010). If leadership can indeed be simplified to be results driven, then the ultimate objective of leadership in medical education, according to McKimm and Lieff (2013), is to benefit today's and tomorrow's patients (McKimm and Lieff, 2013).

However, it is difficult to conceptualise leadership without considering the process or processes (the "how" of leadership) involved in obtaining results. The belief is that leaders act differently from non-leaders (Grint, 2010). When leading in education, it is important to note that it is "never a checklist, always complexity" (Fullan, 2003). Effective leaders rely on a process, enabling them to dynamically respond to the complexities of the environment. Such leaders concurrently act, learn, monitor and

evaluate the situation – thus underpinning the essence of situated leadership. Leaders thus match their behaviours with the performance needs, and provide direction and support through the process of coaching (the experienced guiding the inexperienced) along the way (Adair and Thomas, 2004). These practices are essential within the given context and it is here that practices are more important than competencies, i.e. "not what leaders 'have' but what they 'do'" (Grint, 2010). Such practices include valuing, supporting and caring for both academic staff and students. It also requires aligning the interests of both faculty and stakeholders with the needs of the organisation (Lieff and Albert, 2010).

Thus, leadership within the realm of HPE can be viewed as a complex interplay between the leader as a person, the position of the leader, the desired outcomes or results and the processes involved in obtaining these results (Grint, 2010). This is exemplified by the Academy of Medical Educators' framework of professional standards. The Academy identifies three elements of management, leadership and governance as defined by varied levels of competence (Academy of Medical Educators, 2012). These competencies include: the ability to manage personal time (leadership as a person), resource management, and a consolidated understanding of the role within the faculty (context and the process) in order to benefit the faculty and the needs of the students (product). This of course is required within context, i.e. the medical education domain and within a specific organisation, thus exemplifying the position of the leader. Further investigation on the growth of leaders and leadership development is required in order to understand whether their competencies are innate or required. The next section aims to address this and will look at the growth of leaders and the factors influencing their development.

2. 4 HOW LEADERS DEVELOP

"Leadership must be learned and can be learned …" (Drucker, 1996).

Studies broadly acknowledge that leaders are vital to the success of their institutions' performance (March and Weil, 2005; Agle *et al.*, 2006; Bisschoff and Watts, 2013). However, Bisschoff and Watts (2013) stress the need for a clear understanding of how senior individuals learn or develop their leadership (Bisschoff and Watts, 2013). Leadership development has gained much interest during the past two decades and many organisations are recognising the advantages of investing in the process of enhancing an individual's capacity, knowledge, skills and attitude in order to allow them to participate in leadership roles (McCauly *et al.*, 1998; Day, 2000).

However, two distinct concepts have evolved over time: leadership development and leader development. Leadership development is the investment process in the social capital of an organisation.

Leadership development strives to establish interpersonal networks and cooperation within an organisation (Lord and Hall, 2005). It relies heavily on the interaction between the leader and the social and environmental reality of the organisation (Day, 2000; Offermann and Matos, 2007). A clear definition of leadership development has been provided by McCauley and Van Velsor (2004):

> "[. . .] the expansion of the organization's capacity to enact the basic leadership tasks needed for collective work: setting direction, creating alignment, and maintaining commitment" (McCauley and Van Velsor, 2004).

Alternatively, it can be viewed as:

> "[. . .] a continuous, systemic process designed to expand the capacities and awareness of individuals, groups, and organisations in an effort to meet shared goals and objectives" (Allen and Roberts, 2011).

The second concept of leader development focuses on the development of human capital, i.e. the individual rather than the organisation (Day, 2000; Offermann and Matos, 2001). Leader development has been defined as:

> "[. . .] the expansion of a person's capacity to be effective in leadership roles and processes" (McCauley and Van Veslor, 2004).

For the purpose of the research presented here and the study at hand, we will view leadership development as the development of the beliefs and practices of the collective as well as the development of the leader as an individual (Day, 2000; McCauley, 2008). The stance of McCauley will be maintained throughout when considering the literature.

Yet, two distinct schools of thought exist regarding the innate or acquired nature of leadership. There are those who believe that leaders are born and others argue that it is a learnt skill, especially by individuals who show commitment and interest (Hill 2005; Di Giulio, 2014). Other authors argue that some qualities of a leader can be considered as innate (charisma, vision, energy, kindness and empathy) and some can be acquired or learnt (managing groups, understanding exogenous factors, networking, planning and the ability to organise) (Taylor *et al.*, 2008). There thus exists a dualism when considering individual leadership characteristics. The work of Lord and Hall (2005) suggests that leadership development progresses hierarchically from a beginner, an intermediate and finally, an expert. They continue that leaders exhibit qualitatively different competencies when processing information and knowledge (Lord and Hall, 2005). Trigwell *et al.* (1999) propose that there is a clear link between an

individual's attitude to knowledge and attentiveness to knowledge. This link significantly influences the process of learning and subsequently an individual's development (Trigwell *et al.*, 1999).

Scientific evidence points towards the significance of inherent traits and a leader's capacity to develop. Theorists focusing on leadership traits strongly argue for the notion that a leader is born (Stogdill, 1974). Intrinsic traits are believed to empower leaders to develop relevant skills, devise a vision of what needs to be done and to plan the steps required to realise the vision (Kirkpatrick and Locke, 1991). Additional inherent qualities such as self-regulation and self-awareness are believed to further aid the development of leaders (Luthans and Avolio, 2003). Individual differences should also be considered when bearing in mind a leader's development. Lord and Hall (2005) proposed that individual differences – such as personality, temperament, cognitive capacity, emotional intelligence, personal identity and values – impact the growth of a leader (Lord and Hall, 2005). It therefore makes sense that specific childhood experiences, such as exposure to role models, are related to individual leadership behaviours (Bass and Avolio, 1994; Popper *et al.*, 2000). Future exposure to leadership opportunities is a further variable that can shape an individual (Kotter, 1990). This coincides with any form of leadership development that results from an interaction with environmental events, and a challenging work environment and associated roles (Hooijberg and Quin, 1992). These stressors lead to a shift away from habitual behaviour to the implementation of alternative and new strategies (McDermott *et al.*, 2011).

Leader and leadership development programmes within medical schools and various institutions aim to nurture the skills, knowledge and growth of the individuals within a faculty. Such skills include aspects of leading a team, resolving conflict, and being a role model and mentor. Some examples include programmes set up by the American Medical Association (AMA), the Canadian College of Health Leaders (CCHL) and the UK's National Health Service (NHS) (Rotenstein *et al.*, 2018). Various publications support the delineation between 'leader development' and 'leadership development' (Van Velsor and McCauley, 2004; O'Connor and Day, 2007; Drath *et al.*, 2008). The current body of knowledge on leadership development chiefly focuses on aspects such as the practice of leadership (Leskiw and Singh, 2007), the development of training programmes (Ladyshewsky, 2007) and the nature of leadership (Boaden, 2006). The ultimate goal of these interventions is to develop systems that widen the expertise of individuals who take up leadership roles (Houghton and DiLiello, 2009). Scientific data point towards the merit of such interventions. The predominant aspect in many publications on leader development, as presented in McCauley's extensive review in 2008, focuses on competencies (skills and abilities) and transformative change as a framework. Theoretical frameworks on adult development and transformation come into play for the latter (McCauley, 2008). Here, the focus will be on the understanding of the development process of a leader as viewed in light of their transformation (Day, 2000).

Vilkinas and Ladyshewsky (2011) found that leaders serving as academic programme directors possessed the ability to further build their skills as leaders. The authors found that the 90 programme directors (PDs) who were studied were effective to an acceptable degree, with an emphasis on getting things done and working with people. Other responsibilities were identified and included networking, managing change and supporting their colleagues. The findings of the study further indicate that PDs could become more effective if they critically appraise their leadership practices, reflect on these behaviours and learn from their reflective practice (Vilkinas and Ladyshewsky, 2011). Various studies have reported on the importance of investing in the social and individual capital of organisations. The work of Gunderman and Chan (2007) reinforces this. They emphasised the importance of providing frequent opportunities to invest in an organisation's human capital and to provide room for the development of knowledge and skills within an organisation and within a specific context (Gunderman and Chan, 2007). Lieff and Albert (2010) state that leadership development programmes in medical education should include conceptual frames such as the framework of Bolman and Deal (1992). These frames will permit leaders to reflect on their work from various perspectives and guide their future decisions (Lieff and Albert, 2010). The inclusion of emotional intelligence models, administrative skills and strategic planning in undergraduate and postgraduate programmes are additional development strategies and have gained substantial interest over time (Veronesi and Gunderman, 2012). The acquisition of leadership skills requires immersion within an integrated social process that extends beyond mere knowledge of the various principles and models of leadership (Chreim *et al.*, 2013; Khoshhal and Guraya, 2016). The value of case discussions, the application of newly discovered principles to existing challenges, role-play, simulations and debating are some of the strategies proposed to further develop leadership approaches (Kuo *et al.*, 2010). The use of interactive and integrative programmes that include emotional intelligence competencies has been emphasised (Stoller, 2008; Taylor *et al.*, 2008). A lack of emotional intelligence has been motivated as one of the major reasons why physician-leaders fail (Lobas, 2006). The review by Stoller (2008) focuses on the competencies required by physician-leaders. The author further states that the attainment, expansion, and upholding of leadership competencies of physician-leaders require further investigation (Stoller, 2008).

It is important to emphasise again that leadership development, as discussed in this section, includes the development of the social as well as individual capital of an organisation (Day, 2000). From the literature presented, it is evident that the skills of leaders can be developed, regardless of whether the focus is human capital (leader development) or social capital (leadership development). Leaders' competencies and their ability to do things better can evolve. The literature also focuses on what is developed through leadership development, i.e. competencies, expertise, the change in a leader and a leader's identity.

2.5 SUMMARY

This chapter reviewed the necessity of leadership in medical education as motivated by the global drive to increase the health workforce capacity. It further focused on the roles of leaders within HPE and the growing need for leader and leadership development. The chapter aimed to capture the four approaches of leadership: leadership as a position ("where" leaders operate), leadership as a person ("who" leaders are), leadership as a result ("what" leaders achieve), and leadership as a process ("how" leaders operate). The current deficit in HRH can be addressed, in part, by the establishment of new medical schools and the scaling up of HPE within existing schools. However, both these approaches are over simplified and require the mobilisation of resources and adequate clinical training centres. The evolving nature of the higher education environment requires a matched approach for leadership to succeed. The efforts of knowledgeable and committed leaders will drive such efforts. The challenges faced by new medical schools also appear to be over simplified and require an understanding of the roles and interplay between educators, their institutions, local governments, professional bodies, students and the communities they serve. These interactions play a major role in the leadership development or growth of senior managers within new medical schools in Africa.

The question remains as to how appointed and emergent leaders within new medical schools conceptualise and deal with these challenges. Also, the paucity of research specific to leadership and how leaders build on their current approaches begs further investigation. Factors such as a shift in social systems, organisational context, budget constraints and service demand within the health sector must be considered. Further insights into the pedagogical leadership roles, the perceptions of these leaders and the emergent trends of these elements within SSA and the continent are required.

The next chapter will focus on the research design, the study population, the data collection instruments and analyses, the methodological assumptions, limitations and delimitations, and finally the ethical considerations. Each of these elements will be addressed in detail to align with the goals and objectives of the study.

CHAPTER 3

RESEARCH METHODS

3.1 RESEARCH DESIGN AND APPROACH

Studying leadership in the context in which it is found is important. For this study, exploratory research methods were used to gain a more complete understanding of the research questions and to corroborate the findings of the data collection tools (Onwuegbuzie and Leech, 2005). This is a mixed-methods research study and involves collecting, analysing and integrating quantitative (Likert scales) and qualitative (a multiple case study approach and a qualitative document analysis) data. Thus, a sequential, exploratory mixed-methods design was used to investigate the phenomenon of leadership development (Leech and Onwuegbuzie, 2008).

The distinction from a multi-method approach is made in that the current study will employ three data collection methods to supplement one information source with another. Different data sources will be used to triangulate on the phenomenon of leadership development. The research project has more than one worldview (i.e. combination of qualitative and quantitative research methods) either concurrently (independent of each other) or sequentially (the findings from one approach inform the other) in order to understand the phenomenon of interest (Creswell and Plano Clark, 2007). For these reasons, the study can be considered as a mixed-methods study.

The researcher was involved both as an observer and participant which required significant reflexivity. Reflexive analysis relies on a constructivist paradigm, with the researcher and the researched (participants) collaborating on the construction of knowledge rather than its discovery (Lynch, 2000). A reflexive researcher simultaneously gazes in two directions and thus follows a circular relationship between subject and object (Probst, 2015). Reflexivity therefore attends to the phenomenon at hand whilst being aware of the researcher's own predictions, additions, assumptions, agendas and biases. This double vision or attentiveness will be maintained throughout the study of the phenomenon (Probst and Berenson, 2014). There is, however, the risk of excessive reflexivity at the expense of concentrating on the research participants and phenomenon (Finlay, 2002). Personal reflexivity, i.e. reflective and reflexive practice, was employed to document the role and stance of the researcher in the research process and capture the reflections of the participants. This was done to reflect on the researcher's ideas and perceptions in order to embrace the reflections of the participants (Glanville, 2013). This allowed the researcher to critically assess the knowledge that is produced as well as the researcher's role in the

production of knowledge (methodological congruence) within the phases of the research as described below (Finlay, 2002; Probst and Berenson, 2014). As a researcher, I will make my contributions, opinions, thoughts, and feelings visible, and I acknowledge my involvement in the research process during the presentation of the findings through the use of reflexivity (Ortlipp, 2008; Glanville, 2013).

Thus, the mixed-methods approach of this research project will combine both quantitative and qualitative models to gain a deeper and more meaningful understanding of the phenomenon, i.e. leadership development (Creswell and Plano Clark, 2007). This mixed-methods model is believed to achieve more than the single use of qualitative or quantitative approaches (Creswell and Plano Clark, 2007). It is believed that a mixed-method research inquiry approach was the most suited to address the research questions of this study.

3.2 STUDY POPULATION

The study population included each institution within the consortium (CONSAMS) at the point of ethical approval in 2018 (Appendix I). CONSAMS at the time consisted of: University of Namibia School of Medicine (Namibia); Copperbelt University School of Medicine (Zambia); Mulungushi University (Zambia); University School of Medicine (Mozambique); University of Botswana School of Medicine (Botswana); National University of Lesotho Medical School (Lesotho); University of Oulu (Finland); and Vanderbilt University (Nashville, Tennessee, USA) (Eichbaum *et al.*, 2014a and b, 2015). CONSAMS representatives from the latter two universities were included in this study as it was believed that their representatives might provide objective insights into the developments and endeavours of the African-located schools. The University of Malawi, College of Medicine, was also approached based on the partnership between the Medical Education Partnership Initiative (MEPI) and CONSAMS (Omaswa *et al.*, 2018). The participating members included deans, deputy deans, associate deans, deputy associate deans, programme directors, heads of departments and academic staff. This was motivated by the existing body of literature that points towards their pedagogical leadership positions (both formal and informal) within each medical school (Bordage *et al.*, 2000; Davies *et al.*, 2001; Male and Palaiologou, 2015; Black, 2015). Participants of this study were both male and female and were positioned within recently established medical schools. Some of the participants represented their institutions within CONSAMS.

3.3 CONTEXT AND SAMPLING

As researcher, I am positioned within one of the young medical schools in sub-Saharan Africa, the University of Namibia. I was part of a small group consisting of five pioneers, tasked with the establishment of Namibia's first medical school in 2009 (Wessels *et al.*, 2012). Self-reflection, to understand my own position and transformation during the initial years of curriculum and infrastructure development, revealed that we were all emergent leaders. We were not appointed or elected as leaders; rather, our leadership developed over time as a result of the group's interactions amidst a vast array of responsibilities (Kickul and Neuman, 2000). As part of this team, we played the roles of managers, leaders and, effectively, academic 'foot soldiers'.

CONSAMS was established as the Consortium of New Southern African Medical Schools in 2011 after an initial founding meeting in Ndola, Zambia (Eichbaum *et al.*, 2012, 2015). The consortium represented a partnership of five southern African medical schools at the time. These partners included the University of Namibia (Windhoek, Namibia), Universidade Lúrio (Nampula, Mozambique), Copperbelt University (Ndola, Zambia), the University of Botswana (Gaborone, Botswana) and Lesotho University Medical School (Eichbaum *et al.*, 2012). The primary driver for the establishment of the consortium was the similarity of the challenges faced by these institutions. These challenges include a shortage of academic staff and resource constraints. The alliance serves as a link between medical schools to exchange ideas, learn from each other, share faculty through exchange programmes and develop their context-specific academic curricula (Eichbaum *et al.*, 2012). Two international partners (northern partners), Oulu University (Oulu, Finland) and Vanderbilt University (Tennessee, USA), serve as mentoring institutions within the consortium (Eichbaum *et al.*, 2014b). The northern partners provide guidance on staff training, research grant applications, collaborative research and links to other organisations for funding and collaboration (Eichbaum *et al.*, 2015a).

The southern African medical schools were less than five years in existence when they joined CONSAMS. Mulungushi University (Kabwe, Zambia) soon joined and the consortium changed its name to the Consortium of New Sub-Saharan African Medical Schools (Vanio, 2017). This name change captures the vision of CONSAMS to expand beyond southern Africa to include other African regions. New members continued to join the CONSAMS family, and to date CONSAMS now also includes: Catholic University of Maputo (Maputo, Mozambique), Eswatini Christian University (Mbabane, Swaziland (formerly Swaziland Medical Christian University), Northwest University (Potchefstroom, South Africa) and Masinde Muliro University of Science and Technology (Kakamega, Kenya) (CONSAMS, 2020a). These institutions were not included in the study as they were not part of the consortium at the point of ethical approval.

CONSAMS, through its partnering and shared experiences, lends itself as a platform to investigate the growth of leaders within these young medical schools. For this reason, non-probability convenience sampling was employed in this study based on the researcher's involvement in CONSAMS. The primary drivers for this sampling method included expedited data collection, ease of access and cost effectiveness (Henry, 1990).

The study population included the following institutions within the consortium (CONSAMS): University of Namibia School of Medicine (Namibia), Copperbelt University School of Medicine and Mulungushi University School of Medicine (Zambia), University School of Medicine (Mozambique), University of Botswana School of Medicine (Botswana), Medical School of Lesotho (Lesotho), University of Oulu (Finland), and Vanderbilt University (USA) (Eichbaum *et al.*, 2014a and b, 2015). CONSAMS representatives from the latter two (international) universities were included in this study. It is believed that these representatives might provide objective insights to the development and endeavours of the African schools. Each participatory member of CONSAMS included pedagogical leaders, both formal and informal, within each medical school.

A minimum of four participants from each institution (a total of 24 participants) were targeted. Participant recruitment was done in a non-coercive manner and volunteers were drafted through electronic communication and were provided with a Participant Information Sheet (Appendix II). None of the participants were in a dependent relationship with the researcher.

3.4 DATA COLLECTION INSTRUMENTS

Data collection for this project relied on three instruments: a Likert scale, multiple case studies and document analysis. The three instruments supplemented each other in order to answer the research questions. The first instrument is a Likert scale survey in order to assess the leadership climate within each of the CONSAMS schools as perceived by the participants. A 35-question-survey (Appendix III) was adopted from the work of Souba *et al.* (2007) and assessed the following climate dimensions (scales): participation, transparency, accountability, alignment of educational goals, collaboration, and constructive conflict. The authors extrapolated these seven dimensions of a positive leadership environment from the existing body of literature (Souba *et al.*, 2007). The leadership climate scales were used in the current study to extrapolate the perceptions of the participants regarding leadership in SSA medical schools.

The second instrument is an exploratory multiple case study approach through semi-structured interviews. These interviews were modelled based on the work of Lieff and Albert (2012). The interviews were directed to gain information, allow for further exploration in a particular direction or theme, and served to provide room for open answers and discussions (DiCicco-Bloom and Crabtree, 2006; Lieff and Albert, 2012; Malthus, 2017). The interviews served to gain biographical information, describe existing barriers, extract participants' beliefs as leaders, and explore the aspects of decision making (Appendix IV). The questions served to extract valuable contextual information on the participants' personal development as leaders within their respective medical schools. Representative members of the CONSAMS schools were interviewed, telephonically or through a telecommunications application platform, and digital recordings were made after obtaining consent. The interviews also aimed to provide in-depth insights to the challenges faced within each of the CONSAMS institutions.

The final data collection instrument entails a qualitative document analysis of publications related to CONSAMS and the activities of the consortium since its inception until 2019. This includes minutes taken from CONSAMS meetings and published works by the consortium such as conference papers, agendas, manuals, event programmes, reports and publications produced by the consortium (Bowen, 2009). The selection of this particular period relates to the researcher's active participation in CONSAMS as well as the period of ethical approval. The selected period also accounted for a first-hand experience (Bowen, 2009). Scott (1990) states that documents, for the purpose of qualitative document analysis (QDA), should be studied as socially situated agents and this will be followed. The information that is acquired through the QDA relates to both the physical and social domains within a specific context (Scott, 1990). It is important to note that these documents were not prepared in response to the researcher and can therefore be considered as authentic to the consortium (Guba and Lincoln, 1981). QDA is frequently used alongside other qualitative methods in order to allow for triangulation (Denzin, 1970). The same holds true for the current study.

Thus, the project relied on three data collection instruments to assess the leadership climate within the CONSAMS medical schools, semi-structured interviews of volunteering participants (to elucidate the forces at play and their effects on leadership), and a qualitative document analysis which aimed at assessing the leadership direction and growth of the consortium. Each specific data collection instrument aimed to reinforce the findings of the study and was aligned to answer the research questions and address the aims of the project.

3.5 DATA ANALYSIS

3.5.1 Leadership Climate Survey

A five-point Likert scale was adopted from the work of Souba *et al.* 2007. All the items of the aggregate scale represented seven distinct dimensions, as mentioned in the previous section. The respondents rated their agreement or disagreement in reference to the statements associated with each leadership climate (Appendix III). The ordinal data generated by each scale were analysed for measures of central tendency and included the median and mode (Sullivan and Artino, 2013). The data were also visually presented in the form of diverging stacked bar charts. Negative statements were not reverse-scored; as parametric or non-parametric statistical analyses were not performed. All statistical analyses were done in Microsoft Excel 2007 (Microsoft Corporation, Redmond, WA, USA).

3.5.2 A Multiple Case Study

Participants agreed to be interviewed by the researcher after providing consent (Appendix V) and all interviews were digitally recorded after obtaining consent. Verbatim transcripts were generated by a third party (On Time Transcribers, Cape Town, South Africa). The researcher then compared the transcripts with the audio recordings for consistency. Each interview was individually examined to elucidate the phenomenon of leadership development. An inductive approach for latent themes was followed to elucidate the phenomenon of leadership development (Burnard *et al.*, 2008). Thematic analysis (TA) was manually performed in order to generate the primary and secondary themes (Pope *et al.*, 2000). This method was used to identify and analyse patterns of meaning within the interview data (Braun and Clarke, 2006; Joffe, 2012). The researcher along with his supervisor performed TA on three of the interviews together. This was done in order to familiarise the researcher with the process of TA. TA on each interview was then done anew by the researcher and formed Phase I of the multiple case study approach as depicted in Fig 3.1 (Yin, 2003; Nowell *et al.*, 2017; Sinha and Hanuscin, 2017). Typically, thematic analysis utilises six phases and entails general familiarisation with the transcribed interviews, generation of initial codes, the identification of categories or themes amongst the codes, a review of these themes, and the naming and defining of themes and reporting (Braun and Clarke, 2006; Burnard *et al.*, 2008; Nowell *et al.*, 2017).

A reflexive approach was adopted where the researcher became immersed in the process of data familiarisation, coding and theme development rather than coding reliability and using a code book approach (Braun and Clarke, 2006; Braun *et al.*, 2019). It was believed that this approach would help

construct the underlying aspects of leadership development. The flexibility and potential benefit of providing a deeper understanding of the research phenomenon motivated the use of reflexive TA (Braun and Clarke, 2006 and 2019). It is therefore believed that the intersection of the data and the interpretive framework will actively allow for the generation of themes.

The theoretical and conceptual frameworks mentioned in Chapter 1 served as a lens through which the data were viewed and the process is described in the synthesis stage in Chapter 7 (Braun and Clarke, 2006 and 2019; Braun *et al.*, 2019). The themes that were generated from the first round, i.e. within-case analyses, were then used to elucidate cross-case conclusions as outlined in Fig 3.1 (Yin, 2003).

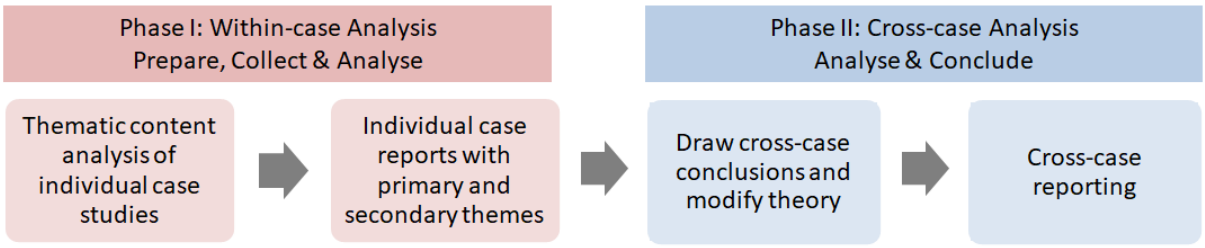

Fig. 3.1. The phases of the multiple case study approach. Phase I considered each case separately with the identification of primary and secondary themes. Phase II drew cross-case conclusions before reporting on the overall themes (adapted from Yin, 2003).

The integration of the data during the second phase, i.e. across the cases, relied on further expansion, condensing, and merging of the within-case themes (Miles and Huberman, 1994; Yin, 2003). The across cases TA required a second round of scrutiny of the identified themes of the within-case themes. The 15-point checklist for good TA, as proposed by Braun and Clarke (2006), was followed for both phases. The checklist focuses on the transcripts (confirming the quality of the transcribed data), coding analysis, allowing enough time for analysis and writing the final report (Braun and Clarke, 2006 and 2019).

3.5.3 Qualitative Document Analysis

A QDA was performed on the reports and minutes generated by the CONSAMS secretariat between 2017 and 2019; based on the ethical approval of this project (Appendix I). The documents include agendas, meeting minutes, reports, event programmes, background papers, and scholarly works (Bowen,

2009). Furthermore, published reports, academic scholarly works and media reports that were in the public domain between 2011 and 2019 also formed part of the QDA. These documents captured the activities and events of CONSAMS and thus had other intended purposes not related to the phenomenon being studied (Denscombe, 1998). The documents were viewed as sources and the subsequent data were considered a reflection of the real world (material world) (Scott 1990: Østbye *et al.* 2007). The documents were thematically analysed through explicit and implicit methods. Once again, a reflexive approach was used to generate the themes. Implicitly, the researcher considered themes that alluded to leadership development throughout. Analysis for explicit themes followed, and here I considered exact words or phrases pertaining to leadership development within the consortium (Mogalakwe, 2006; Bastani *et al.*, 2018).

A four-step Scott method was used in order to ensure that the documents were authentic, credible, meaningful and representative prior to TA. The authenticity of the documents was assured based on their origin, i.e. either representing CONSAMS at a meeting, published in a peer reviewed academic journal or electronically received from the CONSAMS secretariat (Scott, 1990). Documents were deemed to be reliable if they had authority (the authors were CONSAMS members) and they were free from bias (not containing statements of partiality or preference). They were regarded as representative if they were generated by a CONSAMS representative, institution or secretariat. Furthermore, published reports, academic scholarly works and media reports were deemed representative if they explicitly reported on CONSAMS. Finally, the documents were regarded as meaningful if they were comprehensive and had face value (Scott, 1990; Bastani *et al.*, 2018).

3.6 DATA VALIDITY AND RELIABILITY

Data trustworthiness in qualitative research is synonymous with validity and reliability. It specifically includes the following attributes: dependability, confirmability, credibility, and transferability (Guba, 1981). One way to ensure credibility in qualitative research is through triangulation. This involves asking the same research questions to the participants (through the semi-structured interviews in Appendix IV) and by collecting the data through methods such as observation, focus groups and individual interviews (Guba, 1981; Shenton, 2004).

The researcher employed a similar process of triangulation where each volunteering participant was subjected to the same research questions, and additional data were collected through the Likert scales and document analysis. Additional measures to ensure credibility included checking for congruency (Guba, 1981; Shenton, 2004) with the findings of previous academic works, such as that of Mullan *et*

al. (2011) and Chen *et al.* (2014). The researcher also aimed to be reflexive by making reflective commentary on the findings (Shenton, 2004). This process also captured any patterns, theories or concepts that were generated by the researcher.

Transferability refers to the extent to which the findings of a particular study can be transferred/applied to other situations (Merriam, 1998; Shenton, 2004). The issue of transferability was be addressed through the study of the phenomenon, i.e. leadership development, within multiple environments (the various CONSAMS institutions) in order to identify any consistencies or inconsistencies in the data (Shenton, 2004; Korstjens and Moser, 2018). It is believed that the data from this study can be transferred beyond the study population to the rest of Africa. This premise was supported by describing the experiences and behaviours of the leaders within context in a way that is meaningful. In so doing, the reader of the data will be able to find the data applicable (Korstjens and Moser, 2018).

The researcher conducted and analysed the interviews after guidance from his supervisors. The final generated themes were weighed in conjunction with the data of the Likert scales and document analysis. It is believed that this process promoted the validity of the data (Holloway and Todres, 2003).

An additional dependability measure included the employment of overlapping methods, i.e. the focus groups and interviews (Shenton, 2004). Furthermore, it is hoped that the in-depth description of the methodology employed could be repeated by others (Shenton, 2004). The final attribute, i.e. confirmability, was addressed through triangulation in order to reduce investigator bias. The process of reflexivity that I have employed during the proposed study served as a conduit to relay any of my own beliefs and reveal any form of bias (Shenton, 2004).

3.7 METHODOLOGICAL ASSUMPTIONS, LIMITATIONS AND DELIMITATIONS

In this study, no distinction was made between leaders and managers within these institutions. A more contemporary approach was followed where leaders are required to manage and managers are required to lead (McKimm and Lieff, 2013). Furthermore, the premise is that leaders grow regardless of their backgrounds (Drucker, 1996; Lord and Hall, 2005; Taylor *et al.*, 2008; Di Giulio, 2014). The assumption here is that this growth is situated and dependent on context. It is for this reason that the forces at play were considered when studying the phenomenon of leadership development. The study followed an interpretivist epistemology and an ontological belief that reality is socially constructed. It is believed that this stance permitted an in-depth understanding of the context of leadership development and

captured the richness of the data when viewing the participants within their realities (Guba and Lincoln, 1994).

The study focused on CONSAMS and the leaders of the six medical schools within SSA. A leader within this context refers to any person in an academic position within the realm of medical education, and in this context leads a programme, department, course, firm, team, task or students. Leadership development within this study refers to the expansion or growth of the organisation (medical school) and its leaders in order to define and continue down a specific path. This development also allows leaders to be effective in their roles (McCauley and Van Velsor, 2004; Allen and Roberts, 2011).

The limitations to this study include: interview bias, the memory of the participants, exaggeration of concepts and ideas, hidden agendas, misunderstanding, lack of skill by the interviewer, incomplete answers, courtesy, biased questions by the investigator, question order, and the subjective nature of reflexive TA (Nowell *et al.*, 2017; Queirós *et al.*, 2017; Braun and Clarke, 2019). The researcher's involvement during data gathering, which is unavoidable in qualitative research, can affect the subjects' responses. Issues of anonymity and confidentiality can present problems when presenting the research findings (Mackenzie *et al.*, 2012).

Another limitation is that the project initially included a focus group as a data collection point. It was the intention of the researcher to make use of participatory action research (PAR) and permit the participants to provide feedback on the overall findings of the Likert scales and interviews. This element of the project was scheduled for the second month of 2020 due to the need to process and analyse the aforementioned data. However, CONSAMS at the time did not schedule any meetings for 2020 and 2021 due to the global coronavirus (COVID-19) pandemic and restructuring of the consortium.

Finally, the researcher’s own assumptions were digitally recorded prior to the participant interviews. These assumptions were thoroughly interrogated during the presentation of the data. Assumptions and perceptions are part and parcel of qualitative research (Braun and Clarke, 2006 and 2019). Yet, the researcher’s implicit analysis of the documents (through QDA) might position emerging themes to fit the purpose or context of analysis. Objectivity then is hindered by the theoretical ideas of the investigator (Altheide 1996). These biases were revealed throughout the presentation of the findings.

3.8 ETHICAL ASSURANCES

This study involved human participants and was submitted for review by the Faculty of Health Sciences Research Ethics Committee, Universities of Cape Town (REF: 751/2017, Appendix I). Furthermore, permission to conduct the study was obtained from the various CONSAMS participants once ethical approval had been granted. As researcher, I am aware of the fact that the choices I make through the research process might have political and ethical implications. Also, I am aware that participation should be voluntary without coercion. Volunteering candidates were asked for written and voluntary consent (Appendix V) and all the participants' information was handled confidentially and anonymously. To avoid undue influence, subjects were recruited by a general announcement, e-mail communication (Appendix VI) and through the provision of a Participant Information Sheet (Appendix II). The information sheet was mailed to the CONSAMS members and to individuals within new medical schools in the region.

This study did not rely on vulnerable individuals, minors, or patients. It is believed that the methodology employed during the data collection process did not cause or exacerbate any pre-existing physiological or health conditions, and cognitive or emotional factors. No socio-economic or legal issues were foreseen. There were no risks anticipated for the participants.

The feelings and opinions of the participants, assessed through the interviews and surveys, might contain sensitive information, and strict confidentiality of the material was ensured as far as possible (Ramani and Mann, 2016). This was achieved by assigning a numerical identifier to each participant. The interviews may involve some loss of privacy; however, we intend to keep all records confidential. Only the researchers had access to data and digital recordings. All interview transcripts and documented information is stored on an encrypted storage device and all audio recordings are stored in a lockable cupboard. The researcher disclosed his intention to publish and disseminate the findings before commencement of the study.

3.9 SUMMARY

This chapter provided an overview of the methodology, the data collection instruments, proposed analyses, limitations and delimitations, as well as the ethical considerations of the project. The next chapter will present the findings of all three data collection instruments. The findings present and discuss the Likert scale data, the multiple case studies and the qualitative document analysis. The next chapter, Chapter 4 (Fig. 3.2), will present the results of the leadership climate survey. Chapters 5 and 6 (Fig. 3.2)

will convey the findings of the multiple case studies and document surveys respectively. These chapters are aimed at understanding leadership in new medical schools. Through this, it is believed that insights will be gained on the growth and development of leadership. The forces at play will also be considered as they are believed to drive the growth and development of leaders (Fig. 3.2). Each of the chapters will thus capture the findings of the study and will also contain a summary of the results. The findings of this study will be presented as outlined in Figure 3.2.

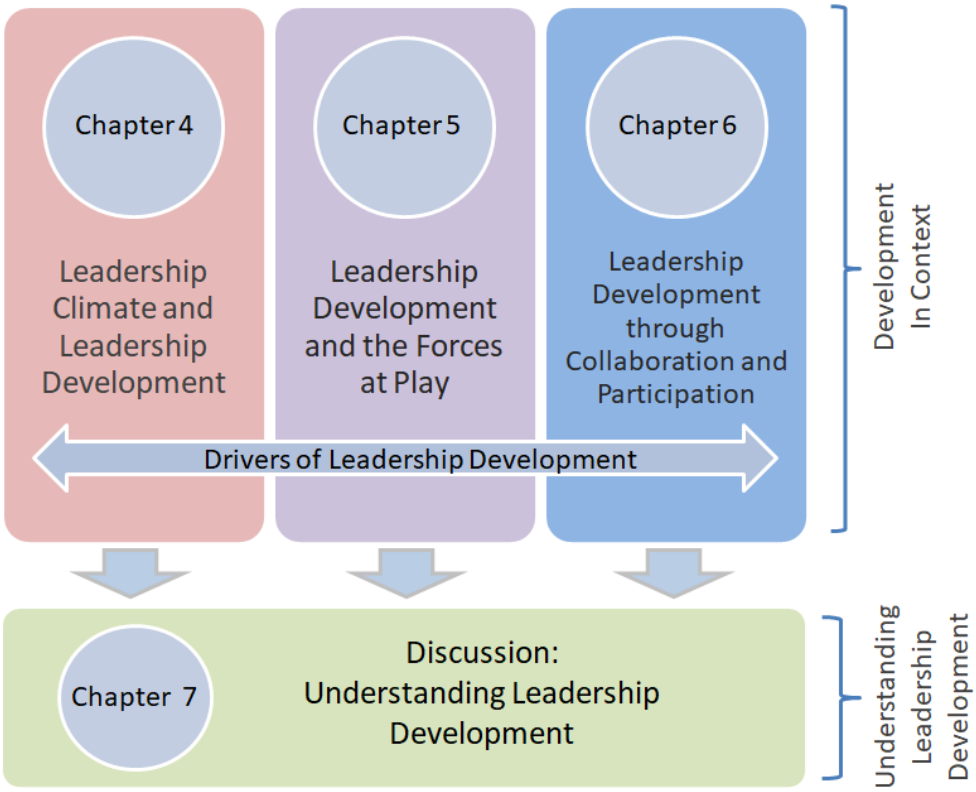

Fig. 3.2. An outline of the presentation of the research findings.

Chapter 7 (Fig. 3.2) will present an overall discussion and will focus on the phenomenon of leadership development. The data from the data collection instruments will be triangulated within Chapter 7. Inductive reasoning will be used to frame leadership development in new medical schools in Africa. This will be done by viewing the theoretical and conceptual frameworks discussed in Chapter 1. The researcher's reflections, as part of the reflexive TA approach, will be presented in Chapter 7 in order to highlight the active choices that were made during data analyses.

CHAPTER 4

LEADERSHIP CLIMATE AND LEADERSHIP DEVELOPMENT

4.1 INTRODUCTION

What is a leadership climate and why is it important to understand leadership development? A clear and methodical definition of climate, as viewed in climatology, has been proposed by Charlotte Werndl (2016). The most suitable definition for climate is "...the finite distribution over time under a certain regime of varying external conditions" (Werndl, 2016). Simplified, the definition states that climate is the spread of external conditions over a specific period. Fleishman (1953) stated that leadership climate refers to the existing leadership and their practices within an organisation (Fleishman, 1953). Leadership climate, from a translational perspective, can therefore be viewed as the conditions or setting instilled by leaders over time under a system of varying external conditions. Fleishman's report is considered one of the first studies on leadership climate. He examined the effects of a leadership training course for foremen. The study assessed the leadership attitudes and behaviours as viewed by foremen within the organisation after they have attended a leadership training course and returned to work (Fleishman, 1953). This was achieved through the completion of a survey questionnaire and evaluated the perceptions of the foreman's manager on leadership attitudes. Both data collection instruments subsequently evaluated the organisational climate (Fleishman, 1953). Unexpectedly, the results of the study showed that foremen who underwent the training demonstrated a significant lower score in their considerate behaviour compared to their untrained counterparts. The study also demonstrated that foremen with considerate bosses will be more prone to be considerate themselves. Fleishman concluded, for leadership training and development to be effective, reformation of the social environment is required (Fleishman, 1953).

Another definition for leadership climate was provided by James and Jones (1974). The authors define leadership climate as the individual perceptions of the workforce of their work environment (James and Jones, 1974). Their definition resonates more with that of an organisational climate as described by Ali *et al.*, (2018); the collective perception of an organisation's planned behaviours, activities, strategies and rewards (Ali *et al.*, 2018). This added dimension, i.e. organisational climate, highlights the potential dual nature of leadership climate. It is therefore dependent on the setting generated by the behaviours of leaders as well as the perceptions and actions of members of the organisation – thus the average weather phenomena and those experiencing it at the time and responding to it. Moreover, this holds true for

individuals who become cognisant of the practices and behaviours of leaders as exemplified by Fleishman's study in the previous section (Fleishman, 1953).

The leadership climate can have a deleterious effect on an organisation. In a study on the challenges of academic leaders in medical schools in Iran, the authors found the existence of a non-conducive leadership climate. Their findings demonstrated that the overall climate did not encourage mutual trust or respect and discouraged transparency (Bikmoradi *et al.*, 2010). The implementation of processes, procedures and policies that enact leadership within an organisation ultimately determines the climate of leadership (Day *et al.*, 2014). A positive leadership climate ensures the inclusion of others in the organisation's leadership actions (Souba *et al.*, 2007). The leadership climate can consequently serve to develop an organisation and its individuals in the same way that a tree adapts to a particular climate over time (Fig. 4.1). This holds true for medical schools and the growth mediated by the leadership climate will be explored.

Fig. 4.1. The effect of climate on growth and development. A windswept tree subjected over decades to the relentless South Easter at Seapoint in the Western Cape, South Africa.

The current chapter explored the perceptions of the participants regarding leadership in SSA medical schools. A 35-question-survey (Appendix III) was adopted from the work of Souba *et al.* (2007) and assessed the following climate dimensions (scales): participation (involvement), transparency (bilateral access to information), accountability (the casting of standards), alignment (linking strategy to vision),

collaboration, (interpersonal connections), constructive conflict (open to disagree), and open communication (being aware of problems).

An important premise to point out is that all the participants are viewed as leaders in their own right as explained in the previous chapter. These leaders might have been formally or informally appointed or elected and their leadership developed over time as a result of their actions when faced with various responsibilities (Kickul and Neuman, 2000). The interplay of climate in the development of leaders will be evaluated in this chapter.

4.2 DATA COLLECTION AND ANALYSES

A total of 45 individuals were approached to take part in this component of the study. The recruitment strategy entailed disclosing my (QW) intent to study the phenomenon at the CONSAMS conference in March 2018 in Windhoek, Namibia. This was also repeated during my CONSAMS conference call participation as representative of UNAM at the time. The participant information sheet was then distributed via electronic mail (e-mail) and contained the intent to conduct a survey and semi-structured interview. The documentation was also accompanied by a letter stating that ethical approval was obtained to conduct the study (Appendix I). Interested parties were then given the consent form and survey to complete. After receiving the completed forms, participants were sent a reminder of the interview (Chapter 5) and a date and time were subsequently scheduled.

A total of 29 surveys (64.5% response rate) were returned and 14 individuals committed to an interview (data presented in Chapter 5). Their academic positions and seniority as leaders included Deans (current and former, n = 3), a Deputy Dean (n = 1), a Programme Director (n = 1), Heads of Departments (HODs) (n = 8), Medical Educationalists (serving within a designated unit or department, n = 3) and Lecturers. The latter consisted of both clinical teaching staff (n = 13) and academic staff (n = 17) and ranged in seniority from lecturer to associate professor. Many of the participants fulfilled multiple roles as a lecturer (linked to the basic medical sciences), a departmental head and/or a clinical teaching position in the hospital. Any additional biographical information was excluded in the study in order to ensure anonymity of the participants. This was deemed extremely important due the disclosure of possible sensitive information, the small sample size and specificity of the participating institutions. Any additional biographical information could potentially be linked to an individual at an institution. Each CONSAMS institution received a code (Table 4.1) and this was done to ensure further anonymity in instances where there were only one or a few participants from a specific institution. The participant representation from each institution is presented in Table 4.1.

Table 4.1. The representation of participants per institution.

Institution	A	B	C	D	E	F	Total
Completed Surveys	1	8	3	1	15	1	29

Seven Likert scales with a set of five items per scale, thus a multi-item scale, were used to determine the leadership climate within the CONSAMS schools. Participant responses were captured through five response levels ranging from strongly disagree to strongly agree with a neutral central point. The perceptions of members of the mentor institutions (northern partners) were also collected. Here, the perceptions were captured that specifically relate to the CONSAMS medical schools and not their representative institutions. In other words, western partners were asked to provide a general view of each of the seven scales and how they perceive the collective of medical schools and thus provided an 'outsider's perspective'. It is important to note that the perspectives of the northern partner (institution F) are not included in the collective perceptions (diverging stacked bar charts) but are reflected in the tables below.

4.3 RESULTS

The first Likert scale measured perceptions on participation or involvement in leadership within each medical school (Souba *et al.*, 2007). The level of agreement and disagreement varied immensely between each of the institutions. The data captured for the participants reflect the various organisational cultures. It is for this reason that the data were presented for each institution as well. The sections that follow will thus present the data collectively in the form of diverging stacked bar charts and in table-format for response levels by institution.

The collective perceptions relating to participation (engagement) are presented in Fig.4.2. A total of 41.3% of the participants agreed (either agree = 37.9% [n = 11] or strongly agree = 3.4% [n = 1]) that leadership is the responsibility of only those at the top. Fourteen percent (13.8% [n = 4]) responded neutrally whilst 44.8% disagreed with the statement (disagree = 31% [n = 9] and strongly disagree = 13.8% [n = 4]) (Fig. 4.2). Not everyone (46.5%) felt encouraged to participate as leaders. Eighteen percent (17.9% [n = 5]) strongly disagreed whilst 28.6% disagreed that participation in leadership is encouraged. The same percentage (17.9% [n = 5]) responded neutrally. Thirty-six percent (35.7% [n =

10]) agreed to the statement (Fig. 4.2). Furthermore, the majority of the respondents (48.3%) disagreed that everyone can be a leader with 31.0% (n = 9) disagreeing and 17.2% (n = 5) strongly disagreeing. A total of 34.5% (n = 10) felt that everyone can be a leader with 13.8% (n = 4) strongly agreeing and 20.7% (n = 6) agreeing. Seventeen percent (17.2% [n = 5]) responded neutrally. Responses regarding the involvement in leadership process showed that 44.8% (n = 13) agreed with 3.4% (n = 1) strongly agreeing and 12 individuals (41.4%) agreeing. A total of 37.9% (n = 11) disagreed with 27.6% (n = 8) disagreeing and 10.3% (n = 3) strongly disagreeing. The percentage of neutral responses totalled 17.2% (n = 5). Finally, the data showed a strong agreement that leadership is widely shared. A total of 48.2% agreed that this is the case with 10.3% (n = 3) agreeing and 37.9% (n = 11) strongly agreeing. The percentage of neutral responses totalled 20.7% (n = 6). The levels of disagreement were 6.9% strongly disagree (n = 2) and 24.1% (n = 7) disagree (total disagreement = 29.0%) (Fig. 4.2).

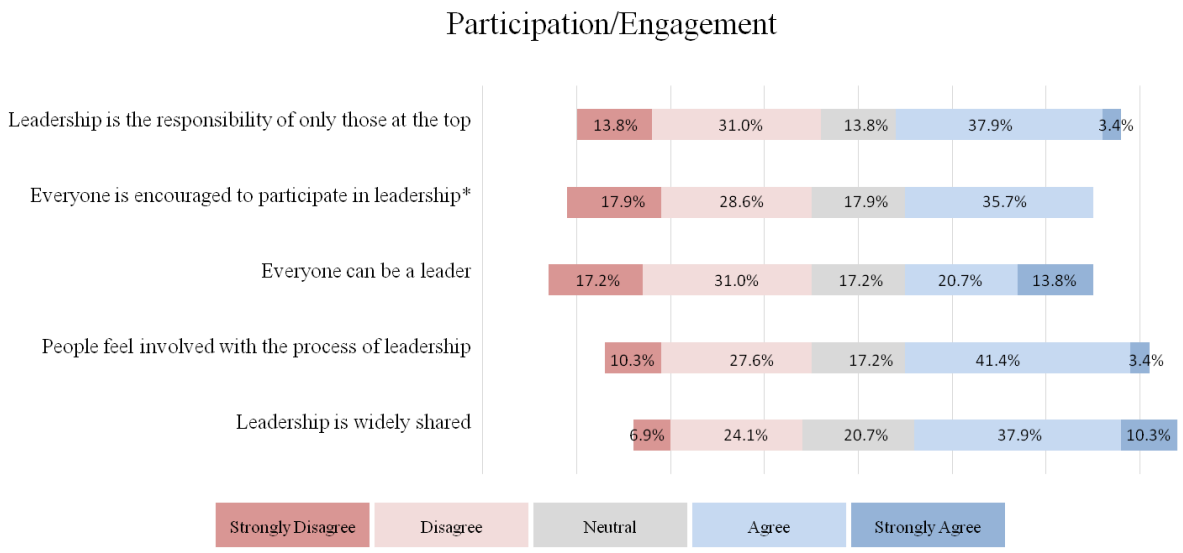

Fig. 4.2. The combined responses of all medical schools for the items assessing the leadership climate dimension of participation (*One respondent did not complete this question).

In summary, more respondents agreed that leadership is widely shared and that they felt involved in the process of leadership. Respondents overall disagreed that everyone can be a leader, that everyone is encouraged to be a leader, and that leadership is the responsibility of only those at the top.

The responses on engagement (participation) in leadership within each institution are presented in Table 4.2. Each institution appears to have its own leadership climate reflecting varying degrees of agreement and disagreement to the statements or questions. Of particular interest is that institution B where 62.5% disagreed that leadership is the responsibility of those at the top. Conversely, institution E showed that 53.3% agreed with the statement. Similarly, views on leadership participation varied greatly. Most institutions (A, B and D) agreed that everyone is encouraged to participate in leadership. Of importance

is that university B showed an overall 71.4% agreement (Table 4.2). Conversely, 60.0% of respondents from institution E disagreed with the statement and the only respondent from institution F also disagreed. Not everyone felt that anyone can be a leader. Individual responses from institutions B and C were either equally in agreement and disagreement (Table 4.2). Of interest is that the only respondents from instructions A, D and F disagreed with this statement. Forty percent (40%) of the volunteers from institution E agreed that everyone can be a leader whilst 46.7% disagreed. The majority of responses from institutions A (100%), B (75.0%) and D (100%) were in agreement that people felt involved with the process of leadership (Table 4.2). Respondents from C (66.6%) and E (60%) felt that they were not involved in the process of leadership. Finally, a similar level of agreement was shown for the statement that leadership was widely shared. Again, the majority of responses from institutions A (100%), B (75.0%) and D (100%) felt this to be the case.

Table 4.2. Participation or engagement as perceived by each medical school.

	Institution (n)	Strongly Disagree/ Disagree (%)	Neutral (%)	Agree/ Strongly Agree (%)
Leadership is the responsibility of only those at the top	A (1)	0%	100%	0/%
	B (8)	62.5%	12.5%	25.0%
	C (3)	33.3%	0%	66.6%
	D (1)	100%	0%	0%
	E (15)	33.3%	13.3%	53.3%
	F (1)	100%	0%	0%
Everyone is encouraged to participate in leadership	A (1)	0%	0%	100%
	B (7)*	28.6%	0%	71.4%
	C (3)	33.3%	66.6%	0%
	D (1)	0%	0%	100%
	E (15)	60.0%	13.3%	26.7%
	F (1)	100%	0%	0%
Everyone can be a leader	A (1)	100%	0%	0%
	B (8)	37.5%	25.0%	37.5%
	C (3)	33.3%	33.3%	33.3%
	D (1)	100%	0%	0%
	E (15)	46.7%	13.3%	40.0%
	F (1)	100%	0%	0%
People feel involved with the process of leadership	A (1)	0%	0%	100%
	B (8)	0%	25.0%	75.0%
	C (3)	66.6%	0%	33.3%
	D (1)	0%	0%	100%
	E (15)	60.0%	13.3%	26.7%

	F (1)	0%	100%	0%
Leadership is widely shared	A (1)	0%	0%	100%
	B (8)	0%	25%	75%
	C (3)	33.3%	33%	33%
	D (1)	0%	0%	100%
	E (15)	46.7%	20.0%	33.3%
	F (1)	100%	0%	0%

(*One respondent did not complete this question)

The dimension of transparency across all medical schools demonstrated variability in the responses of the participants (Fig. 4.3). A total of 13 respondents (44.8%) either agreed (34.5% [n = 10]) or strongly agreed (10.3% [n = 3]) that information is tightly held by those in power (Fig. 4.3). The majority of respondents (48.3% [n = 14]) disagreed, either disagreed (31.0%) or strongly disagreed (17.2%) that decisions are made in secret. Conversely, 51.7% (n = 15) of the respondents disagreed that decision making is transparent to those across all levels (Fig. 4.3). The number of respondents that were in agreement or neutral for this item were both 24.1% (n = 7). An equal number of respondents either agreed (44.8% [n = 13]) or disagreed (44.8% [n = 13]) that information is shared across departments.

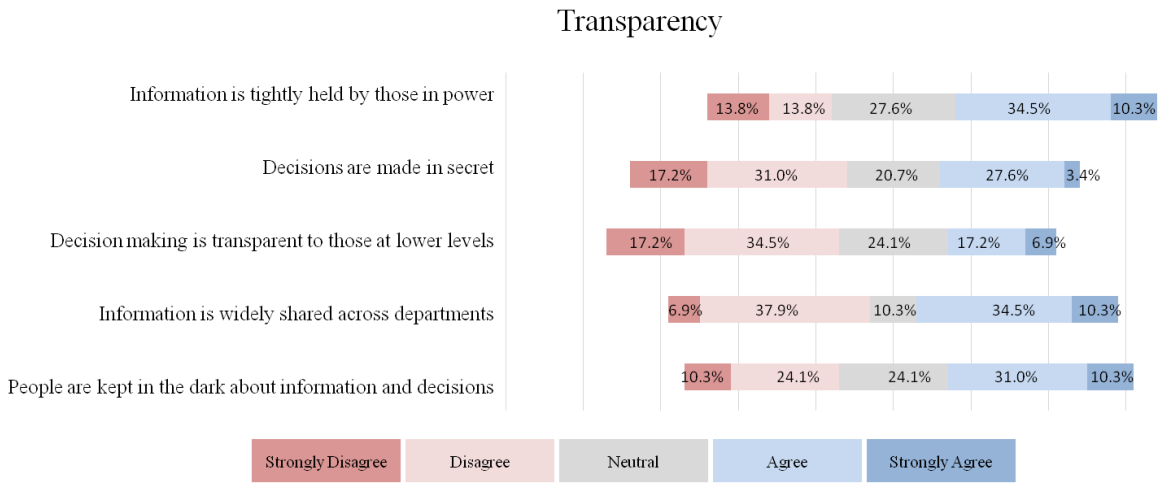

Fig. 4.3. The combined responses of all medical schools for the items assessing the climate dimension of transparency.

Forty-one percent (41.4%) of the participants (n = 12) agreed that people are kept in the dark about information and decisions. A total of 34.5% (n = 10) either disagreed or strongly disagreed and seven respondents (24.1%) neither agreed nor disagreed (neutral) to this statement (Fig. 4.2). Results from this domain indicate that the participants largely feel that there is a degree of transparency in the making of decisions but that some information is withheld from others by those in power.

The leadership climate dimension of transparency varied within each institution (Table 4.3). Respondents from institutions A, C and D (100%, 66.6% and 100% respectively) demonstrated disagreement with the statement that information is tightly held by those at the top. This was in contrast to individuals from institutions E and F where 73.3% and 100% respectively agreed that this was the case. Fifty percent (50.0%) of the individuals from institution B responded neutrally. Perceptions on decision making were similarly diverse. Individuals from two institutions, E (53.3%) and F (100%), agreed with the statement that decisions were made in secret (Table 4.3). Conversely, individuals from intuitions A (100%), B (62.5%) and C (66.6%) disagreed with this statement whilst the only respondent from institution D responded neutrally. The transparency of decision making at lower levels were neutrally viewed by the majority of respondents within institutions B, C and D. Within these institutions, the responses were either equally in agreement and disagreement (for B and C) or singularly neutral (D). The sharing of information was again perceived differently within each institution. Individuals from institutions A (100%), B (62.5%) and D (100%) generally agreed that information is widely shared across departments (Table 4.3). Respondents from institutions B (62.5%), C (66.6%) and D (100%) showed disagreement with the statement that people are kept in the dark about information and decisions. Sixty-seven percent (66.7%) of respondents from institution E agreed with this statement and so did the only respondent from institution A.

Table 4.3. The responses of each medical school for the items assessing the climate dimension of transparency.

	Institution (n)	Strongly Disagree/ Disagree	Neutral	Agree/ Strongly Agree
Information is tightly held by those in power	A (1)	100%	0%	0%
	B (8)	37.5%	50.0%	12.5%
	C (3)	66.6%	33.3%	0%
	D (1)	100%	0%	0%
	E (15)	13.3%	13.3%	73.3%
	F (1)	0%	0%	100%
Decisions are made in secret	A (1)	100%	0%	0%
	B (8)	62.5%	37.5%	0%
	C (3)	66.6%	33.3%	0%
	D (1)	0%	100%	0%
	E (15)	40.0%	6.7%	53.3%
	F (1)	0%	0%	100%
Decision making is transparent to those at lower levels	A (1)	0%	0%	100%
	B (8)	37.5%	25.0%	37.5%
	C (3)	33.3%	33.3%	33.3%

	D (1)	0%	100%	0%
	E (15)	66.7%	20.0%	13.3%
	F (1)	100%	0%	0%
Information is widely shared across departments	A (1)	0%	0%	100%
	B (8)	25.0%	12.5%	62.5%
	C (3)	66.6%	0%	33.3%
	D (1)	0%	0%	100%
	E (15)	53.3%	13.3%	33.3%
	F (1)	100%	0%	0%
People are kept in the dark about information and decisions	A (1)	0%	0%	100%
	B (8)	62.5%	37.5%	0%
	C (3)	66.6%	0%	33.3%
	D (1)	100%	0%	0%
	E (15)	13.3%	20.0%	66.7%
	F (1)	0%	100%	0%

The leadership climate dimension of accountability (Fig. 4.4) also demonstrated variability in the responses of the participants. The majority of respondents (58.6% [n = 17]) disagreed, either disagreed (37.9%) or strongly disagreed (20.7%) that poor performers are held accountable. This correlated well with the responses assessing whether poor performers are held accountable. Seventeen respondents (58.6% [n = 17]) either agreed (34.5% [n = 10]) or strongly agreed (24.1% [n = 7]) that people are not held accountable for their performance (Fig. 4.4). An equal number of respondents either agreed (44.8% [n = 13]) or disagreed (44.8% [n = 13]) that performance expectations are clear and 10.3% (n = 3) responded neutrally. The majority of respondents (55.2% [n = 16]) disagreed, either disagreed (37.9%) or strongly disagreed (17.2%) that leaders are held accountable for their performance. Interestingly, 44.8% (n = 13) of the participants either disagreed (37.9% [n = 11]) or strongly disagreed (6.9% [n = 2) that good performance in rewarded. The overall sentiment is that accountability is lacking within these institutions and that many of the respondents felt that good performance is not rewarded.

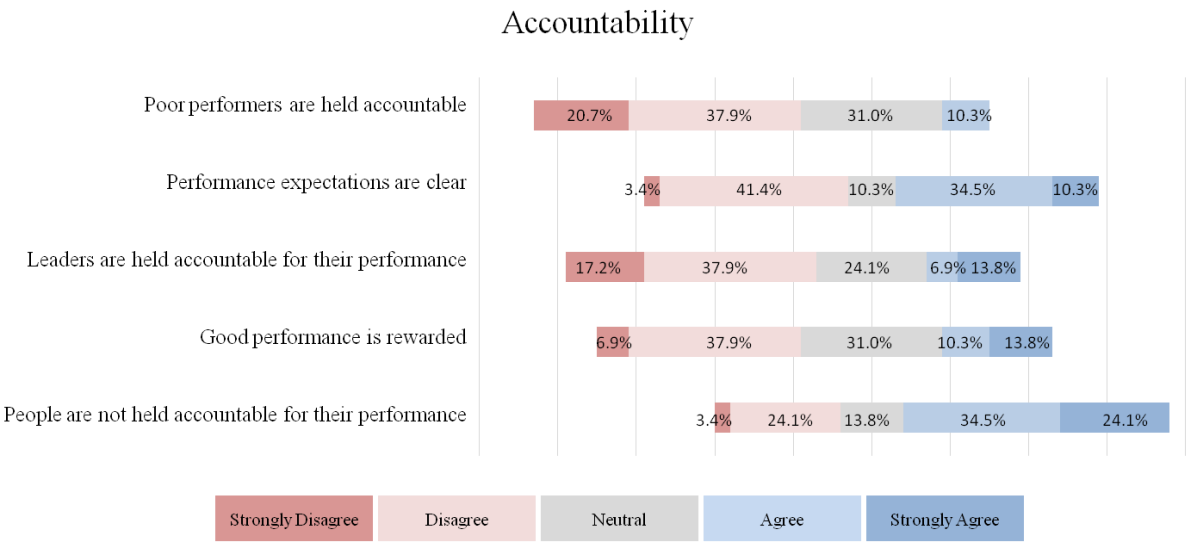

Fig. 4.4. The combined responses of all medical schools for the items assessing the climate dimension of accountability.

Institutional responses on accountability are presented in Table 4.4. Respondents from institutions C, D, E and F (66.6%, 100%, 66.7% and 100% respectively) demonstrated disagreement with the statement that poor performers are held accountable (Table 4.3). The majority of respondents felt that performance expectations, at their institutions, are clear; the levels of agreement were 100% (A), 62.5% (B), 66.6% (C) and 100% (D). Institution E was the outlier and 73.3% of the respondents disagreed that performance expectations are clear (Table 4.4). Respondents' also felt that leaders at their institutions, B (50%), C (66.6), E (60%) and F (100%), are not held to account for their performance. Two respondents, one from institution A and the other from D, agreed that leaders are held accountable. The perceptions of the participants also demonstrate that good performance is not always rewarded. This appears to be the case for institutions C (100%) and E (60%). The respondents from institutions A and F (one from each) agreed good performance is rewarded whilst individuals from B (50%) and D (100%) responded neutrally to the statement (Table 4.4). Perception on the accountability of individuals also varied between the institutions. Respondents from institutions A (100%) and B (62.5%) disagreed that people are not held accountable for their performance. However, the opposite was found at institutions C (66.6%), D (100%) and E (80%) were the participants agreed that people are not held to account for their performance.

Table 4.4. The responses of each medical school for the items assessing the climate dimension of accountability.

	Institution (n)	Strongly Disagree/ Disagree	Neutral	Agree/ Strongly Agree
Poor performers are held accountable	A (1)	0%	0%	100%
	B (8)	37.5%	37.5%	25.0%
	C (3)	66.6%	33.3%	0%
	D (1)	100%	0%	0%
	E (15)	66.7%	33.3%	0%
	F (1)	100%	0%	0%
Performance expectations are clear	A (1)	0%	0%	100%
	B (8)	12.5%	25.0%	62.5%
	C (3)	33.3%	0%	66.6%
	D (1)	0%	0%	100%
	E (15)	73.3%	0%	26.7%
	F (1)	0%	100%	0%
Leaders are held accountable for their performance	A (1)	0%	0%	100%
	B (8)	50.0%	37.5%	12.5%
	C (3)	66.6%	33.3%	0%
	D (1)	0%	0%	100%
	E (15)	60%	20%	20%
	F (1)	100%	0%	0%
Good performance is rewarded	A (1)	0%	0%	100%
	B (8)	12.5%	50.0%	37.5%
	C (3)	100%	0%	0%
	D (1)	0%	100%	0%
	E (15)	60%	26.7%	13.3%
	F (1)	0%	0%	100%
People are not held accountable for their performance	A (1)	100%	0%	0%
	B (8)	62.5%	12.5	25.0%
	C (3)	33.3%	0%	66.6%
	D (1)	0%	0%	100%
	E (15)	6.7%	13.3%	80.0%
	F (1)	0%	100%	0%

Results from the survey for the leadership climate dimension of alignment within the collective are presented in Figure 4.5. The most striking data set relates to the statement that physicians, scientists, educators and administrators share similar values. Fifty-five percent (55.2% [n = 16]) of the respondents disagreed, either disagreeing (41.4% [n = 12]) or strongly disagreeing (13.8% [n = 4]). In contrast, 44.8%

(n = 13) of the respondents agreed that values within their respective institution are aligned to meet educational needs whilst 31.0% (n = 9) responded neutrally and 24.1% (n = 7) disagreed. When asked - "What are we trying to accomplish here?" - forty-six (46.4% [n = 13] of the individuals responded neutrally and 28.6% (n = 8) indicated that a similar answer would be achieved, thus either agree (25.0%) or strongly agree (3.6%). Eleven respondents (37.9%) agreed that departments have their own agendas whilst 27.6 (n = 8) responded neutrally and 34.5% (n= 10) either disagreed (n = 9) or strongly disagreed (n = 1). Finally, the item assessing the alignment of missions between clinical, research and teaching staff indicated that 41.4% (n = 12) felt this not to be the case. Only 31.0% (n = 9) respondents felt that the missions of these three categories of interacting member were aligned and 27.6% (n = 8) responded neutrally (Fig.4.5). Overall, it appears that some misalignment of values and missions exists among scientists, researchers, clinicians and educators.

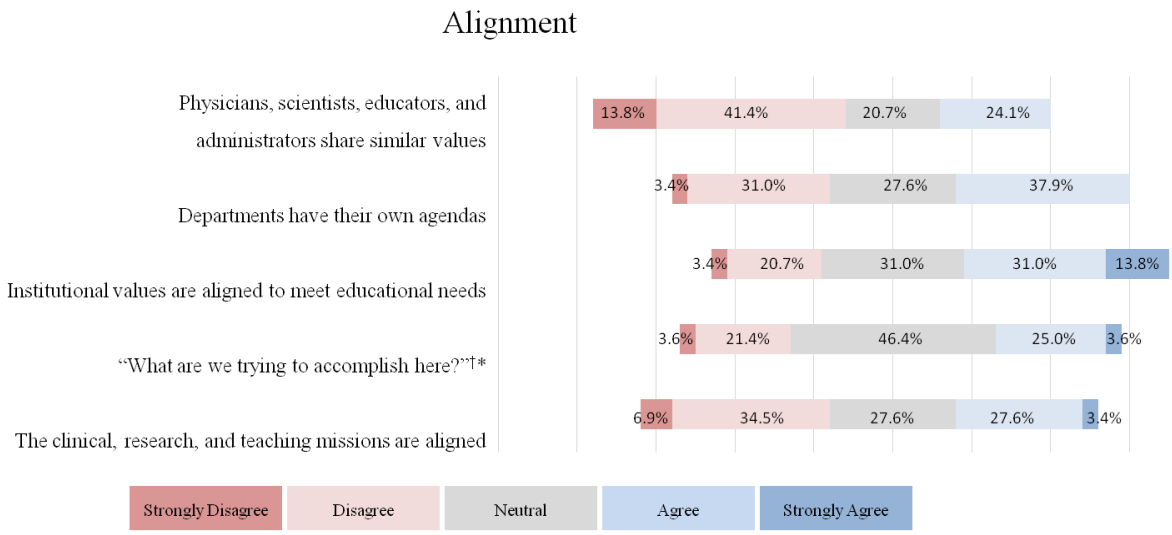

Fig. 4.5. The combined responses of all medical schools for the items assessing the climate dimension of transparency (*One respondent did not complete this question; †People from different parts of the organisation would give similar answers to the question, "What are we trying to accomplish here?").

Institutional responses on alignment are presented in Table 4.5. The data once again reflected the varying range of leadership climates within the institutions. The data show that respondents feel that similar vales are not shared among clinicians, scientists and educators within institutions B (50%), E (66.7%) and F (100%). The only respondent from institution A agreed that similar values are shared whilst the only individual from institution D responded neutrally (Table 4.5). The majority of respondents from institution B (62.5%) disagreed that departments had their own agendas. Conversely, participants from institutions D (100%), E (46.7%), and F (100%) agreed this to be the case. One participant, from

institution A, responded neutrally (Table 4.5). The responses to the statement assessing whether institutional values are aligned with the educational needs showed some agreement from institutions A (100%), B (37.5%), C (100%) and E (40%). However, the percentage of neutral responses from institution B (37.5%) was the same as the responses in agreement. The only respondent from institution F disagreed (Table 4.5). The institutions with the largest number of participants, B (n = 7) and E (n = 15), responded neutrally (B = 71.4% and E 46.7%) when asked from different parts of the organisation would give similar answers to the question, "what are we trying to accomplish here?" The only respondent from institution A also responded neutrally. The majority of participants from institutions C (66.6%) and D (100%) felt that that answers to this question would not be similar. The results thus reflect some levels on disagreement on the perceived overall goal at each institution (Table 4.5). The final aspect of alignment considered the perceptions on the association between the clinical, research, and teaching domains (Table 4.5). Fifty-three percent (53.3%) of the respondents from institution E disagreed that the clinical, research, and teaching missions are aligned. An equal percentage of respondents, from institution B, agreed (37.5%) with this statement compared to the neutral responses (37.5%). Additional neutral responses were observed at institutions C and D whilst the only respondent from Institution A agreed.

Table 4.5. The responses of each medical school for the items assessing the climate dimension of alignment.

	Institution (n)	Strongly Disagree/ Disagree	Neutral	Agree/ Strongly Agree
Physicians, scientists, educators, and administrators share similar values	A (1)	0%	0%	100%
	B (8)	50.0%	12.5%	37.5%
	C (3)	33.3%	33.3%	33.3%
	D (1)	0%	100%	0%
	E (15)	66.7%	20.0%	13.3%
	F (1)	100%	0%	0%
Departments have their own agendas	A (1)	0%	100%	0%
	B (8)	62.5%	25.0%	12.5%
	C (3)	33.3%	33.3%	33.3%
	D (1)	0%	0%	100%
	E (15)	13.3%	33.3%	46.7%
	F (1)	0%	0%	100%
Institutional values are aligned to meet educational needs	A (1)	0%	0%	100%
	B (8)	25.0%	37.5%	37.5%
	C (3)	0%	0%	100%
	D (1)	0%	100%	0%
	E (15)	26.7%	33.3%	40.0%

	F (1)	100%	0%	0%
People from different parts of the organisation would give similar answers to the question, "What are we trying to accomplish here?"	A (1)	0%	100%	0%
	B (7)*	0%	71.4%	28.6%
	C (3)	66.6%	0%	33.3%
	D (1)	100%	0%	0%
	E (15)	26.7%	46.7%	26.7%
	F (1)	0%	0%	100%
The clinical, research, and teaching missions are aligned	A (1)	0%	0%	100%
	B (8)	25%	37.5%	37.5%
	C (3)	33.3%	33.3%	33.3%
	D (1)	0%	100%	0%
	E (15)	53.3%	20.0%	26.7%
	F (1)	100%	0%	0%

(* One respondent did not complete this question)

Teamwork, as assessed under scale of collaboration, appears to be a challenge within the collective (Fig. 4.6). Respondents generally disagreed by 41.4% (31.0% disagree and 10.3% strongly disagree) to the statement that teamwork is practiced widely. The neutral responses to this statement equalled 37.9% (n = 11) and only 20.7% (n = 1) agreed that this was the case. The majority of respondents (65.5% [n = 19]) disagreed, either disagreed (48.3% [n = 14]) or strongly disagreed (17.2% [n = 5]), that basic scientists and clinicians collaborate productively Fig. 4.6). A strong level of neutrality (58.6% [n = 17]) was observed when participants were asked to respond to the statement that competition is the *status quo* between departments. Here, only 10.3% (n = 3) agreed and 31.0% (n = 9) disagreed (Fig. 4.6).

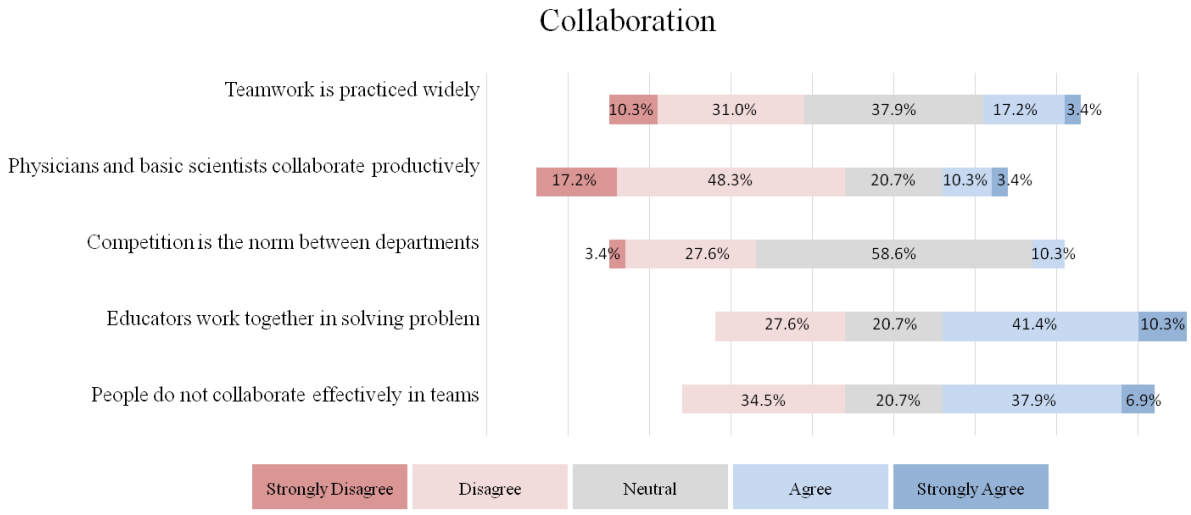

Fig. 4.6. The combined responses of all medical schools for the items assessing the climate dimension of collaboration.

Collaboration among educators to solve problems received a high level of agreement with 41.4% (n = 12) agreeing and 10.3% (n = 3) strongly agreeing. Twenty-eight percent (27.6% [n =8]) disagreed that educators work together to solve problems. Many respondents felt that people do not work together effectively in teams (44.8% [n = 13]). A total of 10 individuals (34.5%) disagreed with this statement. The data from this domain demonstrate the general view within the collective is that educators work effectively together whilst collaboration between clinicians and non-clinicians appears to be lacking.

Institutional responses on collaboration are presented in Table 4.6. Teamwork appears to be practiced widely within institution B with 50.0% of the participants agreeing with the statement. However, an equal percentage of respondents, from institution B, disagreed (25.0%) with this statement compared to the neutral responses (25.0%). The majority of participants from institution E (53.3%) disagreed that teamwork is practiced widely. Similarly, 73.3% of respondents from institution E disagreed with the statement that clinical staff and scientists collaborate productively. The same sentiment was shared by the only respondent from institution F. Collaboration between physicians and basic scientists also appears to be a challenge at institution B with a 62.5% response rate. Interdepartmental competition was identified from the only respondent from institution D and F. Respondents from institution B (62.5%) disagreed that there exists competition between departments whilst participants from institutions C (66.6%) and E (80.0%) responded neutrally (Table 4.6). Data show that educators work together in solving problems and there were high response rates at institutions A (100%), B (75%), C (100%) and D (100%). The same perceptions were not shared at institution E where 46.7% disagreed. Finally, effective collaboration appears to be a challenge for institutions A (100%), E (53.3%) and F (100%). Sixty-three percent (62.5%) of the participants from institution B disagreed that people do not collaborate effectively in teams.

Table 4.6. The responses of each medical school for the items assessing the climate dimension of collaboration.

	Institution (n)	Strongly Disagree/ Disagree	Neutral	Agree/ Strongly Agree
Teamwork is practiced widely	A (1)	0%	0%	100%
	B (8)	25.0%	25.0%	50.0%
	C (3)	33.3%	33.3%	33.3%
	D (1)	0%	100%	0%
	E (15)	53.3%	46.7%	0%
	F (1)	100%	0%	0%
Physicians and basic scientists collaborate productively	A (1)	0%	0%	100%
	B (8)	62.5%	37.5%	0%
	C (3)	33.3%	33.3%	33.3%

	D (1)	100%	0%	0%
	E (15)	73.3%	13.3%	13.3%
	F (1)	100%	0%	0%
Competition is the norm between departments	A (1)	100%	0%	0%
	B (8)	62.5%	37.5%	0%
	C (3)	33.3%	66.6%	0%
	D (1)	0%	0%	100%
	E (15)	13.3%	80.0%	6.7%
	F (1)	0%	0%	100%
Educators work together in solving problems	A (1)	0%	0%	100%
	B (8)	12.5%	12.5%	75.0%
	C (3)	0%	0%	100%
	D (1)	0%	0%	100%
	E (15)	46.7%	26.7%	26.7%
	F (1)	0%	100%	0%
People do not collaborate effectively in teams	A (1)	0%	0%	100%
	B (8)	62.5%	12.5%	25.0%
	C (3)	33.3%	33.3%	33.3%
	D (1)	0%	100%	0%
	E (15)	26.7%	20.0%	53.3%
	F (1)	0%	0%	100%

The collective view presented on constructive conflict (Fig. 4.7) is that there seems to be a lack of appreciation for the value of conflict and debate. A total of 58.6% (n = 17) disagreed (55.2% disagree and 2.4% strongly disagree) with the statement that people understand that debate and conflict create better ideas. Only 31.0% (n = 9) agreed and 10.3% responded neutrally (n = 3). Despite the perceived lack of understanding of the value of constructive conflict, 44.8% (n = 13) respondents agreed that people feel comfortable to disagree over key issues. Thirty-one percent (27.6% [n = 8] disagree and 2.4% [n = 1] strongly disagree) disagreed and did not feel open to disagreeing with others when discussing important subjects and 24.1% responded neutrally. Results show that 44.8% feel that constructive conflict is not permitted. Twelve respondents (41.4%) agreed and one (3.4%) strongly agreed that this was not tolerated, whilst 27.6% responded neutrally (Fig 4.7). Similar perceptions were revealed when the same statement was asked differently and in a positive light. In this instance, 48.3% of the respondents disagreed (44.8% [n = 13] disagreeing and 3.4% [n = 1] strongly disagreeing) that constructive conflict is welcomed and motivated. A total of 34.5% (n = 10) responded neutrally. Surprisingly, 51.7% agreed that junior members of staff can question their superiors on major topics.

The findings from the constructive conflict scales indicate that the value of debate and constructive conflict is not appreciated within the collective but subordinates can question their seniors.

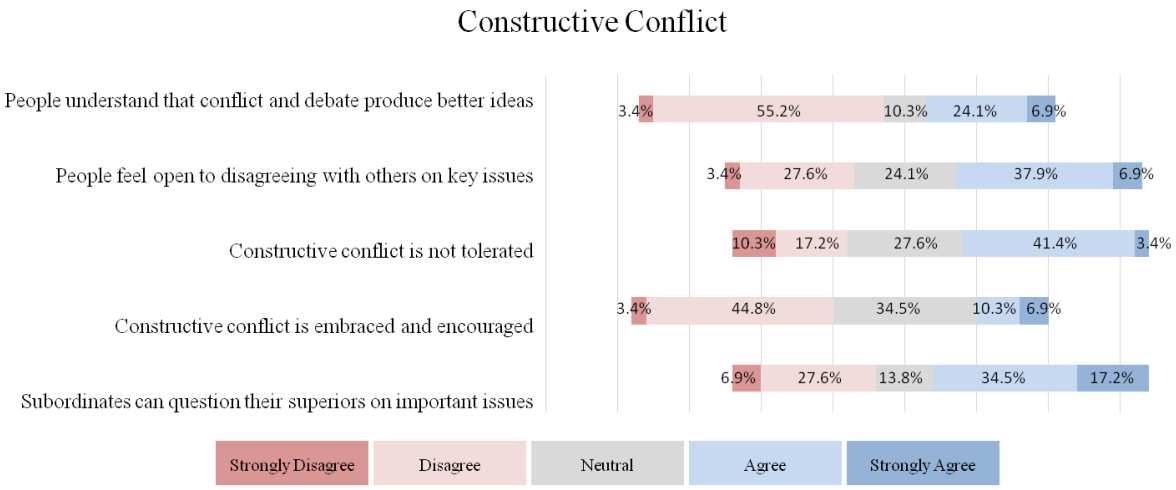

Fig. 4.7. The combined responses of all medical schools for the items assessing the climate dimension of constructive conflict.

Institutional responses on constructive conflict are presented in Table 4.7. The data suggests that that is a lack of understanding of the value of conflict and debate to produce better ideas. This appears to be the case for institutions C (66.6%), D (100%), E (66.7%) and F (100%) (Table 4.7). The outlier in this instance was institution B where 50.0% of the respondents agreed that conflict and debate produce better ideas. The only respondent from institution A also agreed with this statement. Perceptions on openness to disagree on key issues varied with 75.0% of participants from institution B agreeing that this was the case. By contrast, the majority of participants from institution E disagreed that people feel open to disagreeing (Table 4.7). Perceptions to the scales on the tolerance and acceptance of constructive conflict also varied between the institutions. Sixty percent (60.0%) of the respondents from institution E felt that Constructive conflict is not tolerated. The only respondent from institution F also agreed to this statement. An equal percentage of respondents, from institution B, disagreed (37.5%) with this statement compared to the neutral responses (37.5%) (Table 4.7). Furthermore, the majority of respondents from institutions B (50.0%), E (53.3%) and F (100%) disagreed that constructive conflict is not tolerated. The only agreement towards this statement came from the respondent from institution A whilst participants from institutions C (66.6%) and D (100%) responded neutrally. Finally, 62.5% of the

participants from institution B felt that subordinates can question their superiors on important issues. The majority of respondents from institutions C (66.6%) and E (46.7%) disagreed that this was the case.

Table 4.7. The responses of each medical school for the items assessing the climate dimension of constructive conflict.

	Institution (n)	Strongly Disagree/ Disagree	Neutral	Agree/ Strongly Agree
People understand that conflict and debate produce better ideas	A (1)	0%	0%	100%
	B (8)	37.5%	12.5%	50.0%
	C (3)	66.6%	0%	33.3%
	D (1)	100%	0%	0%
	E (15)	66.7%	13.3%	20.0%
	F (1)	100%	0%	0%
People feel open to disagreeing with others on key issues	A (1)	0%	100%	0%
	B (8)	0%	25.0%	75.0%
	C (3)	33.3%	33.3%	33.3%
	D (1)	0%	0%	100%
	E (15)	53.3%	13.3%	33.3%
	F (1)	0%	100%	0%
Constructive conflict is not tolerated	A (1)	0%	100%	0%
	B (8)	37.5%	37.5%	25.0%
	C (3)	66.6%	0%	33.3%
	D (1)	0%	100%	0%
	E (15)	20.0%	20.0%	60.0%
	F (1)	0%	0%	100%
Constructive conflict is embraced and encouraged	A (1)	0%	0%	100%
	B (8)	50.0%	25.0%	25.0%
	C (3)	33.3%	66.6%	0%
	D (1)	0%	100%	0%
	E (15)	53.3%	33.3%	13.3%
	F (1)	100%	0%	0%
Subordinates can question their superiors on important issues	A (1)	0%	0%	100%
	B (8)	12.5%	25.0%	62.5%
	C (3)	66.6%	0%	33.3%
	D (1)	0%	0%	100%
	E (15)	46.7%	13.3%	40.0%
	F (1)	0%	0%	100%

The final leadership climate domain that was assessed relates to open communication (Fig. 4.8). Forty-five percent (44.8%) (37.9% [n = 11] disagree and 6.9% [n = 2] strongly disagree) disagreed that open communication is valued whilst 31.0% of individuals agreed and 24.1% responded neutrally. Perceptions whether open and frank communication is standard practice revealed that an equal number of respondents disagreed (41.4%) with this statement compared to the neutral responses (41.4%). Only 17.2% (13.8% [n = 4] agree and 3.4% [n = 1] strongly agree) felt that open and frank communication is the norm. When asked to respond to the statement that people do not communicate openly, 41.4% (n = 12) of the respondents agreed (37.9% [n = 11] agree and 3.4% [n = 1] strongly agree); thirty-one percent responded neutrally. Some individuals (31.0%) felt that communication is driven by hidden agendas but more respondents (44.8%) disagreed with this statement. Finally, results show that 37.9% of respondents disagreed that people provide honest feedback to others. Only 20.7% agreed (17.2% [n = 5] agree and 3.4% [n = 1] strongly agree) whilst the majority (41.4% [n = 12]) responded neutrally. In general, the responses suggest that open communication within the medical schools is somewhat of a problem.

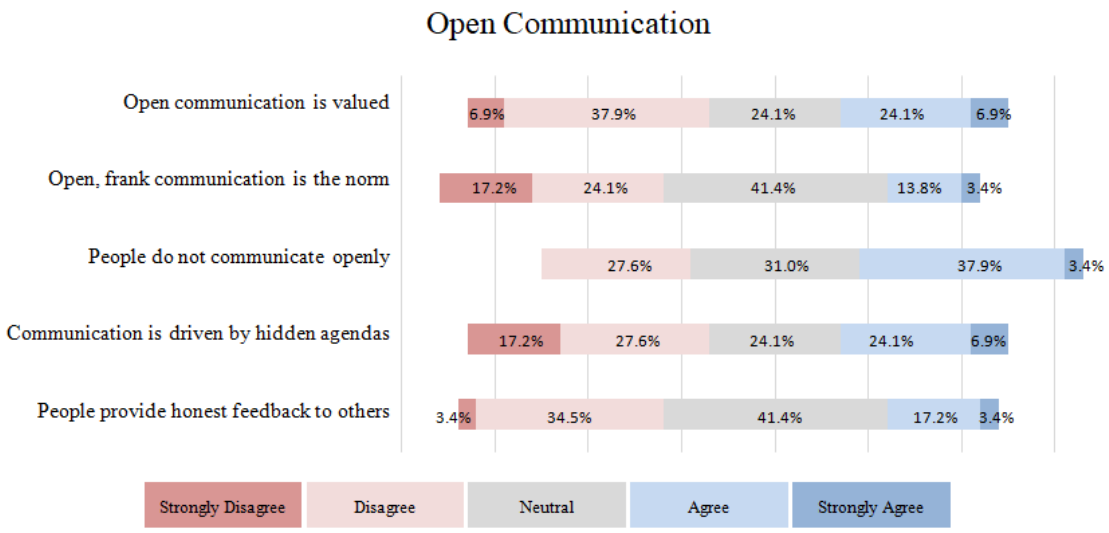

Fig. 4.8. The combined responses of all medical schools for the items assessing the climate dimension of open communication.

The institutional responses on communication are presented in Table 4.8. Perceptions on whether open communication is valued varied between the institutions. For instance, respondents from institutions E (66.7%) and F (100%) disagreed whilst respondents from institutions A (100%) and D (100%) agreed. Fifty percent (50.0%) of the respondents from institution B responded neutrally. Similar levels of agreement were seen on open and free communication. Respondents from institutions E (60.0%) and F

(100%) disagreed that open and frank communication is common practice. Sixty-three percent (62.5%) of respondents from institution B responded neutrally and so did the only respondent from institution D. Furthermore, the majority of respondents from institutions C (66.6%), E (60.0%) and F (100%) agreed that people do not communicate openly (Table 4.8). Sixty-three percent (62.5%) of the respondents from institution B disagreed with this statement. Of interest is that the majority of participants from institution E (53.3%) felt that communication is driven by hidden agendas. The only participant from institution F also agreed with this statement. Conversely, 75.0% of participants from intuition B disagreed that communication is driven by hidden agendas. Participants from intuition C (66.6%) responded neutrally and so did the only participant from institution D. The data suggests that healthy levels of communication exist within institution B whilst this appears not to be the case for institution E.

Table 4.8. The responses of each medical school for the items assessing the climate dimension of open communication.

	Institution (n)	Strongly Disagree/ Disagree	Neutral	Agree/ Strongly Agree
Open communication is valued	A (1)	0%	0%	100%
	B (8)	12.5%	50.0%	37.5%
	C (3)	33.3%	33.3%	33.3%
	D (1)	0%	0%	100%
	E (15)	66.7%	13.3%	20.0%
	F (1)	100%	0%	0%
Open, frank communication is the norm	A (1)	0%	0%	100%
	B (8)	12.5%	62.5%	25.0%
	C (3)	33.3%	33.3%	33.3%
	D (1)	0%	100%	0%
	E (15)	60.0%	33.3%	6.7%
	F (1)	100%	0%	0%
People do not communicate openly	A (1)	0%	100%	0%
	B (8)	62.5%	37.5%	0%
	C (3)	0%	33.3%	66.6%
	D (1)	100%	0%	0%
	E (15)	13.3%	26.7%	60.0%
	F (1)	0%	0%	100%
Communication is driven by hidden agendas	A (1)	100%	0%	0%
	B (8)	75.0%	25.0%	0%
	C (3)	33.3%	66.6%	0%
	D (1)	0%	100%	0%

	E (15)	33.3%	13.3%	53.3%
	F (1)	0%	0%	100%
People provide honest feedback to others	A (1)	0%	0%	100%
	B (8)	12.5%	50.0%	37.5%
	C (3)	66.6%	33.3%	0%
	D (1)	0%	100%	0%
	E (15)	53.3%	33.3%	13.3%
	F (1)	0%	100%	0%

4.4 SUMMARY

The current chapter aimed to assess the perceptions of members of the CONSAMS medical schools of the leadership climate in their institutions. Firstly, participants' perceptions were collectively viewed to gain insights on the overall climate within new medical schools. Secondly, each climate scale was then viewed to gain an understanding of the perceptions within each institution. This chapter, in part, elucidates the leadership experiences of the collective (CONSAMS) and the individuals within each institution.

Some of the aspects that were gauged by the survey were perceptions rated to "what is wrong" and "what can change" within each institution. These perceptions can tell us about the climate dimensions that require change and the leadership values of the participants. An example to the assessment of values relates to participants' perceptions that everyone can be a leader. As a collective, respondents overall disagreed with this statement. However, responses from two institutions (C and E) indicated that the majority of respondents agreed. This is suggestive of organisational hierarchies and the possible impact of the resultant verticalness.

Institution B stood out when the climate dimension of participation was assessed. The level of agreement to the statement "everyone is encouraged to participate in leadership", reverberates the statement that "participation is learning" (Eichbaum, 2017a). Participatory learning is situated and dependent on the social context within which it occurs (Sfard, 1998). Leaders and institutional leadership are provided with the opportunity to grow through participation. The majority of participants from institution E disagreed with this statement. Similar findings were observed to the affirming statement "people feel involved with the process of leadership". Here, the level of agreement from institution B was again high. The levels of disagreement associated with institutions C and E were in contrast also higher. As a collective, the sum of all responses indicates a larger level of disagreement to the statement that everyone is encouraged to participate in leadership.

Results from responses from the domain of transparency, the bilateral access to information (Souba *et al.*, 2007), indicate that the participants largely felt that there is a degree of transparency in the making of decisions. However, the data also suggest that some information is withheld from others by those in power. The flow of information within institution B appears to be favourable with high levels of agreement. Furthermore, participants from this institution indicated that they are not kept in the dark and decisions are not made in secret. Of interest is that responses related to institutions C and E present a contrasting picture.

The overall sentiment within the medical schools show that accountability is lacking within these institutions and that many of the respondents felt that good performance is not rewarded. Furthermore, views from the collective demonstrate that people are not held accountable for their performance. Upon further investigation it became apparent that the collective sentiment relates to leaders within the medical schools in institutions B, C and E. Furthermore, perceptions of the outsider-looking-in (one participant from institution F and a northern-partner) shared the same response. The perceptions from institutions C and E further indicate that people in general are not held accountable and good performance is not rewarded. Of interest is that both B and C largely agreed that performance expectations are clear within their institutions.

Findings from the survey of the current study are suggestive of a collective misalignment between the values of clinicians, scientists and health professions educators. This misalignment also became apparent at an institutional level as demonstrated by the responses from B and E. Data from the domain of collaboration suggest that educators work effectively together whilst collaboration between clinicians and non-clinicians appears to be lacking. Collaboration among educators to solve problems received a high level of agreement. Conversely, the combined responses from all the institutions point towards physicians and basic scientists not collaborating productively.

Findings from the constructive conflict scale indicate that the value of debate and constructive conflict is not appreciated within the collective however; it appears that subordinates can question their superiors. Data from the final leadership climate domain of communication suggest that open communication within the medical schools is something of a problem. One of the parameters of a healthy leadership climate is the opportunity to voice opinions. The ability to resolve conflict enables cooperation and facilitates learning (Souba *et al.*, 2007).

The findings suggest that constructive conflict is not always embraced and encouraged. In some instances, it appears that constructive conflict is not tolerated at all and that people do not have the liberty

to disagree on key issues. Finally, data suggests that healthy levels of open communication exist within some institutions but are lacking in others.

In summary, the findings from the surveys reflect different organisational cultures at the various schools. Each institution appears to have its own leadership climate reflecting varying degrees of agreement and disagreement to the statements or questions that relate to participation. Perceptions on decision-making were similarly diverse with a degree of transparency and information sharing at some institutions but not at others. The results reflect some levels of disagreement on the perceived overall goal at each institution. The missions within the domains of clinical medicine, research, and teaching appear to be misaligned at some institutions. Collaboration between clinical staff and scientists stood out as a challenge within most institutions.

The diversity of the leadership climates within each institution is reflected by the findings. However, this does not represent the entirety and nature of leadership and its development. The findings presented justify the need for a qualitative approach and sets the stage for an in-depth approach as presented in Chapter 5. A further limitation is the small sample size (n = 29) and skewed institutional representation, with one institution having 15 participants and others represented by only one individual, which hampered statistical analyses. Categorical analyses of the responses of educators, clinicians and scientists were not feasible due the multiple roles of an individual within a particular institution. Best practices were to gain a generalised view of the perceptions of the collective and the perceptions of individuals within each institution.

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CHAPTER 5

LEADERSHIP DEVELOPMENT AND THE FORCES AT PLAY

5.1 INTRODUCTION

The aim of this chapter is to explore how leadership develops and understand the various forces that are at play within each institution. Critical studies on leadership development and how leaders negotiate their identities have gained much ground during the past decade (Nicholson and Carroll, 2013; Carroll and Nicholson, 2014; Kjellström *et al.*, 2020). Health professions educators are faced with a wide range of responsibilities that include facilitating students' learning, curriculum design and revision, student assessment, and management. The latter comprise management of departments, teams and programmes (McKimm and Lieff, 2013). Furthermore, health professions educators are also involved in leadership and management activities within the context of clinical services. The roles of medical education leaders, according to McKimm and Lieff (2013), are played out in complex environments and across boundaries. Medical education leadership extends beyond higher education to the communities and health services. Leadership is faced with many uncertainties and requires constant appraisal and reconfiguration (McKimm and Lieff, 2013). Medical education leaders are required to act and learn through experimentation (Snowden and Boone, 2007). When leading change in education, leaders never follow a checklist but are faced with complexity (Fullan, 2002).

The leadership practices of medical education leaders, according to Lieff and Albert (2012), fall into four domains namely, systemic, organisational, interpersonal and intrapersonal. The intrapersonal domain relates to a leader's ability to serve as a role model and to communicate effectively (Lieff and Albert, 2012). This resonates with the biographical domain of Samuel (2008) which includes the cultural, ethnic and religious background of a leader (Samuel, 2008). These factors are known to have an influence on the behaviours and practices of leaders within an organisation (Weick, 1995; Hage and Posner, 2015; Gaitho, 2019). The interpersonal domain of Lieff and Albert speaks to a leader's ability to value relationships and seek support (Lieff and Albert, 2012). This relates to the social intelligence of a leader and reflects the acumen of the leader to decode the motives and intentions of others (Aditya and House, 2002; Dickson *et al.*, 2003). The interpersonal domain in turn correlates with the programmatic domain of Samuel (2008) and the forces at play relate to the practices within the pedagogical environment (Samuel, 2008). The organisational domain of Lieff and Albert captures the leadership strategies that facilitate organisational change. It also relates to the generation of a shared vision, planning and the management of resources (Lieff and Albert, 2012). The principal business of any

medical school is the provision of clinical education and services (Burrows and Laupland, 2021). Fundamentally, this encompasses the institutional domain of Samuel's force field model. This domain considers the micro-contextual factors that relate to the institutional culture and values aimed at quality education (Samuel, 2008). Finally, the contextual forces (Samuel) speak to the systemic domain of Lieff and Albert. This domain relates to the strategic navigation of the macro-environment. This domain also relates to the development of networks and being aware of the political milieu (Lieff and Albert, 2012). It is within this domain that the various stakeholders come into play.

New medical schools, like those currently within SSA, are faced with intimidating challenges (Eichbaum *et al.*, 2015a). The four domains as outlined above require careful and strategic navigation by leaders, both emergent and appointed, within their respective institutions. The challenges faced by new medical schools appear to be over simplified. Many leaders lack formal training in medical education leadership, especially related to the principles of learning and teaching and performing tasks with a medical school (Tandeter *et al.*, 2014; Algahtani *et al.*, 2020). The roles and interplay between educators, their institutions, local governments, professional bodies, students and the communities require further scrutiny. These interactions play a major role in the leadership development or growth of leaders within new medical schools in Africa. The assertion throughout this chapter is that effective leaders are required to manage in the same way that managers are required to lead (McKimm and Lieff, 2013). Managers are therefore considered to be leaders within the current study.

5.2 DATA COLLECTION AND ANALYSES

A total of 45 individuals were approached to participate and 11 individuals (24.4% response rate), seven males and four females, agreed to be interviewed. Interviews were conducted through Skype (Skype Technologies, Microsoft) and digitally recorded through the application's platform. Interviews were only conducted after receiving a signed consent form and participants were then asked whether they agreed to the digital recording at the onset of the interview. The interviews were conducted between May 2018 and September 2019. One of the recorded interviews was not used due to inaudibility of the interview (Table 5.1). The recordings were transcribed (On Time Transcribers, Cape Town, South Africa). The participants included one Dean and one former Dean, a Deputy Dean, one Associate Dean, two Programme Directors (PDs), and lecturing staff. The latter varied in seniority from lecturer (n = 1), senior lecturer (n = 1) to associate professor (n = 2). Again, many of the participants fulfilled multiple roles as a lecturer (linked to a medical science), a departmental head and a clinical teaching position in the hospital.

Table 5.1. The institutional representation and participant interviews.

Institution	A*	B	C	D	E	F	Total
Interview qty.	1	1	3	1	4	1	11

* This interview was not used due to sound quality issues.

The codes generated from the transcripts were viewed as fragments of a whole and expressive labels. These labels, both latent and on the surface, were then evaluated in context and used to generate themes and subthemes or central organising connections. The generated themes and subthemes are presented in this chapter rather than domain summaries that focus on the semi-structured interview questions (Braun and Clarke, 2006 and 2019). This ensured that patterns and meanings were presented instead of participants' responses and followed an inductive approach. It is believed that this ensured richness and crystallised the true nature of leadership development of both appointed and emergent leaders. Finally, my perceptions as a participant researcher were also captured.

5.3 FINDINGS

A total of 11 interviews were conducted of which 10 were used. One interview was excluded due to inaudibility of the recording. The interview process commenced in May 2018 and the final interview occurred in June 2019. The duration of the interviews ranged from 27.3 minutes to 68.6 minutes (Table 5.2).

Table 5.2. The interviews and their duration.

Interview #	Alias (Sex)	Duration (min)	Institution
1	B1 (F)	44.0	B
2	C1 (M)	27.5	C
3	C2 (F)	68.6	C
4	C3 (M)	27.5	C
5	D1 (M)	38.3	D
6	E1 (F)	55.1	E
7	E2 (M)	54.3	E
8	E3 (M)	62.0	E
9	E4 (F)	30.5	E
10	F1 (M)	53.2	F

The sections that follow will present the within-case themes and subthemes and this will be followed by the cross-case themes that were generated. These themes that were generated, within-case analyses (Phase I), were used to elucidate the cross-case themes. The integration of the data during the second phase, i.e. across the cases, relied on further expansion, condensing, and merging of the within-case themes (Miles and Huberman, 1994; Yin, 2003). The across-case TA required a second round of scrutiny of the identified cross-case themes of the within-case themes. The themes and subthemes of Phase I were generated through several iterations. The process entailed an initial collaborative effort between the researcher (QW) and supervisor (SR) reading through three interview transcripts and then discussing the themes and subthemes. This was repeated three times for the first three interviews in order to steer the reflexive TA to answer the question: "What is the leader trying to tell me?" The process of generating themes was reflexive whilst aiming to stay true to the context in which the interviewees responded. Again, as with the previous chapter, the discussion of the results will be addressed in the final chapter. Finally, the titles of the sections include verbatim labels of the themes that were generated in order to retain authenticity.

5.3. WITHIN-CASE ANALYSIS

5.3.1 Interviewee B1: "Being able to lobby"

Interviewee B1 had to get her "feet and hands wet" when she was involved in starting their medical school. The medical school had its origins in an industrial building and the leadership at the time had to obtain "...institution buy-in" as well as that of other stakeholders such as "…the government there, the funders". Stakeholder buy-in into the vision of the medical school was deemed important. However, not everyone supported the start of a medical school. The interviewee stated that there were individuals who felt that they "...can't even have a medical [school]".and "…it's not going to work" and others "...said it's not necessary to have a teaching hospital" (Table 5.3). She refers to "hindrances", more specifically "little blockades" when mentioning the development of the problem-based curriculum and decentralising from the paradigms of the rest of the university. Of importance here is that the interviewee does not use the word challenges or massive hurdles but rather sees small bumps in the road.

The implementation of medical education principles stood out from the interview and the interviewee noted that capacity in medical education "...has to come with passion, it has to come with the knowledge and the ownership of medical education ethos of how you teach". Her prior experiences shaped her and she stated that "...a lot of passion, through medical education principles, have been injected into me to realise and appreciate that some things are key and very necessary, and what is learning" (Table 5.3).

A leader, as viewed by the interviewee, needs to lobby for the needs of medical school. She stated that "...someone needs to be able to lobby through the Ministry of Education, through the Ministry of Health and sometimes when it comes to be, things become very tight". She came to realise that this influence or persuasion is needed to get things done. The national health agenda, urgency of establishing a medical school and pride further drove her. Initially they experienced staffing issues but managed to recruit both biomedical scientists and a clinical staff complement. What stood out from the interview was the importance of programme directors for the problem-based learning (PBL) curriculum as well as obtaining "local" leadership which understands the local "context" and associated "politics". "Individuals coming from elsewhere...", not local, were initially employed in leadership positions (Table 5.3). She agrees that these leadership positions are political in nature and you need someone local to petition at higher levels with knowledge of the local setting.

Table 5.3. The themes, subthemes and code examples generated from the interview of B1.

Themes	Subthemes	Code Examples (Quotes)
Being able to Lobby	Hindrances	*Individuals coming from elsewhere*
		So behind the scenes there were other things that were going under the bridge
		Reporting sometimes took far too long
		We can't even have a medical... I mean it's not going to work
		It's not necessary to have a teaching hospital
	Context and Alignment	*Health Professional Council coming into the medical school to evaluate our progress*
		Lobby through the Ministry of Education, through the Ministry of Health
		Have them understand the ethos of the school as well, and understand where the institution would like to go
		Individuals coming from elsewhere

National Pride	*It's the only medical school*
	It's not just context and climates
	It's a national pride
Medical Education	*Need buy-in of course of the community*
	Buy-in or even the motivation of local academics
	Want to do a problem-based learning curriculum
	You need to monitor, monitoring and evaluation and as well as orientating new faculty
	A lot of passion, through medical education principles, have been injected

The political nature of leadership came to light when the interviewee mentioned that "I remember one professor, who was from (omitted), a very brilliant professor, he said he could never be a Dean in a developing country. And we asked him why? And he said this is a political position. And indeed, it is". Many things happened "...behind the scenes" in terms of the continuation of the establishment of the medical school and the fate of the school. Local expertise from the clinical sector was also recruited and this helped with "...steering the school in the right direction" and "alignment" of efforts. Sharing a vision and working together towards this vision came to light when the interviewee mentioned the need to "hold each other's hands and saying this is where we would like you to go". The interviewee also noted that the shared vision extends beyond the local milieu and climate but national pride; "...it's not just context and climates, because it's a national pride". She also noted that "...the processes of monitoring and evaluation reflecting on what you've done and reflecting whether you're still keeping the vision and the mission of what you want to do and the agenda, is very key".

The primary theme that was generated from this interview is *being able to lobby* (Table 5.3). Specifically, this theme relates to having the capacity to lobby, as well as the passion and drive to advocate for one's school. The secondary themes (four in total) include: *hindrances (little blockades), context and alignment, national pride,* and *medical education* (Table 5.3).

5.3.2 Interviewee C1: "I Solve Problems"

Interviewee C1 noted that he "kind of do what is necessary". He developed into a problem solver where the problems range from making decisions to dealing with clashes: "...clash between the university's program and the expectations, that of the heads of the medical departments" and "There is a clash between these two expectations". The expectations mentioned in the latter statement refer to the expectations of the academic programme within the university and what is expected of the students in the hospital. To this the interviewee stated "...the hospital has its own rules and its own view on what the students should be doing and, us as the university have our own program". The lack of human resources impacts the students and the interviewee also noted that there are not enough specialists in the hospital "...to accompany our students in the different rotations". He also mentioned that "...the hospital is understaffed" and "...they don't have enough specialists". *Clash* was selected as a subtheme and is part of the problems faced by the interviewee that needs solving (Table 5.4).

Table 5.4. The themes, subthemes and code examples generated from the interview of C1.

Themes	Subthemes	Code Examples (Quotes)
Solve Problems	Clash	*Organise everything and solve problems*
		There is no one specific task that I am assigned to
		Kind of do what is necessary
		There is a clash between these two expectations
		Clash between the university's program and the expectations that of the heads of the medical departments
		The hospital is understaffed, they don't have enough specialists
	Building	*Advice would be to focus more on building a system that works*
		Start with a small group
		Focus on building an efficient system in the beginning
		Take some time to understand what are the objectives of the institution or the department
	Decision Making	*It's a democratic system*
		New decision is about to be made it's presented to the faculty and then we get to vote
		They will ask your opinion so when you give your opinion they might not take it very seriously

The interviewee identified various things that could have been done differently. This includes starting small and "building" an efficient system; "...a system that works". Starting small, according to the interviewee, makes "things much easier to, to organise". *Building* becomes a subtheme and the primary theme that was identified was *solve problems* (Table 5.4). The interviewee identified what could have been done differently and he has "...no one specific task" and "...different responsibilities". He has become immersed a maelstrom of "different responsibilities" where he needs to "prioritise" and "organise". These activities emphasise the primary theme of problem solving.

Decisions within the institution are described as being democratic. The interviewee notes that "... when decisions are made here it's, it's a democratic system, there are regular meetings, I think every month or two months, the faculty meets...". Yet, from the interview it appears that there exists a hierarchy: "a lot of our faculty is very young so just myself and sometimes even though you, they will ask your opinion so when you give your opinion they might not take it very seriously." *Decision making* was therefore identified as a subtheme along with *clash* and *building* (Table 5.4).

5.3.3 Interviewee C2: "Pain of the Students"

Interviewee C2 stated that "the biggest challenge is resources" as she "feels the pain of the students". This has been identified as the major theme of the interview. As an emerging leader and former student, she identifies her "personal opinion" regarding the pain of the students and, as a growing leader, she understands the "hard choices" the university has to make. This dichotomy of a former student and current position as "vice co-ordinator" drives her to protect her students and re-consider the university as seen from an outsider and insider perspective. She mentioned that "...the students to purchase their own materials because the university wouldn't be able to give them what we needed to protect themselves in the clinical setting". She also stated that "you should be prepared to protect your students at all costs and if you don't have the simple things like gloves how can you send them to a clinical centre?" This further motivates how the lack of resources impacts the students. *Resources* was identified as a subtheme (Table 5.5) and the interviewee mentioned that "the library at the hospital is poorly equipped except we don't have an area, we cannot furnish it the way that the university would like" (Table 5.5). Staff turnover has also been identified as a resource challenge when she mentioned "its failure is in capacity to keep staff members the turnover is just (inaudible)...". The turnover of clinical staff in the hospital relate to foreign doctors who are employed on a three-year contract. The turnover impacts human resources and ultimately the experience of the students: "...whenever the students

actually feel comfortable with the teacher then after three years has gone". The availability of clinical teaching staff is also a major concern and the interviewee sated, in reference to hospital teaching "...there aren't enough staff in that area...".

As a leader, the interviewee identifies the need to grow as an educationalist and stated that "...being a doctor is not the same as being a teacher". The interviewee identified her own inadequacies in term of medical education but also the "changes" that are experienced within her institution. She noted that "we don't have that much experience to teaching, so the university has to work twice as hard to teach us how to teach other people". The university's reliance on non-local teachers in the hospital results in "...two curriculums" running concurrently. The one is intended curriculum set up by the university and the other is the result of foreign nationals working in the hospitals that are not under the control of the university. To this the interviewee noted that; "...although they have different backgrounds we have been working with them for such a long time." *Teaching experience* was therefore identified as a subtheme (table 5.5).

Table 5.5. The themes, subthemes and code examples generated from the interview of C2.

Themes	Subthemes	Code Examples (Quotes)
Pain of Students	Teaching Experience	*Being a doctor is not the same as being a teacher*
		Although they have different backgrounds we have been working with them
		It makes be sad as well faculty staff because I feel the pain of the students
		You can see that their faces and their minds are just not there because there is just so much going on
		The university should be going above and beyond to help them
		. I know administration sometimes has to make hard choices to make the course go on but to what extent do we want it to go on
	Resources	*Big issue because of the turnover of academic staff*
		So keeping staff for us is very hard
		The distance between the library and the hospital is about two kilometres
		Setting up a library at the hospital
		Students were...in a clinical setting completely unprotected

	You should be prepared to protect your students at all costs
Curriculum	*So I would add a medical career to the curriculum*
	If the curriculum was one, I mean we wouldn't be able to just any time and exchange
	So we try to match those two curriculums
	Way to integrate and organize and unify the curriculum

The interviewee identified the possible value of collaboration and sharing of ideas through CONSAMS "...to easily resolve our issues" and to "integrate and organise and unify" the curricula in the region through collaboration. This would require a standardised curriculum within the region (SSA) and the interviewee stated that student exchange programmes would be more feasible "...if the curriculum was one, I mean we wouldn't be able to just any time and exchange it with any university without difficulties." *Curriculum* was therefore identified as a subtheme as it impacts the experience of the students (Table 5.5).

The primary theme that was generated from this interview is *pain of the students*. The subthemes (three in total) include: *resources, curriculum* and *teaching experience* (Table 5.5). The interviewee can thus be viewed as the spokesperson for the students. She can relate to the turmoil and challenges of the students as a prior student of the same establishment.

5.3.4 Interviewee C3: "Make no noise"

Interviewee C3 feels that "you cannot work too hard" as individuals are not used to hard work in his institution. Working hard threatens others and "...people think you want to occupy some place or you want to be bigger than them". The interviewee stated that he has been working without making "...too much noise", just "going on". He has been keeping himself busy with "organizing things, structuring things" and "focusing on my research and quality of teaching". *Too much noise* was identified as the primary theme in this interview (Table 5.6). It became apparent from the interview that the interviewee withdrew within the institution. The interviewee instead channelled his energy into teaching and research. Interviewee C3 has to deal with the structuring and organisation of the curriculum and courses. He also feels that "...they don't treat students very well".

The biggest challenges that came to light include "...solving mind problems". The interviewee also stated that there "...is some, some problems that were identified in the curriculum. And we have of course, the problem of the teachers". The reference to teachers, more specifically clinical teachers in this instance, relate to foreign clinical staff working in the hospitals. This was an agreement between two stakeholders or as the interviewee stated "...business between the two governments". Insights to the existence of a hierarchical leadership structure were provided when the interviewee stated that "So the mentality here is very uhm, vertical. It is a vertical issue, because you are the chief, you come here, you say yes, and everyone says yes". This was later emphasised when the interviewee, in the same section, stated that "So at all the power here, it is very vertical, you know". *Solve mind problems* was therefore identified as a subtheme with specific reference to the following: curriculum, vertical power, political, and healthcare (Table 5.6). Reference to the latter subtheme was made when the interviewee mentioned that students are "very much left alone and doing things without any supervision". He also noted that students "sometimes doing mistakes and repeating mistakes without anybody to tell that they are not doing well". The disparities in primary healthcare in the country became apparent when the interviewee stated that "we have, we have lots of people going to the hospital because primary health care is low quality".

Another subtheme that was generated from the interview is *resistance* (Table 5.6). The interviewee commented on the challenges within the medical school and mentioned that "...there is a big resistance to change" and again that "there is a resistance, a strong resistance to changing". The resistance particularly related to working hard and changing the organisational culture. This became apparent when the interviewee stated that "you cannot work too much here, because they are not used for this kind of working" (Table 5.6).

Table 5.6. The themes, subthemes and code examples generated from the interview of C3.

Themes	Subthemes	Code Examples (Quotes)
(Not) too much Noise	Going On	*So now I kind of work more lonely* *So I keep going on* *Without doing too much fuss, too much noise* *I am focusing on my research and quality of teaching*

Solve Mind Problems	*I have been trying to solve mind problems*
	Organizing things, structuring things
	But it is a political side that is in power
	All the power here, it is very vertical, you know
	Because primary health care is low quality
Resistance	*Because they are not used to this kind of working*
	Résistance in the community against the uhm, university to, to manage a medical residence
	There is a big resistance to change
	There is a resistance, a strong resistance to changing

5.3.5 Interviewee D1: "Need to be managed"

Interviewee D1 stated that he does not "...hold any leadership position" and then later mentioned that he has "...a couple of leadership roles in the research unit". This ambivalence further manifests when he reverts to using the term management as opposed to leadership. This becomes more apparent when he mentions the various challenges within his institution. It appears that the interviewee pertinently uses management as a synonym to leadership. He also mentions the "tensions" between the key stakeholders and that these tensions will always be there "...but they need to be managed". He specifically mentions the need for management as an essential course in undergraduate medical education. He states that "...management skills need to start; they need to start from high school level". The interviewee feels that "the problem we have is that we think anyone who has done a degree as a physician can manage which is, which is false."

The importance of frequent curriculum reviews was highlighted in the interview. The interviewee stated that the "...curriculum has gone through a series of revisions" and "...should always be reviewed regularly". The curriculum revision was done along with the guidance of international institutions and the revision occurs every five years. The interviewee also emphasised that the curriculum should take the "...local landscape" into account.

In reference to funding, the interviewee stated that "...funding is never adequate" but the college of medicine has its own decentralised management structure, not leadership structure, and budgeting system. The interviewee also stated that "our health system has been under funded for four decades and

some of the very basic equipment for training doctors properly is in short supply and sometimes non-existent". Another very important aspect relates to healthcare and the lack of senior clinical healthcare providers. The respondent commented that "...the problem was that you rarely found senior doctors in the hospital looking after patients". Finally, of importance is the respondent's reference to local and contextual expertise when he stated that: "...it is only a national that know the national aspirations and national needs" of the healthcare system.

The primary theme that was generated is *need to be managed* and the subthemes are: *tensions*, *local healthcare* and *curriculum review* (Table 5.7).

Table 5.7. The themes, subthemes and code examples generated from the interview of D1.

Themes	Subthemes	Code Examples
Need to be Managed	Tensions	*I don't hold any leadership position*
		We still have those tensions here
		There are always tensions between the Ministry of Education and the Ministry of Health and Social Services
		Navigate these two tensions
		Those tensions would always be there but they need to be managed
		A physician can manage which is, which is false
	Local healthcare	*I mean our health system has been under funded for four decades*
		You rarely found senior doctors in the hospital looking after patients
		It is only a national that know the national aspirations and national needs
	Curriculum review	*That curriculum has gone through a series of revisions*
		The revisions have taken into account the, the landscape of the local landscape
		The curriculum should always be reviewed regularly
		We have been very good at international direction so during our curriculum reviews

5.3.6 Interviewee E1: "Learn the hard way"

Interviewee E1 longs for a "community of practice" with a "critical mass" and sees the value of a "span" ("team") that is willing to go the "...ekstra myl" ("extra mile"). She identified her own inexperience and stated that she has never "gemanage" ("managed") before and received no "ondersteuning" (support"). As Deputy Associate Dean of Academic Affairs, she feels "oorlaai" ("overwhelmed") and "moedeloos" ("discouraged"). For her, it was a case of "leer die harde manier" ("learn the hard way") and "...swem of sink" ("...swim or sink"). According to her, getting things done necessitates climbing the ladder in the organisation. She stated that "...moenie ophou tot jy die hoogste sport bereik het nie" ("...don't give up until you have reached the highest step").

As a leader she has identified the need for leadership development and feels that within the institution "...moet jy ook die leiers ontwikkel" ("...you must develop the leaders"), as in the case of staff development programmes in other universities. *Learn the hard way* has been identified as a major theme from the interview (Table 5.8). The interviewee believes that a leader should "...lead by example". She also feels that a leader should be "...'n voorbeeld wees" ("...be an example"). The interviewee continued to describe the desired attributes of a leader and stated that a leader should be punctual and not "...iets sê en dan doen jy iets anders nie" ("...say something and then do something different"). A leader, according to her, "...moet deursigtig wees should be" ("...should be transparent"). The two attributes, leading by example and being transparent, according to her will ensure that people will not grow tired to do things and will trust and respect you.

The interviewee identified decision making and communication and major stumbling blocks within her medical school. She feels that "...as jy 'n leier is moet jy 'n besluit kan maak, populêr of onpopulêr" ("...if you are a leader, you must make a decision, popular or unpopular"). She stated that "...daar moet iets wees wat fout is" ("...there must be something wrong"). She feels that "...ander goeters" ("...other stuff") such as "conflict" and "staff matters" keep her preoccupied. She further mentioned that she has just given up (Table 5.8). The interviewee feels that "...ons is hier met verskillende agendas" ("...we are here with different agendas"). Her perceptions are that "...elke ou ploeg maar voort en doen sy eie ding" ("...everyone plods on and is doing their own thing"). She continued that the agendas will have to come together in order to accomplish certain things. The lack in communication has been identified within the medical school. The interviewee believes that it has improved over time. However, she felt that "...daar is baie min oop kommunikasie tussen verskillende kantore" ("...there is little open communication between offices"). She also believes that, despite the improvement over time, communication is still not enough (Table 5.8).

A lack of motivation by team members has been identified when she stated that the team "...moet voel dat hulle in 'n span werk, dan sal ons goed doen" ("...must feel they are working in a team, then we will do things"). The appointment of *ex officio* leaders has been identified as a major frustration. The interviewee feels that an appointment cannot be made based on his/her title. To this she stated that "...ons kan nie die werk gee vir iemand net oor sy title" ("...we can give the job to someone because of their title"). The interviewee has also described the requirement of a leader to "...soms die rolle ruil" ("...sometimes change roles"). The ability to change roles will enable a leader to be autocratic or diplomatic as needed ("Soms moet jy diplomaties wees wees. Soms moet jy ook autokraties wees" ["Sometimes you have to diplomatic. Sometimes you have to be autocratic"]). The interviewee further identified key topics as part of formal staff development programme. One of the focus points relate to transferring content (subject) specific knowledge to others (Table 5.8). Another addresses conflict resolution ("Wat doen jy in konflik?" ["What do you do in conflict?"]). She motivated that prospective staff members should have a bit of medical education training before joining the faculty. This, according to her, must be a prerequisite for employment (Table 5.8). In reference to staff development and future employment she emphasised the value of teamwork when she stated that individuals "...spanwerk hoog moet aanskryf ("...must subscribe to teamwork").

The growth of the interviewee culminates from her inexperience and the perceived undesirable attributes of her seniors. She recognises what could be improved and the importance of leading by example. She focuses extensively on the desired attributes of a good leader and identifies what skill sets can be developed in medical education leaders through medical education training. Her growth and development as a leader appear to stem from what she perceives as wrong. The primary theme that was identified was *learn the hard way* (Table 5.8). *Something wrong*, *lead by example* and *medical education training* was believed to be drivers for her journey to learn the hard way. These themes were subsequently categorised as subthemes (Table 5.8).

Table 5.8. The themes, subthemes and code examples generated from the interview of E1.

Themes	Subthemes	Code Examples (Quotes)
Learn the Hard Way	Something Wrong	*Daar moet iets wees wat fout is (There must be something wrong)*
		Ek voel baie min ondersteuning (I feel very little support)
		Ek het al net opgegee (I have just given up)
		As jy 'n leier is moet jy 'n besluit kan maak, populêr of onpopulêr (If you are a leader, you must make a decision, popular or unpopular.
		Elke ou ploeg maar voort en doen sy eie ding (Everyone plods on and is doing their own thing)
		Ons kan meer kommunikeer (We can communicate more)
		Ons kommunikeer nie genoeg nie of effektief genoeg nie (We don't communicate enough and efficient enough)
		Daar is baie min oop kommunikasie tussen verskillende kantore (There is little open communication between offices)
		Jy stel mense ex officio aan net omdat hulle in die kantoor is (You appoint someone ex officio just because he is in the office)
		Ons kan nie die werk gee vir iemand net oor sy title (We can give the job to someone because of their title)
	Lead by Example	*Lead by example*
		'n Voorbeeld wees (An example)
		Moet deursigtig wees (Should be transparent)
		Soms die rolle ruil (Sometimes change roles)
		Soms moet jy diplomaties wees wees. Soms moet jy ook autokraties wees (Sometimes you have to diplomatic. Sometimes you have to be autocratic)

	Medical Education Training	*Prerequisite maak dat hulle bietjie medical education training gekry het (Make it a prerequisite that they have a bit of medical education training)* *Content wat jy het, om dit oor te dra aan iemand anders (Content that you have, to transfer it to someone else)* *Spanwerk hoog moet aanskryf (Must subscribe to teamwork)* *Wat doen jy in konflik? (What do you do in conflict?)* *Moet nie net na die spanlede kyk nie, jy moet ook na die spanleiers kyk (Must not only look after the team members, you must also look after the team leaders)*

5.3.7 Interviewee E2: "A Good Captain"

Interviewee E3 (the former Dean of the School of Medicine) is an experienced leader and was involved in setting up medical schools in Africa. The interviewee gets things done by dreaming about it. He stated that "I would usually start, by as it were; dreaming about it" and would then "...sell it to my colleagues". The interviewee feels that his ideas should be sold to the "...teachers first and then the students" (Table 5.9). The vision of the interviewee, his dreams, translates into actions from his own conviction and this became evident when he stated that: "The conviction that what I'm doing is necessary". The interviewee felt that his actions "...must be necessary. It must be right." His personal philosophy within this context is a quote from the poet and playwright, Thomas Stearns Eliot (1888-1965): "Only those who will risk going too far can possibly find out how far one can go" (Table 5.9).

The interviewee used an analogy of "...a plane flight, the flight of an aeroplane" to describe his experiences and the trajectory of his medical school at the time. He mentioned that "you need a good captain" and that his "...school is still in the growing phase" (Table 5.9). The interviewee feels that medical school in terms of its development is "...still ascending". He continued that: "I don't think we have come to cruising height yet". His experiences relate to the "headaches and heartaches" of establishing a new medical school. These headaches and heartaches caused him to state that the challenges faced "were not during happiest few years". The headaches manifested in the form of constraints such as "finical resources" and "...human resources, and other type of resources" (Table 5.9). Time, as a resource, has been identified as "...a major constraint" (Table 5.9). He also mentions inertia when he stated that "...the major barrier has been that of inertia". The interviewee also felt that inertia manifests in that "people are not giving you the benefit of their ideas" and then have to "...keep on

nudging them" in order to get things done. *Good captain* has been identified as a major theme throughout the interview and a captain's vision (*dreaming*), his actions (*get it right, get it done*), and challenges (headaches and headraces) as subthemes (Table 5.9). A good captain has to make "sacrifices" that rely on "evidence" to direct activities and there "must be a good basis for changing focus". The school is "still in the growing phase" and he feels that "...we must not put the school on autopilot yet" and for this "...you need to get a good captain ". The interviewee realised that he has to "...keep on nudging" to break through the "inertia" to sell his dreams.

The interviewee understands that a medical school is "different" and "...not special". *Different, not special* has been identified as another theme. It is believed that a good captain should be aware of the different nature of a medical school. Medical schools require different policies and traditions (Table 5.9). The training of future medical doctors is different and the interviewee noted that "The way we train people is a little different from the way things are done in the rest of the university". This is essential to understand when aspiring to the desired "attributes of a doctor" (Table 5.9).

The importance of a medical education unit came to light under the uniqueness of a medical school. To this end, he feels that such a unit "…would help to direct our activities". The interviewee stated that such a medical education unit "...will continuously be looking at what we are doing and helping us to navigate" (Table 5.9).

Table 5.9. The themes, subthemes and code examples generated from the interview of E2.

Themes	Subthemes	Code Examples
Good Captain	Dreaming	*I would usually start, by as it were; dreaming about it*
		I sell it to my colleagues
		Usually the teachers first and then the students
		I started with the Dean and said what is our focus? What are we trying to achieve?
	Get it Right, Get it Done	*Only those who will risk going too far can possibly find out how far one can go*
		The conviction that what I'm doing is necessary
		It must be necessary. It must be right
		But let us continue and get it right, and get it done

	Headaches and Heartaches	*I would say the major barrier has been that of inertia* *People are not giving you the benefit of their ideas* *The recipients of this document they don't even put too much premium on it* *You keep on nudging them* *Yes, and some of them were not during happiest few years* *I'm talking about financial resources. I'm talking about human resources, and other type of resources* *Even time. Time is a major constraint* *So in the clinical areas we are grossly under staffed* *An adjunct, their patients come first* *Three years ago things were very turbulent* *The headaches, the heartaches* *So far we are still ascending* *I don't think we have come to cruising height yet* *So I believe we are still building* *So our school is still in the growing phase* *We are still climbing* *We must not put the school on autopilot yet* *So these are the headaches* *Until we get to that autopilot stage, everybody, must be alert, continue wearing your seat-belts* *And you need to get a good captain*

Different, Not Special	*We did not have any traditions*
	We did not have many policies
	We only beaten ourselves on the university's policies
	We were not special, but we were different
	The way we train people is a little different from the way things are done in the rest of the rest of the university
	Different from all other medical schools
	Let us stand out
	The attributes of a doctor
	We need a unit like that
	That will have all the things that would help to direct our activities
	The unit that will continuously be looking at what we are doing and helping us to navigate

5.3.8 Interviewee E3: "Steep Learning Curve"

Interviewee E4 is a young emerging leader and Course Co-ordinator for the Allied Health Sciences programme at his medical school. The interviewee was tasked with the responsibility establishment of allied health degree programmes without asking for it. His original capacity was as a consultant and he noted that he was asked to work on the programmes "...op konsultasie basis, nie om die hele program te stuur soos huidiglik vandag nie" ("...on consultation basis, not to steer the entire programme as is the case today"). In reference to the programme development he stated that he did not have the "...expertise daarvoor" ("expertise for it"). The interviewee felt that it would have been helpful if "...ons die inligting gehad het en die bestuur transparent was" ("...we had the information and management was transparent"). As a team, they felt "abandoned". They realised that "...nou moet ons ons eie planne maak" ("now we have to make our own plans"). It was a "...steep learning curve" for the interviewee (Table 5.10). The primary theme that was generated was a *steep learning curve* and *make a plan* was selected as a subtheme (Table 5.10).

The interviewee, upon reflection, feels that a leader tasked with the responsibilities he faced "...needs to be a leader and a soldier". *Leader and soldier* was therefore selected as another subtheme. The interviewee realised that he needs to be proactive and apply "gentle pressure" to obtain the required

administrative documentation. Furthermore, he came to realise that "...jy lei deur mense wat jy respek by gewen het" ("...you lead through people who you have earned their respect") (Table 5.10). He also learnt that "...jy lei nie deur mense wat in vrees onder jou staan nie" ("...you don't lead through people who stands in fear under you"). He also stated that he is "...baie pro-kommunikasie ("...very much pro-communication"). Finally, as a leader and a soldier the interviewee stated that it is important to "...maak seker dat die regte mense in plek" (...ensure you have the right people in place").

The biggest challenges of the interviewee related to "...staff kapasiteit" (staff capacity"), "workload", "permanente spasie" ("permanent (teaching) space") and accreditation of the programmes. In reference to the latter he stated that "...die program is huidiglik nog nie geakkrediteer nie" ("...the programme is currently not accredited"). "Krisis bestuur" ("crisis management") has been the order day. The challenges related to human resources, space and the accreditation of the curriculum necessitated crisis management on his projections (Table 5.10). As a leader and soldier, he came to realise that "...dis links, maar daar is gewoonlik vyf – partykeer van my af vyf links om uit te kom by die persoon wat dit nodig is" ("...its links, but there is usually five – sometimes five links to reach the person that is needed"). Getting things done extends beyond this vertical hierarchy and also requires establishing links with the private sector (Table 5.10). Interviewee E4 explicitly stated that he was exposed to various styles of leadership during his endeavours and this has become his "framework van 'n goeie of slegte leier" ("...framework of a good or bad leader"). He faced "bulldozer leadership" and, in some instances, no leadership at all (Table 5.10). The development of his own leadership framework enabled him to deal with the various challenges and crises. He found it difficult to gauge when to push things or let it run its natural course. He has learnt to apply "pressure", be more "proactive", getting the right people in place, forming links and knowing the university "sisteme" ("systems"). *Crisis management* was thus selected as a subtheme under the primary theme of *steep learning curve* (Table 5.10). The crises ranged from staffing issues, finding a teaching space, accreditation of the programme and being exposed to the leadership approaches of his seniors.

Table 5.10. The themes, subthemes and code examples generated from the interview of E3.

Themes	Subthemes	Code Examples
Steep Learning Curve	Make a Plan	*Op konsultasie basis, nie om die hele program te stuur soos huidiglik vandag nie (On consultation basis, not to steer the entire programme as is the case today)* *Want ons het nie die expertise daarvoor nie (Because we did not have the expertise for it)* *Vir ons sou dit dan gehelp het as ons die inligting gehad het en die bestuur transparent was (It would have*

	helped if we had the information and management was transparent) *Toe het ons so half 'n bietjie abandoned gevoel (Then we felt a bit abandoned)* *Maar nou moet ons ons eie plan maak (Now we have to make our own plans)* *Maar as ek vandag daarna kyk, was dit 'n steep learning curve (If I look at it today; it was a steep learning curve)*
Leader and a Soldier	*Maak seker dat die regte mense in plek (Ensure you have the right people in place)* *He needs to be a leader and a soldier* *Jy moet mense gaan sien in die privaat sektor en links maak met hulle (You have to see people in the private sector and make links with them)* *Dis links, maar daar is gewoonlik vyf – partykeer van my af vyf links om uit te kom by die persoon wat dit nodig is (Its links, but there is usually five – sometimes five links to reach the person that is needed)* *Moet jy maar gentle pressure opsit (You must apply gentle pressure)* *Jy lei deur mense wat jy respek by gewen (You lead through people whom you have earned their respect)* *Jy lei nie deur mense wat in vrees onder jou staan nie (You don't lead through people who stands in fear under you)* *Ek is baie pro kommunikasie (I am very much pro-communication)*
Crisis Management	*Almal is oorwerk (Everyone is overworked)* *Daarvoor het jy die staf kapasiteit notdig, en op hierdie stadium is vir ons gesê - "julle sal die nie kan kry nie"(For this you need the staff capacity and we were told – "you will not get it")* *So op die stadium het ons probeer vir adjunks motiveer (So at this stage we are trying to motivate for adjuncts)* *So ons het permanente spasie nodig (So we need permanent space)* *Die program is huidiglik nog nie geakkrediteer nie (The programme is currently not accredited)* *Nou moet ek op my projeksies krisis bestuur doen (Now I have to do crisis management on my projections)*

Nou moet mens krisis bestuur doen in die tyd wat jy die minste het (Now one need to do crisis management in the time of need)

Framework van 'n goeie of slegte leier (Framework of a good or bad leader)

Ek wil amper sê bulldozer leierskap amper, mense wat net totaal autokraties oor jou hardloop (I want to say bulldozer leadership, almost, people that autocratically completely overrun you)

Hoe hulle optree en dit raak jou framework van 'n goeie of 'n slegte leier (How they act this becomes a framework of a good or a bad leader)

5.3.9 Interviewee E4: "Dealing with Things"

Interviewee E4 was involved in capacity development focussing on medical education throughout Africa. She was one of the northern partners and joined the faculty at one of the medical schools as a permanent staff member. She was also involved in the initial stages of the establishment of CONSAMS. It appears that her collaborative efforts through the consortium and her dealings within African medical schools caused her to state that she *"...*good connections to everyone". She feels that "...you need the mission and you have to be strong enough to take or choose that kind of way of dealing with things". She feels "... that everyone need to adjust to enable something to happen" but she also pointed out that "...it's also about the difficulty to change the culture of dealing with certain things". The importance of cooperation within her medical school came to light. She stated that cooperation is needed at some levels in order to accomplish things. To this end she stated that "...dealing with cooperation at certain levels that you don't have to ask to permission from the president, basically, to do certain things" (Table 5.11). The primary theme that was generated from the interview is *dealing with things*. Fromm the interview it became apparent that in order to deal with things, *co-operation, motivation* and *communication* is needed. These factors have been selected as the subthemes as they speak to the primary themes of dealing with things as outlined below.

The interviewee is of the opinion that guidelines are essential in order to lead. She stated that, in reference to guidelines; "You need them. They need to be clear and if something goes wrong there has to a way to deal with it". She came to realise that "...getting things done ...depends very much on personalities". There are "...cultural differences" to factor in. To get things done "...you really need a team" (Table 5.11). She also expressed that leaders should "...just allow" people to do things. This highlights the need

for mutual co-operation. The need for cooperation was further emphasised when the interviewee implied that "...cooperation at certain levels" will permit you to do certain things without the need for "...permission from the president, basically, to do certain things" (Table 5.11). This implies that cooperation is needed from all the stakeholders.

Cooperation helps getting things done. In reference to this the interviewee stated that "...you really need to build that trust that, that connection, and it needs time" and to share responsibilities ("I think it's about sharing the responsibilities"). She further stated that the "...willingness to adjust, that everyone need to adjust to enable something to happen" is required (table 5.11). She feels that one of the key issues in terms of cooperation is "...the difficulty to change the culture of dealing with certain things". The value of CONSAMS, and its cooperative efforts, came to light when she referred to its potential to "...make an exchange program where CONSAMS students can do part of their studies in another country, all the lecturers are being able to rotate". Both cooperation and teamwork have been identified to exist within the consortium and she noted that the collaborative "...ideas are, they're excellent" but she wonders "...why is it so bloody difficult?" to implement them.

Table 5.11. The themes, subthemes and code examples generated from the interview of E4.

Themes	Subthemes	Code Examples
Dealing with Things	Cooperation	*Yeah, you need a team*
		You really need a team that you can trust or from whom you can ask basically anything or advise people from who you should ask something else
		I had good connections to everyone
		You really need to build that trust that, that connection, and it needs time
		I think it's about sharing the responsibilities and trusting
		Dealing with cooperation at certain levels that you don't have to ask to permission from the president, basically, to do certain things
		The fact that, in practice this cooperation seems to be more difficult than was expected
		The willingness to adjust, that everyone need to adjust to enable something to happen

	But it's also about the difficulty to change the culture of dealing with certain things
	To really make an exchange program where CONSAMS students can do part of their studies in another country, all the lecturers are being able to rotate
	The ideas are, they're excellent
	But then why is it so bloody difficult?
Motivation	*You need to have motivation in your team, if motivation level in your team is not the same*
	You are very sparse with personnel, there are very few of you and then all of you don't have the same burden, the same motivation
	You have to give them happiness too, you have to give them possibilities to do something that they really like, and want to do it and enjoy the work
	You have to take care of the people, you have to lead them well
	And as a leader you need to see that… you need to be able to provide that [motivation] for everyone at each level
	And that's why you need a leader at a lower level
	The top leader can't see every level of the organisation
	So it needs to… willingness from everyone to really do it also the leaders just to allow it
	And for those who want to try something new and make something in a different way to be willing to just do it
Communication	*It also depends very much on personalities*
	If you are easy with people then it's easier for you
	I don't know, it's about communication, it's about transparency, but it's also about the difficulty to change the culture of dealing with certain things
	The transparency and communication, and being trustworthy, reliable
	That's why it is so crucial to meet people in person
	Very important you know where the actions are taking place and are there and you have been there so that you can understand what is going on

Communication is a difficult issue... the cultural differences come in so quickly
Yeah communication is a key issue, always

Motivation was chosen as a subtheme and the interviewee noted that as leader you "...need to have motivation in your team". Motivation came into play in the context teamwork. The interviewee identified a lack of human resources as a major challenge in her medical school when she stated that: "...you don't have the same burden, the same motivation" (Table 5.11). A team, according to her, should know that they share the "...same burden" and "...same motivation level". She continued to state that as a leader you "...have to give them possibilities to do something that they really like, and want to do it and enjoy the work". "...give them happiness" and "...give them possibilities". She continued that "...you have to take care of the people; you have to lead them well" (Table 5.11). The interviewee very importantly noted that the reason why "...you need a leader at a lower level" is because you "...need to be able to provide that [motivation] for everyone at each level". Finally, the interviewee noted the importance of "...leaders just to allow it" in reference to curriculum changes. The freedom to allow changes to be implemented can serve as motivation to get things done.

Finally, *communication* was selected as a subtheme as stated previously. The interviewee feels that "...communication is a key issue, always" and communication should take the "...cultural differences" into account (Table 5.11). She feels that transparency and honesty aids communication and ensures and understanding what the institution's leadership wants to attain. As a leader, you have to be trustworthy and reliable ("The transparency and communication, and being trustworthy, reliable"). The importance of face-to-face communication to her became apparent when she noted "...you can make drastic mistakes in just one email in worst case". For this reason, she feels that this is the reason why "...it is so crucial to meet people in person" (Table 5.11). The interviewee's emphasis on communication and its importance in order to get things done has been selected as a theme above the other leadership attributes that were mentioned. The importance of communication is further emphasised when she stated that: "...communication is a difficult issue... the cultural differences come in so quickly" and "...communication is a key issue, always" (Table 5.11).

5.3.10 Interviewee F1: "New Medical School"

Interviewee F1 represents a major northern partner of the consortium (CONSAMS) and is one of the founding members. He was also involved in the establishment of Namibia's first medical school. The interviewee realised that many of the new medical schools face similar problems and "...a consortium that deals with the problems of new medical schools" was established. Interviewee noted that the consortium's "...activity has declined" over the "...past year or two" and that CONSAMS "...had very few successful Skype meetings". Participation, due to a lack of "...human capacity", appears to be one of the main issues and the interviewee stated that there "...have been problems in getting people involved" (Table 5.12). He feels that the purpose of CONSAMS is "...setting up post graduate training, training programs and as well as research training". He believes that obtaining funding for research "...will increase the capacity, research capacity, in the new medical schools". The CONSORTIUM also serves "...to help also in basic education" and it is believed that "...the northern partners could provide the experienced staff" that is needed to assist the southern partners within the consortium (Table 5.12). The latter entails a teacher exchange programme among the members. *Consortium* was subsequently selected as a theme from this section of the interview.

Furthermore, the interviewee identified that there exists a "...hindrance in developing medical education" in new medical schools. The interviewee acknowledged that "...there are so few people working and teaching in the new medical schools that they are fully occupied with the teaching load" (Table 5.12). From his experience with new medical schools, he advises that clinicians should be "...on board as early as possible" because they can "...teach the basic subjects" such as anatomy. From his experience a "...lack of personnel" and research experience hinders new medical schools. The interviewee also identified the lack of local expertise in Africa when stated that "I think it all goes back to the lack of personnel due to lack of experience of personnel who could be leaders of research projects" (Table 5.12). *Hindrance* was subsequently identified as a theme. Both *consortium* and *hindrance* can now be considered as subthemes under the primary theme of *new medical school*. This primary theme was generated as it forms a central focus point in relation to the consortium and the hindrances faced by new schools.

The final subtheme that was generated is *medical education unit*. The interviewee is of the opinion that another important function of CONSAMS is "...to help people establishing medical education units" (Table 5.12). The experience of the interviewee led him to believe that such units will oversee the "...implementation of the curriculum" and will serve to "...provide help to students as well". He noted that students find it difficult to ask questions and get support due to a "hierarchy" that is followed within African medical schools (Table 5.12). He urges that new staff members should "...get involved in the

various aspects of developing medical education". He also noted that "...there are people who are more experienced in pedagogy and so on, so they should be part of that practice as well" (table 5.12).

Table 5.12. The themes, subthemes and code examples generated from the interview of F1.

Themes	Subthemes	Code Examples
New Medical School	Consortium	*Why don't we establish a consortium that deals with the problems of new medical schools?*
		The activity has declined and now there has been over the last year or two have been problems in getting people involved
		Participation in the annual meetings have not been as high
		We had very few successful Skype meetings
		I think my primary task would be to help setting up post graduate training, training programs and as well as research training
		We need to help also in basic education as much as we can by trying to find teachers if there is lack of those and so on
		Support the establishment of specialist training or post graduate training as well as research
		Trying to get funding for research as well so that we can include students from the CONSAMS medical schools into our research projects
		It will increase the capacity, research capacity in the new medical schools
		I think it would be very important to make a joint effort so that we could the northern partners could provide the experienced staff and then help your staff

		I think has been the way how we have organized staff exchange and this could have been better
	Hindrance	*I think a major drawback is lack of human capacity that there are so few people working and teaching in the new medical schools* *They are fully occupied with the teaching load that they have* *I think this is still anyway the most important hindrance in developing medical education is that there are so few people* *To start with a medical school first of course you need the curriculum and then you need the staff* *But I would advise to get also clinicians on board as early as possible because they can also teach basic subjects* *I think it all goes back to the lack of personnel due to lack of experience of personnel who could be leaders of research projects*
	Medical Education Unit	*To help people establishing medical education units* *To help people get education or get courses over other education in medical education* *I would also urge to setup a medical education unit that is kind of having an overall look at the implementation of the curriculum* *That makes or organizes some courses for staff in medical education* *Start small evaluations or something what they are currently doing by themselves so that they can then improve those* *This medical education is unit should provide help to the students* *African schools are rather I would say they want to follow the hierarchy* *It's not very easy for them to ask questions or to… just to support the students as well in their studies* *I think it would be very important that to get new staff members involved in the various aspects of developing medical education*

There are people who are more experienced in pedagogy and so on, so they should be part of that practice as well

5.4 CROSS-CASE ANALYSIS

The themes that were generated from the first phase (within-case analysis) capture, in part, the challenges and development of leaders within their respective medical schools. Each institution presents with its own unique systemic, organisational, intrapersonal and interpersonal milieu. The premise is that these variables act on and drive growth of leaders in medical schools.

Findings from the current study reveal that leaders conceptualize the challenges at varying degrees of magnitude and complexity. Some view these challenges as "hindrances", more specifically "little blockades" (B1) whilst others refer to "tensions" (D1). One leader revealed a more personal connection and considered the challenges as "the headaches, the heartaches" (E2) associated with setting up a new medical school. At an interpersonal level the challenges are perceived as "inertia" (E2) when engaging members of the school and the effects of the challenges causes "turbulence" (E2). At an organisational level some of the challenges include "a big resistance to change" and "all the power here, it is very vertical, you know" (C3). Contextually, one leader stated that "behind the scenes there were other things that were going under the bridge" (B1) and another referred to *a clash between expectations* (C1). The clash mentioned by interviewee C1 relates to the misalignment of objectives between the university and teaching hospital. One possible explanation is that with "an adjunct, their patients come first" (E2). Elmberger *et al.,* (2019) noted that patient care takes precedence in a clinical setting and education becomes less important. Findings from the leadership climate of alignment further alludes this; particularly in reference to the statement that physicians, scientists, educators and administrators share similar values.

From the interview with B1 it came apparent that the interviewee developed into a leader who navigates the interplay between hindrances, the *need to lobby*, medical education principles, the climate and the national pride of establishing a medical school (Table 5.13). The subthemes that were generated from the interview with C1 speak to the primary theme of *solve problems* and the interviewee can therefore be viewed as a strategist. The interviewee developed over time into a strategist based on a climate where decisions are made based on a hierarchical system and clashes exist due to differences between the university and hospital teaching programmes (Table 5.13). However, the same leader also stated that he has no *specific task* and this points to a lack of a clear directive from leadership. The primary theme of

the interview with C2 captures the *pain of the students* and it is believed they speak of the challenges the students face. From the interview it came apparent that the interviewee has become a spokesperson for the students (Table 5.13). She has developed into an activist who carries the plights of the students. As a leader, the C3 developed into a silenced leader who has over time withdrawn due to resistance and the *mind problems*. It appears that his strategy is to focus on things that he can manage (*going on*) such as his teaching and research whilst keeping his head down. As a leader he became an outlier and developed into a *silenced leader*. The subthemes associated with D1 were viewed as the things that required management (*need to be managed*) in this context. It became apparent that the interviewee identified himself as a manager and developed into a managing leader i.e., *the leader as a manager* (Table 5.13).

Table 5.13. A summary of the primary themes based on interviewees, their medical schools and the within-case and cross-case themes that were generated.

Institution	Interviewee (Sex)	Within-Case Themes	Meta-themes
B	B1 (F)	Being able to Lobby	Navigator
C	C1 (M)	Solve Problems	Strategist
	C2 (F)	Pain of Students	Spokesperson for the Students
	C3 (M)	Too much Noise	Silenced Leader/Outlier
D	D1 (M)	Need to be Managed	Leader as Manager
E	E1 (F)	Learn the Hard Way	Defeated Leader
	E2 (M)	Good Captain	Leader in Front/Ideal Leader
	E3 (M)	Steep Learning Curve	Becoming a Leader
	E4 (F)	Dealing with Things	Collaborative Leader
F	F1 (M)	New Medical School	Big Picture Leader

As a leader, interviewee E1 had to *learn the hard way* and she admittedly gave up. She was not granted the capacity and support. She can therefore be regarded as the defeated leader. Interviewee E2 has been identified as the spokesperson for the *good captain* and has developed based on necessity and getting things done in order to ascend as a medical school. He has become the leader in front and can be considered as an ideal leader. Of interest is the case of interviewee E3 where the interviewee represents

a forced leader. This forced leadership drove him to make plans and he developed into a leader and soldier. It was a *steep learning curve* and thus captures the process of *becoming a leader* (Table 5.13).

Collaboration, interpersonal relations and communication was very important to interviewee E4. She talks of people and not things and was part of the faculty of institution E. Her initial involvement in CONSAMS along with her immersed experience in one of the new medical schools allows her to provide both an outside and insider perspective. She has developed to become the proverbial oil in gears and developed into a *collaborative leader* (Table 5.13). Finally, F1 is immensely immersed in CONSAMS and sees the big picture of the ultimate aims and goals of new medical schools. As an outsider he represents the collaborative leader and has developed over time to become a leader that brings people out of their silos to in order to collaborate.

The cross-case analyses point towards the complexity of leadership in new medical schools. The meta-themes should not be regarded as separate entities but rather as a collective representation of the development of leadership in new medical schools. This collective representation permits the condensation of the 10 meta-themes into five archetypes of pedagogical leadership development as depicted in Fig. 5.1. Leaders navigate the various challenges that are presented and negotiate their leadership approach and stance based on prior experiences and current perceptions. The negotiation occurs both internally and externally and suggests that some leaders set goals and strategies in place where none exist (C1). This archetype can be considered as a *strategist*. Some leaders are either silenced (C3) or give up (E3) and represent the *silenced leader* (Fig. 5.1). Leaders who carry the burden of the students undergo development to become their spokesperson (C2) but have to balance competing agendas. The competing agendas drive the growth of this particular leader and the archetype of *becoming a leader* is also represented (Fig. 5.1). Similarly, other leaders view their development as learning the hard way (E1) and as a steep learning curve (E3) (Fig. 5.1). Both the aforementioned leaders are in the process of negotiating their identities and roles within their respective organisations. More experienced leaders can be viewed as *the leader in front* (Fig. 5.1: B1, E2, E4 and F1). The practices of experienced leaders are directed towards organisational change by being *a good captain* as opposed to following a *steep learning curve* and *dealing with things.* The ability to see the big picture and to lobby for a cause allow these leaders to have an active influence within their respective medical schools. The final archetype that was identified is the *leader as manager* (D1). This leader feels that things *need to be managed* and identifies the need to take charge of the challenges and the business of running a medical school. Furthermore, the perceptions of the *leader as manager* is that they *do not hold a leadership position*.

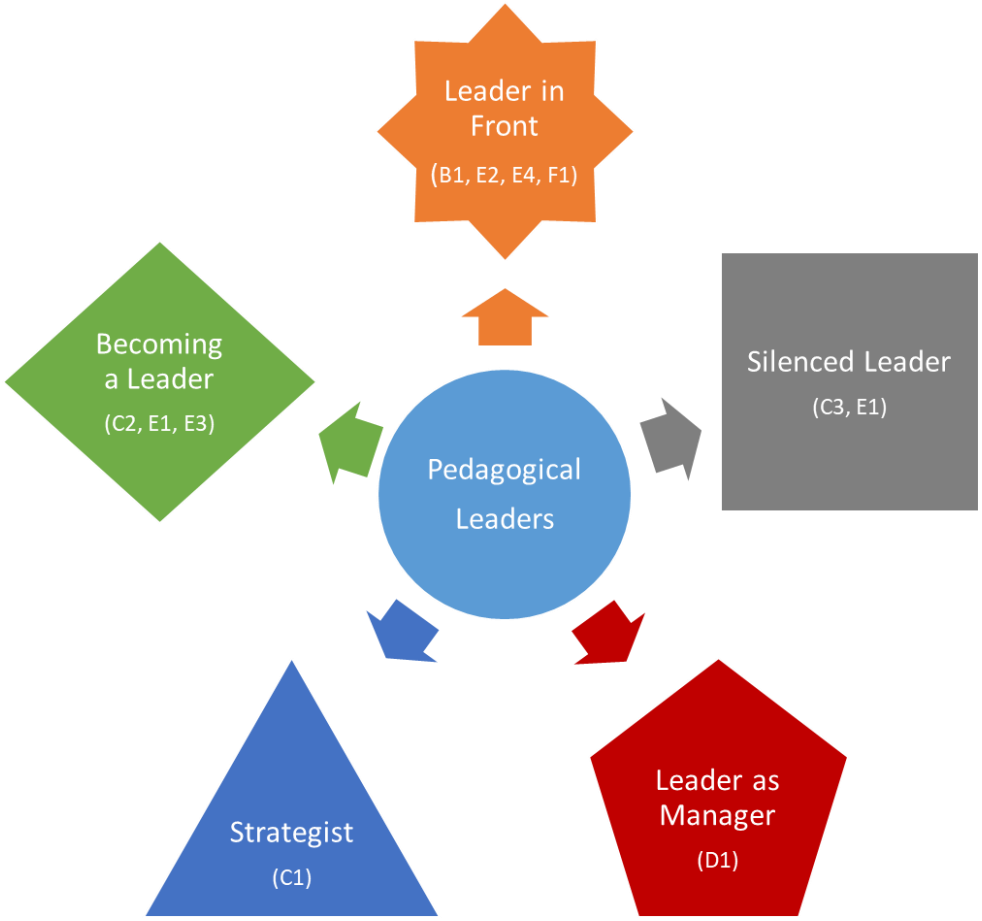

Fig. 5.1. Pedagogical leadership development archetypes based on the cross-case analysis.

The leadership development archetypes thus stem from the cross-case analyses and the meta-themes as presented in Table 5.13. The archetypes represent a systemic view of participants' behaviours and is a starting point to gain a handle on the complex nature of the research phenomenon. It serves as an attempt to make sense of the leadership complexity within new medical schools. The generation of the archetypes serve to frame the leadership behaviours as a collective. However, it is important to note that there exists an overlap between the archetypes of each leader and that the respective archetypes represent the dominant leadership behaviour. For instance, the *leader in front* can be a *strategist* or a *leader as manager* and this depends on the situation that presents itself. Similarly, the *leader in front* stands the risk of becoming a *silenced leader* over time due to systemic resistance and inertia.

5.5 PARTICIPANT OBSERVER DATA

The current section has been written in the first person in order to capture my observations and perspectives as research participant. I believe that the complexity of leadership roles in new medical schools is underappreciated. My own experience as an emerging leader led me to believe that leader and leadership roles within new medical schools are in a state of flux. My initial perceptions were that we, as inexperienced and emerging leaders, were left in the trenches to fend for ourselves. It reflects my sense of detachment from the guidance and support from my institution's leadership. This feeling of detachment was captured in the form of a metaphor early in the research process. At the time I believed that the "…top general was drinking a cup of tea somewhere in a tent, whilst the lieutenants were out on the battlefield".

I was appointed as lecturer and out of necessity became involved in establishing Namibia's first and only medical school in 2009. As a team, we were at a critical stage of developing the curriculum, infrastructure planning (lecture halls, laboratory space, seminar rooms and dissection laboratories), procuring the necessary equipment and ordering textbooks (Wessels *et al.,* 2012). Lectures commenced in February of 2010 and we relied heavily on the graces of other faculties to provide us with interim lecture venues and office space. As a young academic and expatriate on contract, I was driven to make it work despite unclear performance expectations. My perceived accountability (felt accountability) was also driven by the prospects of being evaluated based on my performance. Yet, no evaluation and subsequent sanction or reward followed my efforts. This made self-regulation extremely challenging for me and coincides with a lack of clear performance expectations linked to the climate dimension of accountability (Souba *et al.,* 2007; van Diggle et al., 2020). As an emergent leader I often wondered whether senior management's approach at my institution was strategically implemented to gain project momentum or the result of poor planning.

One of the biggest challenges we faced at UNAM SoM related to student numbers. Our school planned an initial and subsequent intake of 50 students per annum (Magadza, 2009). Staff members were surprised when the intake increased to 68 students in 2011. I served on the Infrastructure Committee at the time and we were busy with construction of our facilities with the intent to accommodate 50 students per cohort. Phase-I of construction only finished in April of 2011 and the increase in student admissions was not communicated effectively (Wessels *et al.,* 2012). The sudden change in student numbers necessitated the reallocation of resources towards larger auditoriums and student accommodation. The latter was necessitated after the SoM adopted a quota-based admission policy where students are selected from the representative regions of Namibia (Eichbaum *et al.,* 2015a). Many students from rural settings subsequently required accommodation near the SoM. The school also faced a shortage in clinical

educators and clinical training facilities. The number of student admissions was eventually capped at 80, including repeating students (Lamprecht, 2014 and 2018; Kaminzi, 2021). The reflections above relate to the bilateral flow of information and the climate dimension of transparency (Souba *et al.*, 2007). Matters were further complicated at UNAM SoM due to poor relations with the MoHSS due to poor communication. Placements of the senior students within a clinical setting became a challenge and the hospitals in Windhoek became overcrowded (Lamprecht, 2014). It is worth noting that the medical school in Botswana continue to restrict their student admissions to 36 students per annum (Matlhagela *et al.*, 2018). A slight change in student numbers can have a cascading effect on resource allocation. Early and effective bi-lateral communication between all the stakeholders might have mitigated these stressors. My perceptions and interpretation of the climate indicator of transparency, as it relates to UNAM, emphasises its importance in setting the tone for collaboration. Effective bilateral communication is essential during the inception and development of medical schools.

Another challenge of setting up a new medical school is ensuring an efficient staff complement. The majority of medical schools in SSA have a shortage in teaching staff (Mullan *et al.*, 2011) and this can hamper the unison of the collective efforts and missions within an institution (the organisational domain). These constraints further affect *human capacity and workload* (E3 and F1) within each institution. Staff shortage within the clinical specialties was highlighted: "The hospital is understaffed, they don't have enough specialists" (C1); and "So in the clinical areas we are grossly under staffed" (E2). Matlhagela and co-authors allude to one possible reason for the staff shortages. Their publication 2018 captures the early years of their medical school at the University of Botswana. They refer to slow and centralised reporting structure that hindered the appointment of expatriate members of staff and delayed contract renewals for others. Initially, reporting entailed a multi-tiered structure through the Faculty of Health Sciences. This changed in July 2014 after the School of Medicine gained Faculty status and thus gaining autonomy and broke away. Organisational change was achieved as a collective where all the members of the medical school petitioned at government level (Matlhagela *et al.*, 2018). The collective effort referenced here reflects the ability to function as a team and is characteristic of effective leadership (van Diggle et al., 2020). It also captures the need to identify organisational issues and appreciate the wider agenda of the medical school (Swanwick and McKimm, 2011).

The impact of "verticalness" (C3) or the "hierarchy that is followed within African medical schools" (F1) is exemplified by the challenges of establishing a Department of Medical Education (DME) or Medical Education Committee (MEC). UNAM SoM established a MEC in November of 2016. The MEC was responsible for the curriculum review, ensuring integration (both horizontal and vertical) of the subjects, establishing a mentor system for the students, assessment and facilitating admissions. Prior to this, the curriculum, assessment and student admissions were dealt with at School Board level or

through an ad hoc committee. The MEC was then transferred under the stewardship of the then Dean of the School. Sadly, the MEC failed to gain critical mass due to many constraints and the MEC reverted back to default under the School Board. This is where Botswana made tremendous headway and they have managed to establish a DME from the onset. Their DME directed curriculum alignment issues during the early stages of the curriculum development. Of interest is that they emphasised the dire need for "all academic staff to realise that they are members of DME" (Matlhagela *et al.*, 2018). The points towards the need for a collective effort and they continued to suggest that this could be achieved by having a representative from each department that serves within the DME (Matlhagela *et al.*, 2018). The importance of an MEC or DME relates to the alignment of institutional efforts and forms part of the strategic approach of the organisation. MECs or DMEs enhance the pedagogical roles of medical schools (Al Shawwa, 2012).

My lived experiences mentioned above form part of the early history of teaching and learning at UNAM SoM. These reflections reverberate the roles and challenges captured within the current chapter. Upon reflection, I can agree that leaders in new medical schools have to get their "feet and hands wet" (B1) and my growth and development followed a "steep learning curve" (E3) by "learning the hard way" (E1). The archetypes that I can identify with are the *leader in front* and *becoming a leader*. Furthermore, I am trying to be a *strategist* whilst investing in my own development as a leader. The impact of my lived experience in the interpretation of the data is captured in the Reflectivity Statement (Section 7.3) in Chapter 7. Finally, the lived experiences captured in this section recapitulate the notion that new medical schools are facing similar challenges (Eichbaum *et al.*, 2012). It also forms part of the collective representation of the development of leadership in new medical schools.

5.6 SUMMARY

Leadership is a multifaceted phenomenon that relies on the interplay of a leader and organisational and his/her socio-cultural environments (Porter and McLaughlin, 2006). Leader and leadership development are co-dependent and should be incorporated into a new leadership strategy with an organisation (Dalakoura, 2010). Findings from each institution demonstrate that leaders are presented with unique challenges. The findings also represent the authentic aspects of leadership development rather than drawing on the exhaustive body of literature on leadership theories and practices. The themes and subthemes generated from the interviews portray the responses of leaders to these challenges within their respective institutions. They capture the biographical backgrounds (intrapersonal domain) of the leaders as well as their personal reflections on the leadership of their seniors. The values, expectations and goals

of a medical school form part of the interpersonal and organisational domains of the leaders (Lieff and Albert, 2012). Within these domains, the leader has to grapple with motives and intentions of colleagues, and build collegial relationships and rally support. The curriculum, its effective implementation and management, forms part of the programmatic challenges that are faced by leaders. In the backdrop are the contextual forces, the outside world, of government driven policies and collaborations, and economic stressors. These factors influence the behaviours and practices of leaders within an organisation in order to get things done or implement the necessary change (Weick, 1995; Hage and Posner, 2015; Gaitho, 2019). Furthermore, the factors drive the growth and development of leaders and they subsequently transform into a *leader in front*, *strategist*, *leader as manager*, or become silenced and defeated (the *silenced leader*) or is undergoing the process of *becoming a leader*. Finally, it is important to note that each of these archetypes become activated at any given time and activation is driven by the need to respond to challenges. The findings presented in this chapter will be consolidated in further detail in Chapter 7.

CHAPTER 6

LEADERSHIP DEVELOPMENT THROUGH COLLABORATION AND PARTICIPATION

6.1 INTRODUCTION

The concepts of "leader" and resultant "leadership" (the collective) necessitate the involvement of other people. Leadership is therefore "a collective or group process" (Astin and Astin, 2000). The leaders of today are acting in environments that require collaboration (O'Leary *et al.*, 2010). Collaborative leadership activities can be viewed as a means of facilitating change. Change in this context can be considered as "a planned activity whose goal is to realign the organisation with its environment" (Suchan, 2006). An external force such as collaboration within a consortium can serve as a change agent (Lunenburg, 2010). Intra- and inter institutional linkages depend on the extent of collaborative involvement. Talib *et al.* (2015) writes that through collaborative consortia, African universities learn to develop personal relationships, engage all levels of leadership, and foster cultural and hierarchical changes within their institutions. Active participatory and collaborative efforts of a consortium thus serve as a catalyst for transformational change. Leaders within this milieu subsequently develop their skills as a result of this change-agentry, i.e. the activities associated with the facilitation of change. Their learning and growth entail the promotion of personal relationships with the faculty of other institutions. The barriers caused by the competitive nature of local universities are broken down and the sharing of resources become a priority in order to serve the national health needs (Talib *et al.*, 2015). Intrinsically, leaders from all levels are activated to start intra- and interinstitutional dialogues and this communication and networking, in turn, is believed to contribute towards leadership development. Frenk *et al.* (2010) proposed that institutional collaboration and participation through "networks, alliances, and consortia" can serve to capacitate and strengthen existing health systems (Frenk *et al.*, 2010). The Consortium of New sub-Sahara African Medical Schools (CONSAMS) is an exemplary initiative and was established in 2011. The consortium was established with the aim to promote the sustainable growth of new medical schools in low- and middle-income countries (LMICs) in southern Africa.

The pivotal role of collaboration and partnerships has been highlighted within the narratives of establishing new medical schools. Malawi's only medical school opened its doors in 1991. By 2001, the College of Medicine successfully graduated 169 medical doctors (Muula and Broadhead, 2003; Muula, 2009). It was believed at the time that the new medical school in Malawi would attract prospective students from countries without their own programmes on offer at the time. For instance, Botswana,

Namibia, Lesotho and Swaziland (now known as Eswatini) did not have their own medical schools in 1991 (Muula and Broadhead, 2003). The successes of Malawi's College of Medicine include the retention of home-grown graduates and to accommodate those who furthered their studies abroad in local leadership positions (Muula, 2009). The challenges of new medical schools in developing countries typically relate to economic constraints. The authors also noted that two primary forces were at play within the new college at the time of its inception. They refer to the "centrifugal forces" associated with departments seeking autonomy and "centripetal forces" related to curriculum integration (Muula and Broadhead, 2001).

The many constraints associated with new medical schools in LMICs drive resourcefulness but also emphasise the value of collaboration. Collaboration in research and medical education improves academic advancement through the acquisition of funds and the development of local expertise (Muula and Broadhead, 2001; Eichbaum *et al.*, 2015a). The value of such partnerships is demonstrated in the case of Mozambican medical schools, with the establishment of postgraduate degree programmes (Fronteira *et al.*, 2014). A recent development at UNAM's SoM, through CONSAMS, was an online course for African medical educators on the establishment of online courses on Moodle. Regional linkages allow institutions to share their experiences and human resources through staff and student exchange programmes (Eichbaum *et al.*, 2014a and 2014b). Effective collaborative partnerships ensure that institutions no longer have to function in isolation (Eichbaum *et al.*, 2015a). Capacitation of research efforts and health professions education activities can be considered as one of the primary deliverables of collaborative efforts. A very important outcome of collaboration and participation is learning. Learning through acquisition, based on the metaphor of Sfard (1998), is the acquisition of knowledge by an individual. This learning can be transferred across contexts and can be assessed. Learning through participation is a dynamic process that relies on participation and interaction. Participatory learning is therefore situated and dependent on the social context within which it occurs (Sfard, 1998). Eichbaum captured the essence of this when he stated that "participation is learning" (Eichbaum, 2017a).

The current chapter, through a qualitative document analysis (QDA), will consider the participatory and collaborative activities of CONSAMS. The documents studied in this chapter are viewed as socially situated agents (Scott, 1990). The QDA will draw upon these activities to understand how leaders develop through participation and collaboration in light of the deliverables of these partnerships.

6.2 DATA COLLECTION AND ANALYSES

The QDA relied on a four-step Scott method in order to ensure that the documents were (1) authentic, (2) credible, (3) meaningful and (4) representative of the activities of the consortium. Documents were considered authentic based on their origin, i.e. either representing CONSAMS at a meeting, published in a peer reviewed academic journal or electronically received from the CONSAMS secretariat (Scott, 1990). The reliability of the documents depended on the authorship and this criterion was met when the authors were CONSAMS members at the time. Publications in scholarly (peer reviewed) journals or books were considered during the QDA. Minutes of meetings, generated by the secretariat, were accepted, based on an internal review process by the secretariat. Representative documents, for the purposes of the QDA, refer to documents that were generated by a CONSAMS representative or secretariat. Furthermore, published reports, academic scholarly works and media reports were deemed representative if they explicitly reported on CONSAMS. Finally, the documents were regarded as meaningful if they were complete and included a stated value related to CONSAMS (Scott, 1990; Bastani *et al.*, 2018).

A QDA was performed on the documents generated by the CONSAMS secretariat between 2017 and 2020, based on the ethical approval of this project (Appendix I). The documents include agendas, meeting minutes, event programmes, background papers, and scholarly works (Bowen, 2009). Furthermore, published reports, academic scholarly works and media reports that were in the public domain between 2011 and 2019 were also subjected to a QDA. The documents were obtained through a strategic search for publications produced by members of CONSAMS in PubMed and Google. The approach that was followed is outlined in Table 6.1 and followed the process of Maggio *et al.* (2016). Agendas, minutes and reports of CONSAMS meetings were obtained during my involvement with the consortium and, as stated above, were included based on the period of ethical approval (2017 to 2020). Furthermore, any of the works generated by CONSAMS, that were freely available in the public domain, were also included.

Table 6.1. Strategies employed for finding researcher publications in PubMed and Google (Maggio *et al.*, 2016).

Strategy	**Examples**
Search for CONSAMS	CONSAMS Consams consortium Consortium of New Southern African Medical Schools* Consortium of New Sub-Sahara African Medical Schools
Search by author (Last name, followed by the addition of first and middle initials where applicable or complete first name)	Wessels Wessels Q Q Wessels Quenton Wessels
Combining the author name with the research theme	Wessels AND CONSAMS Wessels AND consortium Wessels AND Consortium of New Southern African Medical Schools* Wessels AND Consortium of New Sub-Sahara African Medical Schools
Combining the author name with the affiliated institution	Wessels AND Copperbelt University Wessels AND Copperbelt Medical School Wessels AND Copperbelt School of Medicine
Consult database or search engine to determine the command for searching	PubMed: Wessels Q [Author], Wessels [Author], Quenton Wessels [Author] CONSAMS [All fields]; Google: Author: Wessels; Wessels Q; Q Wessels; Quenton Wessels; "CONSAMS"; "Consortium of New Southern African Medical Schools"* etc.

* Former naming of the consortium.

An inductive approach was followed during the QDA. The researcher implicitly considered themes that alluded to leadership development throughout the document analyses and this was followed by the

generation of explicit themes. The generation of explicit themes considered exact words or phrases pertaining to leadership development within the CONSAMS (Mogalakwe, 2006; Bastani *et al.*, 2018).

6.3 FINDINGS

The QDA considered a total of 58 documents that ranged from meeting agendas and reports, scholarly works, book chapters, newsletters, external reports, conference proceedings, and the CONSAMS constitution (Table 6.2). Documents that were deemed authentic, credible, meaningful and representative of the activities of the consortium totalled 39. The majority (15) were in the form of presentations on the activities and progress at annual CONSAMS meetings. Eight of the documents that were used were peer reviewed scholarly publications. A total of five reports were included for the period of 2017 to 2020 (Table 6.2). It is important to note that the accompanying agendas were considered as part and parcel of the reports that were reviewed. The constitution of the consortium, external newsletters (four in total) and two book chapters were also included in the final QDA (Table 6.2).

Table 6.2. Categories of the final studied documents.

No.	Categories of final studied documents	No. of Documents	Reference(s)
1	CONSAMS constitution	1	CONSAMS, 2014
2	CONSAMS agendas, and reports/minutes	5	CONSAMS 2017; CONSAMS 2018a, 2018b, 2018c; CONSAMS 2020b
3	CONSAMS meeting presentations	15	Bowa, 2012; Eichbaum, 2012; Matlhagela, 2012; Mokoena, 2012; Menon, 2012; Mulenga, 2012; Odonkor, 2012; Pires, 2012; Tlale, 2012; Vanio, 2012; Bowa, 2014; Eichbaum, 2013; Pires, 2013; Eichbaum, 2017b; Eichbaum, 2018b
4	Conference proceedings	4	Varkki and Tervaskanto-Mäentausta, 2014; Badlangana *et al.*, 2014; Pasricha and

			Eichbaum, 2015; Eichbaum *et al.*, 2015c
5	Scholarly (peer reviewed) journals	8	Eichbaum *et al.*, 2012; Vorster, 2013; Talib *et al.*, 2015; Eichbaum *et al.*, 2015a; Badlangana *et al.*, 2016; Eichbaum, 2018a; Matlhagela *et al.*, 2018; Omaswa *et al.*, 2018
6	External reports and newsletters	4	UNAM, 2013; GHETS, 2014; UNAM, 2014; UNAM, 2015
7	Book chapters	2	Eichbaum *et al.*, 2015b; Jacobson *et al.*, 2015

According to the QDA, four main themes were generated during content analysis. The themes are: *partnerships*, *medical education*, *healthcare challenges* and *leadership* (Table 6.3). Each of the themes will be outlined in the sections that follow.

Table 6.3. The main themes and sub-themes linked to leadership activities within CONSAMS.

Themes	Subthemes	Code Examples (Quotes)
Partnerships	Research and Teaching	*Technology* *Internship and student exchange* *External examiner initiative* *Staff and faculty development initiative* *Knowledge exchange, skills development and improved understanding* *Training facilities* *Joint education and health planning mechanisms* *Medical education capacity development* *Sharing ideas and innovations* *Network forms a common medical training ground for our students* *Similar challenges*

		Address manpower constraints
		Promote south-south partnerships
		Better mutual benefit
		Northern guidance
		Peer-to-peer learning
		Raised visibility through publications and presentations
		Overcome the historical culture of individualism
		Participation in national and international forums
Medical Education	Contextual and Appropriate Curricula	*Curriculum review, development and alignment*
		Moodle, academic development, performance assessment
		Instructional development
	Staff Training	*Education that aims to enhance teamwork between health professionals, administrators, policy makers, and community leaders*
		Manage curriculum development and postgraduate programme development
		Strengthen medical education in the region
		Assessment and evaluation
		Development of regional accreditation standards
		Innovative pedagogies
		Transprofessional programmes
Healthcare Challenges	Human Resources for Health	*Geographic, economic and cultural challenges*
		Joint education and health planning mechanisms per country
		Initiatives aimed to stem the "brain drain" of physician graduates from sub-Saharan Africa
	Capacity Development	*Health service and health promotion*
		Focus on family medicine as main tool to improve health service
		Creative participation – family health
		Develop medical competencies
		Quota-based student admissions policies
		Community-based programmes
		Community medicine programmes

		Improving the well-being of families, and enhancing community development *Health workers feel better connected with peers* *Retention of health work force and training of workers* *Under-capacitation of health workers in rural areas* *Community-based education and service* *Tackle our healthcare challenges* *Africa-centric medical education* *Context-specific medical competency training* *Postgraduate programmes - Water and sanitation, health promotion, HIV management, value chain and medicine distribution*
Participative Leadership	Engaging and Involving Transformation through Participation	*Mobilize leadership towards institutional and instructional reform* *Discuss CONSAMS objectives* *Hosting of CONSAMS meetings* *Reporting to university management* *Private funding, grants and seed funding* *Learning and teaching policy development* *Transformative level of learning – leadership attributes* *Leading curriculum development and quality improvement* *One student, one family – leadership skills development* *Organisational development* *Change management* *Participative leadership* *Collaborative leadership* *Secretariat provide leadership in the activities of the consortium* *Partners communicate frequently to exchange ideas and report on the progress of key objectives* *Expansion* *Engaging/involving leadership* *Administrative setbacks* *Effective communications*

6.3.1 Partnerships

Partnerships within the consortium appear to drive research and teaching efforts in the region. The teaching efforts relate to both student and staff exchange programmes (Table 6.3). For instance, lecturers from UNAM served as external examiners of anatomy and physiology at Copperbelt University (Bowa, 2014). Faculty exchange initiatives serve as a method of assuring quality through monitoring and support of content delivery and the setting of standards (Matlhagela, 2012; Mulenga, 2012; CONSAMS, 2014; CONSAMS, 2018c; Eichbaum, 2018a and b). The exchange programmes also mediate knowledge exchange, reciprocal skills development and improved understanding of the regional health needs (Mulenga, 2012). The findings further indicate that joint education is promoted and this requires planning to address the health needs of the region (Eichbaum, 2012). Collaboration and participation promote south-south partnerships, the sharing of "ideas and innovations" (Table 6.3) (Eichbaum, 2013; Eichbaum *et al.*, 2015a). One of the members pointed out that collaboration helps to "overcome the historical culture of individualism" and the collective can work towards "common goals" and "discuss common issues" (Talib *et al.*, 2015).

Another deliverable of participation is research. The document analysis points towards the promotion of collaborative research and research aimed at regional health systems (Eichbaum *et al.*, 2015b; Jacobson *et al.*, 2015). It is also believed that the research efforts of the consortium will raise its "visibility through publications and presentations" (Table 6.3) (Eichbaum *et al.*, 2015b). However, it has also been pointed out that the regional research output is hampered by the teaching and administrative burden of academic staff (Eichbaum *et al.*, 2015b).

The findings from the QDA indicate that students also benefit from the partnerships. One data source stated that "our unique network forms a common medical training ground for our students" (Table 6.3) (Badlangana *et al.*, 2016). Student exchange efforts were documented between the University of Botswana, Copperbelt University (Zambia), University of Lesotho, and Lúrio University (Mozambique) (UNAM, 2013). Students also participated in exchange and elective programmes between the northern and southern partners. Eichbaum reported in 2013 that such exchange initiatives occurred between Vanderbilt University School of Medicine, Copperbelt University (CU) and the UNAM SoM (Eichbaum, 2013). UNAM students also completed their electives at Oulu (Vanio, 2012).

Overall, the "mutual benefit" (Table 6.3) through partnerships and "peer-to-peer" learning with "northern guidance" has been identified as one of the major deliverables of collaborative participation (Bowa, 2012; Eichbaum *et al.*, 2015b; Eichbaum, 2018a and b). The regional needs drive the efforts

within the consortium as a collective. These needs primarily relate to capacity building within each participatory medical school.

6.3.2 Medical Education

The second theme that was generated, *Medical Education*, relates to the development of contextual and appropriate curricula within the region (Table 6.3). Findings from QDA point towards a concerted effort by the collective to achieve this. The consortium strives to develop pedagogy "that aims to enhance teamwork" between the various stakeholders (Table 6.3). These stakeholders include community leaders, policy makers, health professionals and administrators (Eichbaum *et al.*, 2012). Within the domain of medical education, the consortium endeavours to "manage curriculum development and postgraduate programme development" (Pires, 2013). It is believed that the efforts of the consortium "can strengthen medical education in the region" (Table 6.3) (Badlangana *et al.*, 2014).

The new medical schools in the region identified the need of "staff training and medical education capacity development" (Table 6.3) (Bowa, 2014). One of the deliverables of the collaboration was the review of biochemistry at CU (Bowa, 2014). The development of accreditation standards within the region has been identified as a priority (Eichbaum *et al.*, 2015c). The authors continue that the development of "transprofessional programmes", created by Lúrio University, encourages lecturers to develop and implement novel curricula. Students, through the One-Student-One-Family initiative, are provided with an opportunity to work within the communities alongside traditional healers, community workers and volunteers (Eichbaum *et al.*, 2015c). Thus, collaboration within the consortium fosters "Africa-centric medical education" and "innovative context-based medical curricula" (Table 6.3) (Vorster, 2013; Eichbaum *et al.*, 2015c).

6.3.2 Healthcare Challenges

Medical schools in Africa face many challenges and some of these include "geographic, economic and cultural challenges" (Table 6.3) (Eichbaum, 2012). The findings of the QDA further highlight the need to strengthen HRH in the region. The consortium endeavours to achieve this through "initiatives aimed to stem the 'brain drain' of physician graduates from sub-Saharan Africa" (Pasricha and Eichbaum, 2015). The third theme that was therefore generated is *Healthcare Challenges* and the efforts of the consortium are aimed at tackling the lack of *Human Resources for Health* (subtheme) (Table 6.3).

Student selection strategies and community-based education and service (COBES) have been highlighted as methods in addressing the ever-growing deficit in HRH.

The consortium serves as a catalyst where "community-based programmes", such as COBES within the curriculum of UNAM, is aimed at "improving the well-being of families, and to enhance community development" (Mulenga, 2012; Eichbaum *et al.*, 2015b). Specific curricula, such as that of Lúrio University, are geared to "focus on family medicine as the main tool to improve health service" (Pires, 2013). It is believed that "health workers feel better connected with peers" (Table 6.3) when faculty and students are deployed within their respective communities they serve (Eichbaum *et al.*, 2015b). The "under-capacitation of health workers in rural areas" along with the "retention of health work force and training of workers" have been identified as major challenges (Tlale, 2012; Eichbaum, 2013). It is believed that "quota-based student admissions policies", currently implemented at UNAM SoM, will encourage graduates "to later practice in rural areas" (Table 6.3) (Eichbaum *et al.*, 2015a and b). An additional approach by CU, one of the CONSAMS institutions, is to sponsor their postgraduate students. It has been reported that "sponsored graduates commit to return to their institutions as junior faculty" (Talib *et al.*, 2015).

The findings of the QDA illustrate the collaborative efforts within the consortium that are directed to address the HRH deficit in the region. The strategies that are employed include the placement of students in their respective communities and to focus on strategic admission policies. This in turn is believed to encourage graduates to return to their communities of origin.

6.3.4 Participative Leadership

The final theme that was identified is *Participative Leadership* (Table 6.3). The CONSAMS Secretariat was established at UNAM SoM. This decision followed the third CONSAMS meeting in 2012 at the University of Botswana, School of Medicine, Gaborone (Bowa, 2014). Leadership activities within the consortium appear to be participative. The current section will explore the aspects of participative leadership within the consortium (Varkki and Tervaskanto-Mäentausta, 2014).

The only explicit reference to leadership development was in reference to Lúrio's one-student-one–family initiative. Pires (2012) stated that through this programme "leadership skills development" is facilitated (Table 6.3). A family is assigned to each student and this is aimed at the delivery of pre-service health education. The students are tasked with assessing the impact of socio-cultural and economic factors on the health and well-being of their assigned families and family members (Pires,

2012; Eichbaum *et al.*, 2015b). Leaders, from a student's perspective, are thus developed within the community and can be achieved through a "transformative level of learning" (Table 6.3) (Eichbaum, 2012).

The efforts of the consortium have the potential to "mobilize leadership towards institutional and instructional reform" (Eichbaum, 2012). The "collaborative leadership" extends from the day-to-day operations within the consortium to the participating institutions. Intrapersonal development stems from the tasks and activities that are assigned to individual members. This includes the administrative responsibilities of arranging a face-to-face or virtual meeting, preparing documents, and driving funding initiates. It also appears that the interpersonal growth of the consortium members is further driven by activities such as: "curriculum development and quality improvement", "reporting to university management", facilitating institutional "change management", "learning and teaching policy development", and "engaging/involving leadership" at an institutional level (Matlhagela, 2012; Mulenga, 2012; Odonkor, 2012; Pires, 2013; Talib *et al.*, 2015). These activities implicitly allude to the development of leaders within CONSAMS.

The objectives of the consortium are discussed during annual meetings. These meetings serve as a platform to "exchange ideas and report on the progress of key objectives" (Matlhagela, 2012; Badlangana *et al.*, 2016). The "expansion" of the consortium through the recruitment of new medical schools has been identified as a strategic objective (Table 6.3) (Bowa, 2012; CONSAMS, 2014). However, the consortium has faced some "administrative setbacks" and the need for "effective communication" has been identified (CONSAMS, 2018c).

6.4 SUMMARY

The findings of the QDA indicate that decision-making is shared and based on mutual agreements, i.e. the goals of the constitution. This shared decision-making or shared leadership captures the essence of participative leadership (Veale, 2010). The collective, through collaboration, strives to establish: context appropriate and transformative medical curricula, postgraduate training programmes, accreditation standards, equitable admission policies, and research programmes (CONSAMS, 2014; Eichbaum *et al.*, 2015a and b). It is believed that "global networks, alliances and consortia" can address the ever-growing shortfall in HRH (Frenk *et al.*, 2010; Eichbaum *et al.*, 2012).

Collaborative efforts through research and those aimed at improving medical education standards progress academic advancement (Muula and Broadhead, 2001). The breaking of competitive barriers

lifts institutions from isolation. Furthermore, it is believed that capacitation of individuals and institutions can be achieved through collaboration. (Eichbaum *et al.,* 2015a; Talib *et al.,* 2015).

Each member of CONSAMS can be considered a leader and change agent within their respective institutions. As a collective, they are agents of change, aiming to impact medical education and healthcare in the region. Institutional activities within the consortium contribute towards individuals' learning and subsequent development through participation. This aspect of leadership development appears to occur at faculty level due to the engagement of CONSAMS members with their institutional leaders. However, the findings of the document review reflect the aspirations of the consortium (the collective) amidst the challenges and struggles at ground level. Findings also reflect the struggles at an institutional level whilst aspiring to form linkages to redress curriculum and staffing issues.

CHAPTER 7

DISCUSSION: UNDERSTANDING LEADERSHIP DEVELOPMENT

7.1 INTRODUCTION

This study sought to understand how leadership develops within new medical schools. The overall aim of the study was to conceptualise the role and development of leaders and leadership capacity, while pursuing joint and individual projects by each medical school within CONSAMS. Leadership development is concerned with an increase in the collective capacity of the members within an organisation in order to take part in leadership roles. The current study also considered leader development due to the mutually inclusive nature of leader and leadership development (Day, 2000; McCauley *et al.*, 1998; Dalakoura, 2010). In order to appreciate leader development, we should ask "what qualities do we need to develop in our leaders?" and for leadership development "what qualities do we need to develop in our organization?" (O'Toole, 2001). Thus, within the context of the current study we essentially should ask: "What qualities have developed in our leaders and organization?"

The sections that follow will consider and discuss the findings of this study. I will start with a brief background to my personal reflections that led to the inception of the project. The purpose of this is to affirm my role as participant observer. I will continue to discuss the research findings, address the research questions, and present a sequential synthesis of a framework to understand leadership development. Finally, I will continue through reflexivity to reveal my views and assumptions regarding the study and how this influenced the execution of the research project.

The Consortium of New sub-Sahara Medical Schools (CONSAMS) was considered a suitable target population for the project. My involvement as representative of UNAM SoM within CONSAMS and exposure to other new medical schools prompted several questions. Upon reflection I came to understand my own position and transformation during the initial years of curriculum and infrastructure development. I was part of a pioneering team of five members and we all were emergent leaders at the time; but we were not appointed or elected. Our leadership developed over time as a result of interactions at various levels amidst a vast array of responsibilities (Kickul and Neuman, 2000). My perceptions led me to believe that we were managers, leaders and foot soldiers trying to navigate the rough terrain caused by both driving and restraining forces. Subsequently, I wanted to know why the new medical schools are facing similar challenges (Eichbaum *et al.*, 2012). Is there commonality in the challenges? I also wanted to know how members of new medical schools talk about and understand what is going on?

What do I see and what are my perceptions? Is there a leadership issue within these new medical schools, i.e. from the top down or the bottom up? How do the challenges, within new medical schools, influence leaders and leadership in the long run? Ultimately, my questions honed in on leader development (individual) and leadership development (the collective within a medical school). I wanted to know how these factors impact the growth of leaders and ultimately, leadership. My primary assumption was that everyone involved in establishing a new medical school can be considered a leader. These leaders typically fulfil multiple roles that include curriculum development and implementation, facilitation of programmes, stakeholder engagement, coordination of clinical placements, and resource planning and allocation (McKimm and O'Sullivan, 2016; van Diggle *et al.,* 2020).

The various questions outlined above led to the inception of this research project and the following research questions were subsequently formulated:

1. What are the pedagogical leadership roles and/or experiences (collective and individual) within each institution in the consortium (CONSAMS)?
2. How do appointed and emergent leaders conceptualise and address anticipated challenges?
3. How is the nature of leadership development (collective and individual) experienced in response to these challenges?
4. How is pedagogical leadership development collectively perceived and conceptualised within CONSAMS?

The current chapter will return to the research questions to determine whether they have been answered and ultimately to conceptualize the nature of leadership development in new medical schools. My approach will be to use the conceptual framework referenced in Chapter 2 as a lens through which the study phenomenon is viewed (a summary is outlined in Table 7.1).

Table 7.1. The conceptual framework formulated from the three theories in parallel (Section 1.5 of Chapter 1).

Force Field Model (Samuel, 2008)	Four-domain framework (Lieff and Albert, 2012)	Pedagogical Social Axes (Male and Palaiologou, 2015)
Biographical	Intrapersonal (self-awareness)	Internal and external axes of pedagogical leadership
Programmatic (direction of teaching and learning practices)	Interpersonal (fostering informal networks)	
Institutional (micro-contextual forces)	Organisational (creating a shared vision)	
Contextual (macro-social, political, historical context)	Systemic (strategic navigation)	

The framework (Table 7.1) consists of three theories and examines the relationship between them. A detailed outline of the conceptual frameworks is provided in Chapter 1. Paraphrased segments (in italics) and direct quotations from the interviews will be used throughout this section. My understanding of research findings in reference to the literature will also be presented. This will be accompanied by a progressive synthesis of a model to understand leadership development in new medical schools. The framework will also be conveyed through my own visual representation of each element of leadership development and how I understand it.

7.2 SYNTHESIS

7.2.1 The Pedagogical Leadership Roles and/or Experiences

A reductionist view of the leadership roles has been captured by Chen *et al*. (2004), Mullan *et al*. (2011), and more recently, Diggle *et al.*, (2020). However, the need to focus on the interaction between a myriad of varying elements as opposed to individual agents has been emphasised by Male and Palaiologou (2015) and Alonso-Yanez *et al*. (2021). The conceptual framework employed within the current study points towards leadership roles that are much more diverse and complex. At an individual level, leaders carry the pain of the students whilst grappling with institutional constraints. This exemplifies the force of biography which relates to a leader's pedagogical capacity that has developed through lived

experiences (Samuel, 2008). The force of biography elicits an internal dialogue where the leaders are negotiating their position and roles and relation to the efforts of others and the subsequent impact on students' teaching and learning. The biographical force allows leaders to draw strength from their own experiences, which they have cultivated over time, in order to fulfil their roles. Moreover, the forces proposed by Samuel (2008) act synchronously on the direction of teaching and learning practices (the programmatic force) and compete with the biographical force in this instance.

Findings indicate that competing agendas is the norm in new medical schools and associated leadership roles include solving problems related to a clash of interests between the institution (micro-contextual force) and teaching hospital (macro-contextual force). Furthermore, leadership roles are influenced by leaders' interpretation of the events and occurrences within each medical school. Emergent leaders negotiate their position whilst simultaneously navigating the challenges. They sometimes feel overwhelmed and unsupported. Furthermore, leaders are required to be cognisant of the objectives of the institution or department. This reflects aspects of the programmatic force and the direction and alignment of pedagogical activities and the institution's ethos. The institutional ethos can be regarded as the "underlying and overt mission and theoretical underpinning of an institution" (Samuel, 2008). Alignment and clear communication of the collective vision within medical schools remain a challenge. The experiences of leaders also point towards a level of detachment brought about by 'verticalness' (C3, Table 5.6) within the organisational structure, i.e. the organisational domain. This apparent misalignment constitutes the programmatic force of the curriculum and the roles of leaders to address the contextual health needs (the contextual or macro-social force) of the region.

The domains of Lieff and Albert (2012) represent the areas of pedagogical leadership as practiced within each school. Samuel's forces represent the factors that stimulate or hamper the fulfilment of leadership roles. The forces that act on leaders are multifaceted and are influenced by all of the forces. The leadership roles appear to occur within a contextually bound climate that varies within each institution (Fig. 7.1). The roles and actions of leaders are dependent forces that bear down on leaders. This occurs within a long-term leadership climate. The leadership roles and actions in turn are directed to mitigate or correct the forces (the short-term weather) and occur within the four domains of Lieff and Albert (2012). Each institution presents with its own leadership climate and is contextually bounded by the macro-social forces that are at play (Fig. 7.1). Findings from the current study indicate that open and frank communication might be encouraged in one institution but not tolerated in another. Furthermore, clear and open bilateral communication has been identified as a major constraint in some institutions and points towards misalignment of strategic objectives and roles. The flow of information within an institution is essential for fostering collaboration (Souba *et al.*, 2007). Transparency is a fundamental component of authentic leadership, the idea where a leader's decision making and actions are true or

genuine to themselves (Luthans and Avolio, 2003; Avolio and Gardner, 2005). Furthermore, transparency is an attribute of authentic leadership (Souba *et al.*, 2007). Lessons from health services research indicate that a positive leadership enhances engagement and staff involvement (Dawson *et al.*, 2011). This empowerment reciprocates continued growth and development within an organisation ((Brian) Joo *et al.*, 2021).

Leaders' perceptions from the current study suggest that accountability is lacking within some of the institutions and that many of the respondents felt that good performance is not rewarded. Accountability has been cited as one of the many challenges of leadership development (Hanson, 2013). Accountability creates social order within an institution and is vital for good convergence (Hall *et al.*, 2017). The climate dimension of accountability is a key indicator of effective leadership. Accountability relates to the setting of clear and well-defined performance standards and holding others and oneself accountable for meeting those standards (Souba *et al.*, 2007). Accountability links to leadership development in that it strengthens others within the collaborative effort (Kouzes and Posner, 2002; Souba *et al.*, 2007).

Clear performance expectations and the implementation of reward systems appear to be lacking within some medical schools of the current study. These parameters could be linked in terms of a mismatch between intrinsic motivation, performance-contingent rewards, the nature of performance expectations and self-regulation. Self-regulation, a meta-competency, entails learning and adjustment in order to accomplish long-term goals. Self-regulation is not a foreign concept in the spheres of clinical and educational psychology (Karoly, 1993; Nenniger, 2005). Recently has it gained interest as an important driver or the 'how' of the development of leaders and leadership (Yeow and Martin, 2013; Hall *et al.*, 2017). Carver and Scheier (2000) capture self-regulation as an individual's efforts to address the discrepancy between the desired outcome and current state of affairs (Carver and Scheier, 2000). It could be that the performance expectations within a resource-constrained environment are deemed unrealistic to some and that no institutional performance-contingent rewards are in place.

The collective misalignment between the values of clinicians, scientists and health professions educators in new medical schools has been highlighted by the findings. One possible explanation relates to different priorities of these three systems or tripartite arrangement. Patient care takes precedence in an academic or teaching hospital and education and training become less important (Elmberger *et al.*, 2019). Additional factors that come into play are the stated values (espoused values) of the organisation versus the behaviours and choices (enacted values) of its members. It could also be that the educationalists are not represented in the clinical setting or that formal educational discussions do not occur (Elmberger *et al.*, 2019). Similarly, the values of scientists might not match that of educators or the clinical teaching

staff. Another factor to consider is the possibility that the clinical teaching staff do not share similar values due to a lack of understanding of the principles and practices of HPE.

Findings further indicate that leaders are shaped based on their exposure to climatic factors. The climatic factors serve directly and indirectly as drivers and agents of change. Individual perceptions tell us, indirectly, of the things they perceive as wrong or right. However, individual perceptions depend on the level of seniority, responsibilities and domain (educator, clinician, scientist and combinations thereof) of the leader within the institution. This might influence the level of open communication and perceptions. It is therefore difficult to pinpoint and generalise what the issue/s is/are, hence the need for a more in-depth approach (for example, qualitative semi-structured interviews). Furthermore, factors such as fiscal solvency, governance, and organisational structure were not accounted for (Souba *et al.*, 2007). However, a myriad of independent variables can influence individual responses and act upon the dependent variable of leadership development. The diversity of the leadership climates within each institution is reflected by the findings. The climate or emotional tone set by leaders within an organisation can either stimulate or hinder growth and development of individuals. It can thus impact both leader development and leadership development. The way in which leaders understand organisational priorities and communicate these priorities creates a social learning process. This process develops as a result of staff members' interaction and observation of their leaders (Berson and Avolio, 2004; Chreim *et al.*, 2012).

Thus, the roles of leaders and their experiences are influenced by the course that is plotted by the institution's leadership (Samuel, 2008). The appointed leadership, top-down, creates the climate and represents the long term and averaged patterns of events (Fig. 7.1). Leadership development within a conventional vertical system relies on a tier-based progression (Kjellström *et al.*, 2020). Moreover, research suggests that shared leadership is viewed as being more important than vertical leadership when it comes to working effectively in a team (Wu and Cormican, 2021). From the literature it became apparent that this verticalness and the multilayer reporting structure almost threatened the existence of one of the institutions that partook in this survey. Their school was subsequently under-represented at faculty level and this resulted in delays in the renewal of employment contracts of expatriates. Furthermore, the employment of prospective applicants was also delayed. This however changed in 2014 when the medical school broke away and became a stand-alone faculty to gain more autonomy (Matlhagela *et al.*, 2018).

The organisational climate is comparable to the way that climate zones exist based on geographical regions. The climatic events reflect the levels of alignment, interpersonal connections, openness to disagree, and being aware of problems. Leadership (top down) determines the climate and bears down

on leaders and sets the tone within each institution. The leadership climate of Souba and colleagues (2007) thus provides an opportunity to recognise the differences in the leadership climate within each new medical school. The forces can metaphorically be viewed as weather, i.e. the short-term events that happen on a day-to-day basis, and can sometimes be erratic. The weather is perceived by the leaders, who in turn act to correct or augment the effects of the forces (Fig. 7.1). The different forces are not constant, they act jointly and they exert both positive and negative energies (Samuel, 2008). The impact and resultant effect of the forces appear to be subjective to the leader's constructed reality.

Figure 7.1 serves as a conceptual building block to understand the institutional leadership climate and the forces that act upon leaders within new medical schools. In answering the research questions, a layered model will be progressively presented to navigate the complexity of leadership development.

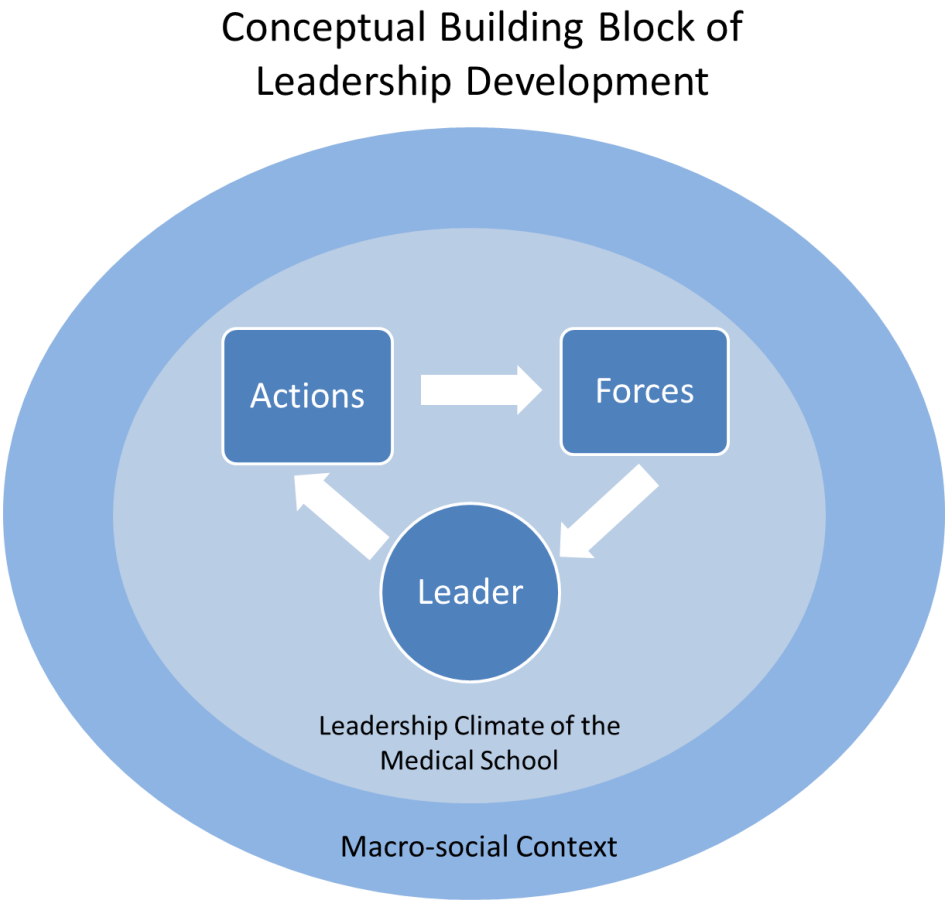

Fig. 7.1. The roles and experiences of leaders and the forces at play.

The social axes or social realities, as explained by Male and Palaiologou (2015), are linked to the desired outcomes of pedagogy and pedagogical leadership. The axes of pedagogical leadership complement the forces and domains (Samuel, 2008; Lieff and Albert 2012). The internal axes relate to the customs, culture, beliefs and values of the community that are served by pedagogy. External axes relate to the macro-social aspects of pedagogy (global economy, national educational curriculum, societal values, information and communication technologies, and social networking). Both axes span across all four forces and domains but do not run in parallel. The external axes contain aspects of programmatic force as well as the macro-social aspects of the contextual force. Similarly, the internal axes include components of the micro- and macro contextual forces. However, the axes of Male and Palaiologou (2015) serve as a vantage point of the context in which leaders operate. The contextual axes factor in aspects of secondary schooling of aspirant medical doctors, the local economy and politics within each country (Fig. 7.1).

Within the collective, the archetypes that were identified in this study include the *leader in front*, the *leader as manager*, the *defeated leader*, the *developing leader* and the *strategist*. Each of these leaders respond to varied events and occurrences within their respective institutions. The day-to-day leadership roles in new medical schools are based on emergent circumstances that arise within dynamic environments. Each new medical school is linked to communities they wish to serve (internal axes) through efforts such as the One-Student-One-Family initiative of Lúrio Medical School and COBES at UNAM SoM (Eichbaum *et al.*, 2015b and 2015c). The quota-based student selection process employed at UNAM, with the hopes that graduates will return to serve their communities of origin, is another example of context driven activities (Eichbaum *et al*., 2015a and b).

However, the findings indicate that leadership roles within CONSAMS are reductive in nature and are aimed at addressing the immediate needs of the medical schools in the region. These efforts do not account for the emergent circumstances within each medical school. The efforts of the consortium are aimed at addressing the resultant effects of leadership complexity, rather than focusing on an understanding of its nature. It appears that the roles of CONSAMS leaders are aimed at the symptomatic treatment of systemic issues within each institution. They address the lack of capacity in research and teaching by forming partnerships and focus on engaging and involving other schools in medical education efforts. It is not a case of a lack of research expertise in new medical schools but rather a lack of time, due to institutional fatigue, that hampers efforts. These efforts of CONSAMS are commendable but could have a bigger impact through a better understanding of complex phenomena within new medical schools.

7.2.2 How Appointed and Emergent Leaders Conceptualise and Address Anticipated Challenges

Findings from the current study suggest that leaders conceptualise the challenges at varying degrees of magnitude and complexity. Some view these challenges as *hindrances* or little *blockades*, whilst others perceive them as *tensions* that will always be there. The perceptions of leaders can be visceral at an individual and biographical level and were expressed as *headaches* and *heartaches*. At an interpersonal level the challenges are perceived as *inertia* and even *nonchalance* when leaders engage members of the school (the programmatic force). Furthermore, the conceptualisation of challenges is linked to the day-to-day activities of the leader within the four domains (Lieff and Albert, 2012). For instance, senior leadership functions within the systemic domain where political and historical forces are exerted (macro-social forces). These forces are generated by the local health needs and based on current disparities, *national pride* associated with a medical school, political undercurrents and public opinion. The same leader also functions within the interpersonal and organisational domains. In this instance, the programmatic and institutional forces of the curriculum, assessment, and constructive alignment are at play within the context of the university and teaching hospitals. Within these domains, the challenges can be perceived as either a *clash*, *mind problems*, or *tensions*. Furthermore, it appears that challenges are conceptualised as either immediate crises within the interpersonal domain (driven by programmatic forces), problems within the organisation, or *turbulence* at a macro-social level. It is important to note that medical school leaders function within all four domains of Lieff and Albert (2012) and that their roles are transitional in nature (Bordage *et al.*, 2000; Davies *et al.*, 2001; Black, 2015).

The challenges at an organisational level, as identified through the findings, include resistance to change and a verticalness of power. The contextual force within the systemic domain is referenced in the form of undercurrents and there exists a misalignment of objectives between the university and teaching hospital. One possible explanation relates to adjunct teaching staff, who prioritise their patients above teaching. Elmberger *et al.* (2019) noted that patient care takes precedence in a clinical setting and education becomes less important. Findings from the leadership climate of alignment further alludes to this; particularly in reference to the climate dimension assessing whether physicians, scientists, educators and administrators share similar values. Misalignment of values was found to be present in most of the schools that were surveyed.

How do leaders address the anticipated challenges they are faced with? Findings indicate that institutional hierarchies and verticalness (micro-contextual forces) necessitate leaders to escalate the matter through every tier to get things done. Others gain the buy-in of colleagues (programmatic force and institutional domain), as well as that of the community (the macro-social force). Day-to-day activities at an interpersonal level relate to staff matters that take up a lot of a leader's time. Blockades

and hindrances at higher levels (the macro-social force) elicited a response where leaders have to lobby through the Ministry of Education and the Ministry of Health. Sometimes leaders have to apply gentle pressure against the bureaucracy in order to get things done. In other instances, leaders *dream* of a solution and try to sell their dreams and ideas to the students, staff and senior leadership.

The challenges in some institutions, as interpreted through the findings, are the result of poor bilateral communication among colleagues and from the top down. Bilateral communication among colleagues and the institutional leadership relate to the interpersonal domain and the programmatic (pedagogical) force. The resulting challenges are addressed through crisis management, in order to negotiate a lack of human resources and teaching space when information is not shared. Leaders are aware of the tensions between stakeholders (macro-social forces) and feel that these tensions should be navigated and need to be managed. Cooperation through the establishment of linkages with the stakeholders in the private sector has been used to address the contextual forces. The implementation of systems was another approach that was mentioned, but sometimes there is resistance or inertia, and this reflects the micro-contextual forces that are at play.

In summary, emerging and appointed leaders address challenges differently and their actions are situated and contextually bound. Their biographies and learnt experience permit them to approach the anticipated challenges differently and in some instances more strategically. Findings point towards leaders' ability to negotiate and/or influence the forces that are at play. Some leaders have come to terms with the forces, such as tensions, and view them as the *status quo*. Leaders either address the anticipated challenges exerted by the forces in isolation with a sense of detachment, or form part of a community through cooperation. The latter emphasises the importance of the development of connections through teamwork, cooperation and earning the trust of others.

7.2.3 The Nature of Leadership Development Experiences in Response to Challenges

The nature of leadership development at an individual level, i.e. the knowledge of how the leaders in question act, reflects levels of self-awareness and experience. The current study has found that inexperienced leaders recognise that they have to *learn the hard way* and their development entails a *steep learning curve*. Their inexperience is met with little to no support and they subsequently feel abandoned by the institution's senior leadership. Leader responses to these challenges were the realisation that they have to *make a plan* and *deal with things*. However, leaders can reach a breaking point where they feel overwhelmed and discouraged, to the point where they give up. Others withdraw

and are silenced (silenced leader) and focus on their interests on things that they can control, such as research.

Emergent circumstances, as documented in the current study, result in the development of problem solvers and the leader as manager. The actions of these leaders are not indicative of their inexperience but are driven by the need for prompt action to prevent disaster. It became clear from the findings that their actions are responsive in nature rather than proactive. They navigate and negotiate obstacles as opposed to planning a route of action in advance. One possible reason for this has been the lack of human resources. It is for this reason that some leaders also develop into a leader and a soldier in order to get things done. Furthermore, the daily activities linked to *other stuff* and acting as a soldier taxes the strategic functioning of a leader. Competing or conflicting agendas have been documented as major challenges that health education leaders face (McKimm, 2004). This not only speaks of the misalignment between the expectations of the stakeholders at a macro-social level, but also at an institutional level. The existence of conflicting agendas, as demonstrated by the current study, might explain the difficulty some new schools face in plotting the direction of educational activities and thus managing the programmatic force.

More experienced leaders, within the current study, have established their roles and identities. Their development affords them the ability to lead change and understand the environment in which they operate (Oates 2012). Furthermore, through their actions, they strategically navigate the systemic domain (Lieff and Albert, 2012) and engage stakeholders to have them understand the ethos of the school as well, and understand where the institution would like to go. Over time, their development enables them to see the bigger picture (Swanwick and McKimm 2011). Within the conceptual framework, it has been found that experienced leaders identify the macro-social forces that extend beyond climate and context to a national level (i.e. national pride). They acknowledge that it is only a national individual that understands the national aspirations and national needs. Experienced leaders are contextually grounded and possess a holistic view of the macro-social forces that are at play.

The findings of the current study indicate that leadership development enables a leader to recognise the need to be a *good captain*. The leader is aware of the *turbulence,* but they have the capacity to interpret and understand all the forces, their confluence and their resultant effects. The *good captain* epitomises the leader in front, who considers all the navigational parameters with the destination in mind. This leader knows the required steps and sequences to obtain the desired outcomes, as captured by the literature (Oates, 2012; van Diggle *et al.*, 2020). Findings show that the *leader in front* exhibits the ability to communicate effectively at all levels. This aligns with leader developed competencies over time, that include the setting of goals and sharing opinions with confidence, as documented by Oates in 2012.

The current study found that the nature of leadership development at an individual level relates to a leader's ability to negotiate and/or influence the forces that are at play. The forces can have a positive or negative effect on leadership development (Samuel, 2008). The perceptions of these forces and the leader's construction of their own reality, allows the leaders to negotiate their roles and identity and exert influence. The actions of a leader are directed to influence the effects of the forces (Fig. 7.2). For instance, self-awareness of leadership inadequacies (the force of biography) can prompt a leader to consult a mentor and/or pursue a leadership development programme. The leader subsequently embodies the archetype of *becoming a leader*. The result could be that the leader gains expertise and subsequently influences this biographical force. Similarly, conflict resolution regarding assessment standards (interpersonal domain and the force of the programme) and the inability to facilitate a resolution will lead to extensive negotiation, with limited influence, and subsequent change that is mediated. In this example, the leader has not succeeded in "switching off" the force (Fig. 7.2). Another example relates to one of the interviewees who lobbied the cause of their medical school at a national level. This leader embodies the archetype of the *leader in front*. The macro-contextual forces were at play and the leader functioned within the systemic domain of Lieff and Albert (2012). The actions of this leader were influential towards the change of national policies and thus succeeded in altering the influence of the force, i.e. switching off the force. The actions of leaders occur within an averaged series of leadership events; the leadership climate (Fig. 7.2). The net effect of the actions of leaders can be either positive or negative (+/-) as they negotiate and/or influence the forces based on their constructed reality (Fig. 7.2). Their experience dictates the level of influence as opposed to their negotiation of their roles, position, inadequacies and course of action. The magnitude of the forces bears down on the leader. The leader subsequently interprets these forces in order to negotiate their roles, position and course of action. More experienced leaders act to influence and mitigate the force(s) and thus switch the force off. The climate is determined by leadership and leads to improvisation and innovation, or can be a deterrent.

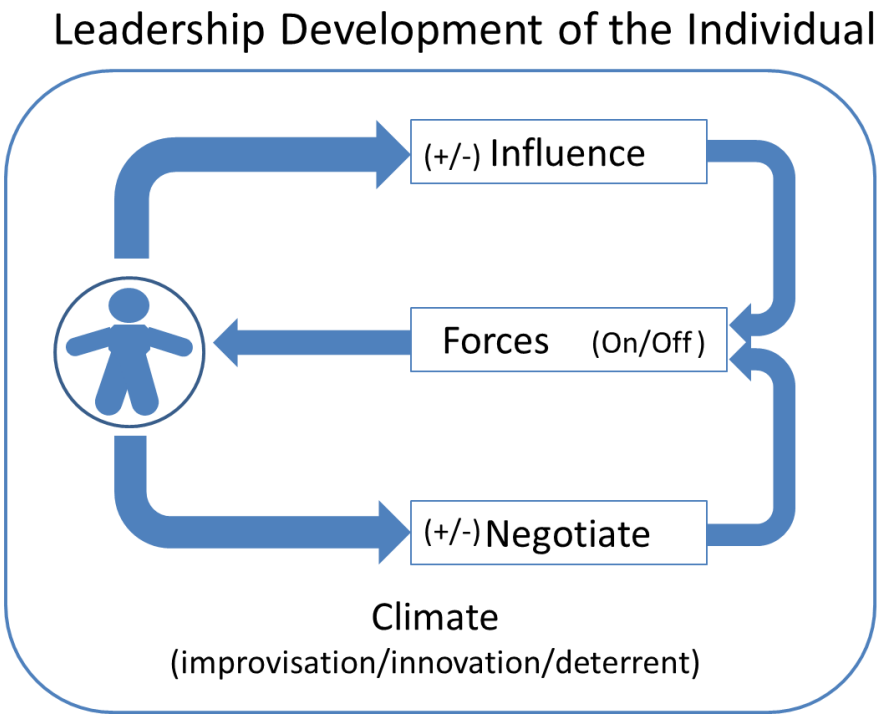

Fig. 7.2. Leadership development experiences at an individual level in response to challenges.

The nature of leadership development at institutional and interinstitutional levels, as interpreted from the findings, will be considered in the current section. Teamwork, team-building and the ability to lead teams are pivotal leadership competencies (Oates 2012). Findings indicate that leaders contend with the motives and intentions of colleagues whilst trying to build cooperative efforts. The competing forces also relate to the hierarchical nature within some medical schools. Sharing leadership is more important than conventional vertical leadership, and this requires cooperation (Wu and Cormican, 2021). Cooperation can solve many of the issues within new medical schools, and this extends to *sharing the responsibilities* and *building trust*. Remedial action is required to address the organisational culture, and cooperation seems to be more difficult than was expected. Comments by the interviewees are indicative of long-lasting systemic issues.

The values, expectations and goals of a medical school form part of the interpersonal and organisational domains of the leaders. Within these domains, the leader has to grapple with motives and intentions of colleagues, build collegial relationships and rally support. The curriculum, its effective implementation and management, forms part of the programmatic challenges that are faced by leaders. In the backdrop are the contextual forces, the outside world, of government driven policies and collaborations, and economic stressors. Open communication enables teamwork and reciprocates learning and thus development (Souba *et al.*, 2007). Leadership development is not only driven by effective

communication but also stems from collaboration between organisations (Clawson, 2006). Again, a lack in human resources could account for the poor flow of information. Leaders are left behind to deal with issues at ground level, whilst the leadership advances forward. The result is a disjunction in the flow of information. The activities of leaders within new medical schools are directed at reactive responses to the forces that are at play. The actions of leaders are aimed at creating stability and to correct what is wrong at any given moment. Leadership development archetypes manifest in response to the forces.

Interpretation of the findings indicate that leadership development at an institutional level occurs within a hierarchical system (Fig. 7.3). Findings suggest that in some new medical schools, leaders function and develop in isolation at their respective tiers. The formation of teams and coalitions is hampered by climate factors such as ineffective engagement of colleagues, perceived misalignment of the values and unsuccessful collaboration. The day-to-day activities of leaders are reactive in nature in a bid to negotiate the various forces. Leaders become bogged down by *mind problems* and *other stuff*. The emotional burden of the forces became apparent when considering the *clash between expectations*, *pain of the students*, and *the quality of healthcare*. These emotions represent the force of biography that are in conflict with the values of the leader. Samuel (2008) stated that the forces do not act in isolation. The conflicting forces of biography are thus compounded by that of the programme (pain of the students and their pedagogical experiences) and the contextual force of poor healthcare. However, the biographical forces mentioned above represent the intrinsic values of different leaders within the same institution. They are equally important within HPE and should be embedded with the educational ethos of the institution. Instead, they are now stressors to developing leaders.

Communication appears to be a major barrier in most new medical schools. Ineffective communication can negatively impact cooperation and the overall understanding of the institutional vision and strategy (Hill, 2005). For example, the silenced leaders of the current study (Fig. 7.3) withdrew and one gave up. This in turn hampers the flow of communication, not because of their refusal or inability to communicate, but due to a lack of support (Fig. 7.3). Little to no support is offered to address the mismatch between their existing and required competencies associated with their careers (Hill, 2005). Furthermore, the vertical nature of institutional hierarchies as depicted in Fig. 7.3, along with the work-load burden leads to detachment and isolation of individual leaders. The levels of effective communication vary (Fig 7.3) and deleteriously impact the transfer and understanding of the institution's vision and strategy. Leadership development experiences at an institutional level are, therefore, responsive in nature and are driven by emergent circumstances.

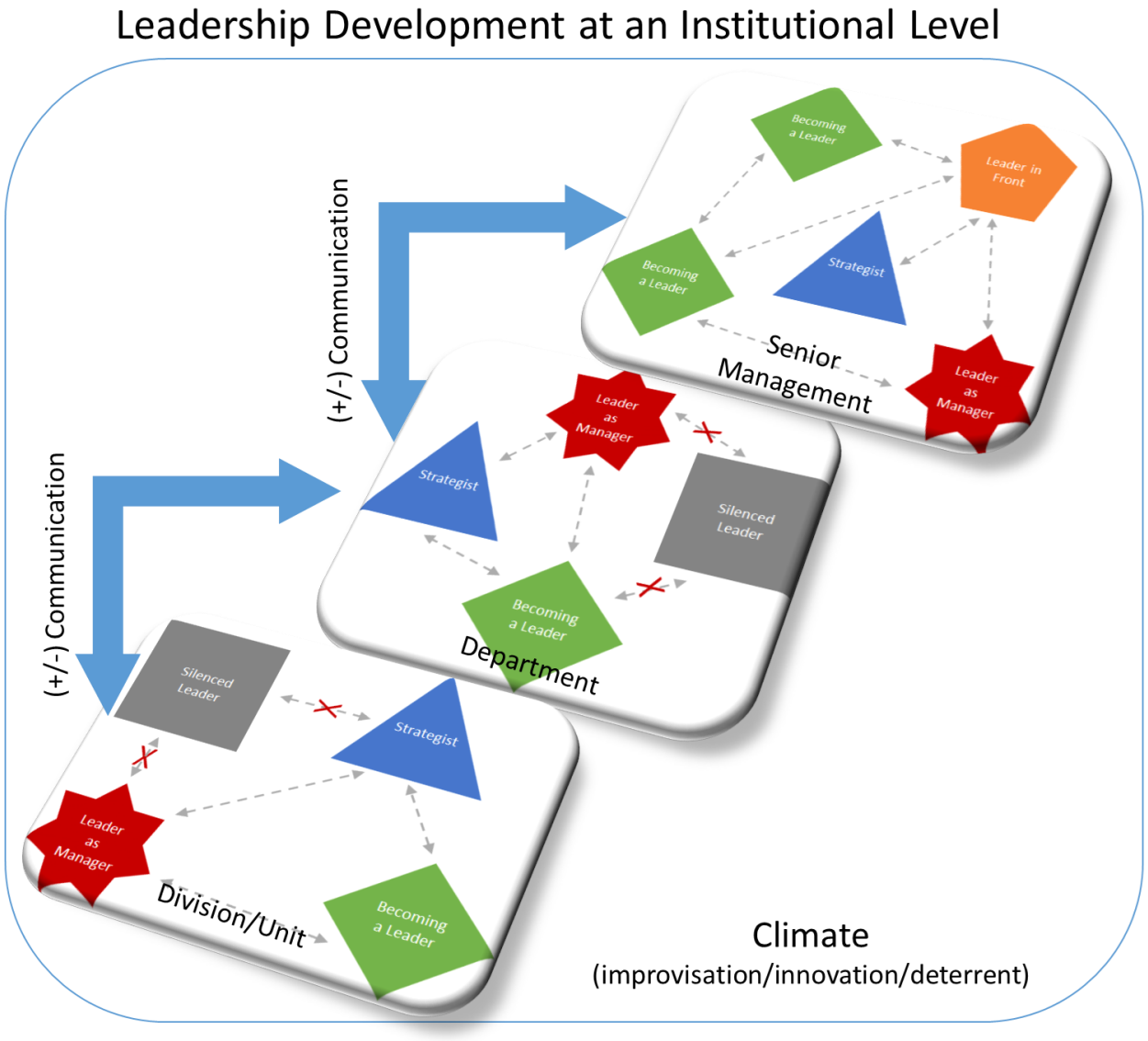

Fig. 7.3. A diagrammatic representation of collective leadership development experiences at an institutional level in response to challenges. Verticalness and detachment/isolation of individual leaders at their respective levels are some of the major challenges. Effective communication varies within each institution, which hampers cooperation and the understanding of the institutional vision and strategy.

Interinstitutional collaboration has the potential to address some of the issues in new medical schools. Collaboration through consortia such as CONSAMS can strengthen and capacitate not only leadership but also health systems by working together (Frenk et al., 2010). Furthermore, collaboration can lead to isomorphism, which was defined by DiMaggio and Powel (1983) as the "process that forces one unit in a population to resemble other units that face the same set of environmental conditions". Souba et al. (2007) stated that collaboration within an institution promotes the development of excellent connections.

Collaboration has the potential to act as a catalyst for learning and development (Dutton and Heaphy, 2003). New medical schools in Africa face similar challenges (Mullan *et al*. 2011; Eichbaum *et al.*, 2015a). This similarity of challenges was the primary driving force to establish CONSAMS.

Findings from the current study point towards the potential of CONSAMS in strengthening medical education and ultimately HRH. Leadership development at a collective level is participative in nature. Seasoned leaders represent their institutions within the consortium and serve senior leaders within their medical schools. The activities of CONSAMS relate to development of: contextually relevant and transformative medical curricula, improving equitable admission policies, accreditation standards, postgraduate training programmes, and research programmes (CONSAMS, 2014). Yet, the consortium also faced challenges and these include technological challenges related to poor internet during virtual meetings, and of lack of participation during the annual meetings.

Leadership development within the CONSAMS, based on the current study, is primarily driven by all the forces of Samuel (2008) and acts within all the domains of Lieff and Albert (2012). The consortium leaders act to foster participative leadership (biographical force), promote medical education (programmatic force), address healthcare challenges (macro-social force), and establish partnerships (macro-social force). The biographical force mentioned here relates to their learnt experiences through participation at an institutional level. However, the biographical force is dynamic and continues to have power within the collaborative milieu of CONSAMS. The formation of networks and alliances drives the learning experiences of leaders within the consortium (Eichbaum *et al.*, 2015a, b and c; Eichbaum, 2017a). The nature of leadership development within the consortium is therefore participatory (Fig. 7.4).

However, the consortium faced challenges in representation and participation, and the global COVID-19 pandemic further hampered their efforts (see CONSAMS, 2020a). Furthermore, the bidirectional flow of information between the members of the consortium and their representative institutions could improve (Participant F1, Section 5.3.10). The consortium's efforts within the interpersonal and organisational domains are therefore neglected. Leadership development is driven by the forces (biographical, programmatic and macro-social) that are switched on. However, the force of the institution appears to be switched off (Fig. 7.4). The lack of this force makes it difficult to fully translate the impact of the consortium's efforts. Findings once again highlight the need for a deeper understanding of the emergent circumstances or forces within the organisational domain. This will enable the consortium to address the core issues within each medical school as opposed to addressing the symptoms that arise from the forces that are not accounted for.

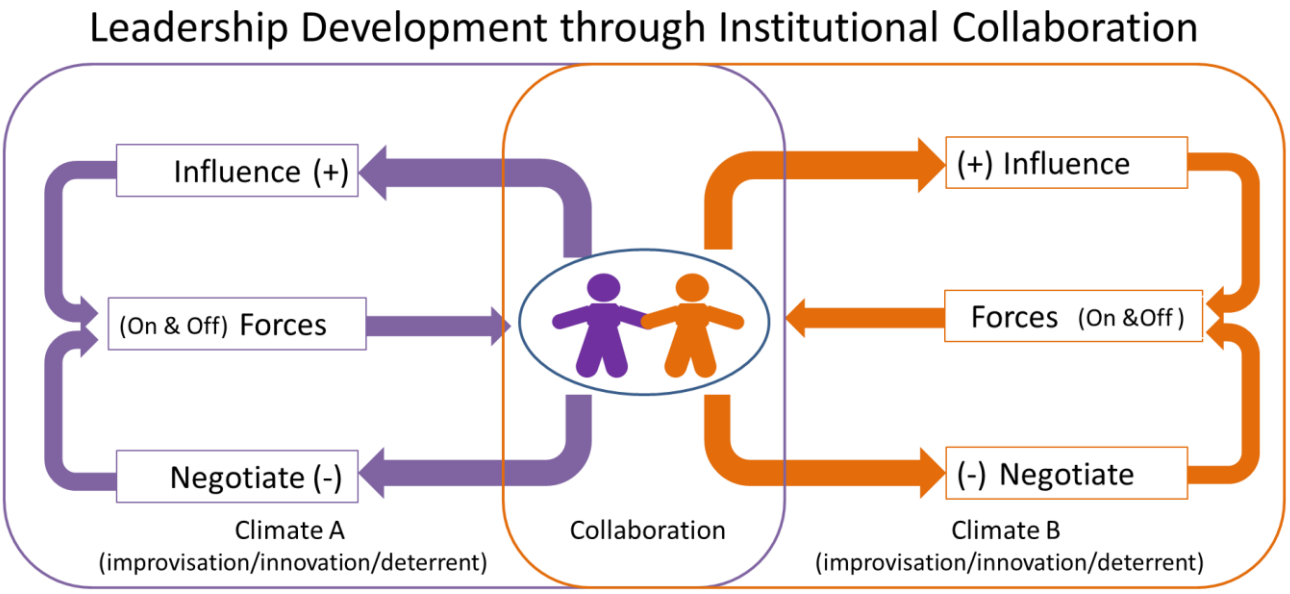

Fig. 7.4. Leadership development experiences at a collaborative level in response to challenges. CONSAMS permits the formation of alliances and leadership development results from shared learnt experiences in an effort to address the educational, research and health needs within the region.

In summary, collaboration and communication maximise the benefits of diversity. Alliances such as CONSAMS are a good idea because they stimulate more collaboration and communication beyond what would normally occur within each institution. Findings indicate that a consortium permits the formation of a novel and contextually relevant functional entity that relies on the diversity of its representative members.

7.2.4 The Collective Perceptions and Conceptualization of Leadership Development

Leadership development within the collective should be regarded in view of the archetypes of leaders: the *leader in front*, the *strategist*, the *silenced leader*, *becoming a leader* and the *leader as manager* (Section 5.4 of Chapter 5). From the findings it became apparent that leadership development is driven by the need to address the emergent circumstances they are faced with. Leaders within some schools are not afforded any assistance to address competencies that they may lack. Their development, in most cases, is self-driven in instances where institutional collaboration does not exist.

Leaders within the consortium regard their development as growth through collaboration. Findings indicate that leaders understand that participatory leadership can address the shortage of HRH by

bolstering research and medical education in the region. It is important to note that the reference to medical education in this context relates to undergraduate medical degree programmes, as opposed to the larger scope of HPE. Furthermore, the findings support the idea that collaborative efforts through research and medical education collaboration promote academic advancement within institutions (Muula and Broadhead, 2001). Leadership development is promoted by breaking competitive barriers, and the exchange of knowledge and expertise occurs within the consortium. Collaboration and participation promote the bilateral flow of information, and effective communication occurs outside institutional constraints. This in turn has the potential to return the voice of the *silenced leader* (Fig. 7.5). The dynamic and interchangeable nature of the leadership development archetypes permits such a shift, from being silenced, to expressing the nature of one of the other archetypes. A uniquely African entity is formed in the process that is directed at addressing the challenges at an institutional and regional level. Through this unique entity, aspects of capacitation in HPE and HRH can be addressed (Fig 7.5).

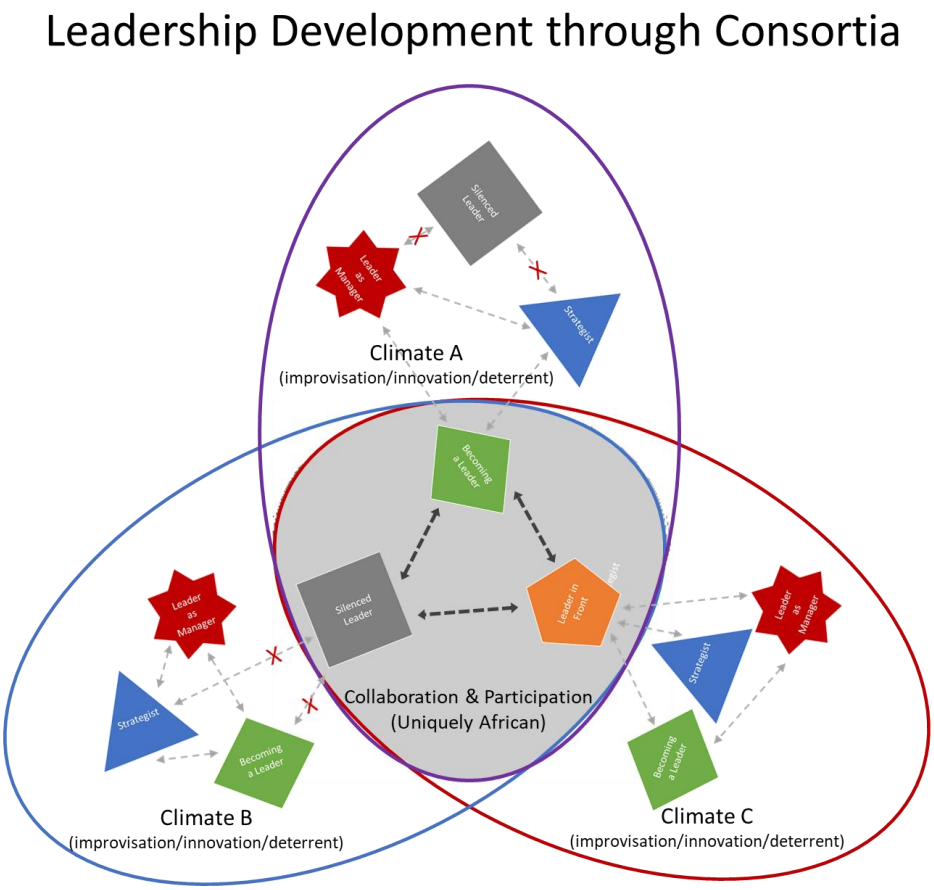

Fig. 7.5. A diagrammatic representation of leadership development between institutions and within a consortium such as in CONSAMS (note that only three participatory institutions are represented for illustrative purposes).

It is important to note that the envisaged impact of the collaborative efforts is limited to the member schools that actively participate. Faculty and student exchange programmes, external examination across institutions, and curriculum benchmarking, capacitate both individuals and institutions. This capacitation is, however, dependent on frequent and sustainable collaboration, institutional representation and the number of staff members that are provided with the opportunity to participate and engage within CONSAMS.

The aspirations of the consortium can be achieved by increasing its critical mass and by effective communication of the benefits of collaboration. The complexity of pedagogical leadership in new medical schools is not accounted for within the consortium. Yet, the consortium has the potential to facilitate the formation of a uniquely African entity (Fig. 7.5) through collaboration and participation. The key to effective collaboration is communication and feedback between stakeholders.

The strength of a consortium such as CONSAMS, based on the current findings, lies in the heterogeneity of its members. Each active participant contributes through reflection of their lived experiences and their negotiation of the forces that are at play within their respective contexts. Leaders within a consortium are freed from institutional constraints such as inertia, resistance and hierarchies. Mutual growth is fostered and the *silenced leader's* voice can return due to a safe environment that is generated. Interactions within the consortium encourage leaders to challenge their own perceptions and their roles, position and identity within their respective institution. They are offered an opportunity to meet with individuals who echo or question their challenges, concerns and efforts. Within the consortium, leadership archetypes are tested, challenged and strengthened. Interactions within the consortium permit freedom, more so than within each institution.

Although the consortium has a stated purpose and a pragmatic way in dealing with things (CONSAMS, 2014), it unintentionally leads to unspoken dynamics. Participants gain an awareness of the dealings of their counterparts. In doing so, they are working out things and bouncing off ideas that do not directly relate to the objectives of the consortium in order to bring about changes within their organisations. These unspoken dynamics of the consortium feed off the heterogeneity of the leadership archetypes. Leaders subsequently have to go away from the consortium and have to reflect and negotiate their position and roles in their respective institutions. This reflective practice drives further individual development.

7.3 REFLEXIVITY STATEMENT

I started this final chapter during my institution's most turbulent period of curriculum transformation, of which I was appointed as chair, and a faculty and departmental merger. The merger resulted in a reduction from the 12 former departments to four amalgamated departments. The former pre- and para-clinical departments are now known as the Human & Biological Sciences & Translational Medical Sciences, and I accepted the position of Chair of this new department. The contracts of many of the former departmental heads (HODs) expired prior to the transformation. These HODs now form part of the academic complement. There was no formal handover and I still need to meet all the individuals within my department. My own development is driven by self-directed learning in an attempt to understand what is expected of me after receiving the envisaged strategic key performance indicators of the university. The paucity of leadership development literature in HPE makes this a daunting task (McKimm and Lieff, 2013; Lieff and Yammarino, 2017). I am faced with the challenge of motivating and empowering staff within my department (leadership) whilst dealing with managerial tasks such as resource allocation and establishing systems and procedures related to pedagogy (Swanwick and McKimm, 2011). Things need to be sorted and a lot of my time is spent on the university-wide curriculum transformation, preparation for a curriculum audit, and research supervision. No administrative support in the form of a secretary or personal assistance has been provided.

I am trying to be a strategist and a good captain whilst investing in my own development as a leader. I am living the reality of the research project; the duality of being a good captain whilst becoming leader. The current study proved very therapeutic for me and resulted in my personal reflection on my position, role and development. I realised that I need to acquire skills of conflict resolution and deal with the cultural diversity within my organisation. The interviewees of the current project articulate a lot of what I am experiencing and the challenges that I am facing. I am close to the subjects that I have interviewed and I might have inadvertently amplified their issues and neglected others. I identify with the archetypes of *the leader in front* and *becoming a leader* (Fig. 5.1). Upon reflection, I can state that I am not defeated nor silenced. My perceptions and identification with the archetypes mentioned above may have unconsciously exaggerated the views and perceptions of the participants or curtailed the others. As a result, I might have shut down the voices of the *silenced* or *defeated* leader due to my desire to be a *leader in front*. This desire might have inadvertently resulted in undue emphasis on the *good captain, navigator, big picture leader* and *collaborative leader* (Table 5.13).

The initial stages of the thematic analysis were performed by myself and my supervisor. The supervisor has extensive qualitative research experience. The early co-analysis was done to discuss the codes and categories that were generated. Data interpretation and the identification of key texts were facilitated by

the supervisor. The combined approach was aimed at guiding the researcher to stay true to the data and the stories of the participants. This process was applied to three of the 10 interviews. Thereafter, I continued with the thematic analyses of the remaining interviews. I subsequently met with my supervisor to discuss the themes that were generated. Various iterations followed and I, with time, gained expertise in the process of thematic analysis.

My own beliefs and judgments and subsequent impact and influence on the research process were captured at the onset and throughout the data collection process (Finlay, 1998). This was achieved through an interview of myself as the researcher by the supervisor, early during the data collection process (July 2018) and journaling my thoughts and perspectives. My initial perceptions were of the complexity of leadership within new medical schools and my sense of detachment I experienced as an emergent leader as portrayed in Section 5.5 of Chapter 5. These beliefs and biases were embedded within the discussions in the preceding sections through reflexivity. However, reflexivity has the potential danger of each judgement being too layered by personal and subject specific criteria, and stated values. My approach to mitigate this was to illustrate the patterns of data interpretation, rather than focusing on every reflexive judgement (Johnson and Duberley, 2003). I sought to reduce my own bias through the use of different data sources (Dingwall, 1992). I further mitigated potential biases through my emic participation. In so doing, I gained a much deeper understanding of the research phenomenon and portrayed a richer picture of the issue than an outsider could have.

7.4 STUDY LIMITATIONS

The objectives of the study (Section 1.3 in Chapter 1) related to the planning of the next steps of collaboration within CONSAMS through participatory action research and subsequent monitoring and evaluation. My intention was to examine the research phenomenon and propose change through cooperative planning and reflection (Wimpenny and Savin-Baden, 2012). Transformation within the consortium's organisation structure, poor attendance, both virtually and face-to-face (refer to Table 5.12), and the global COVID-19 pandemic (see CONSAMS 2020a) at the time deleteriously hampered CONSAMS's activities and the subsequent execution of these objectives. The objectives mentioned above could subsequently not be fulfilled. The researcher consequently included recommendations in Section 7.6 in an attempt to redress this. An alternative approach, upon reflection, could have been to host a virtual focus group on the findings to the member schools instead of the consortium. Such an initiative might prove useful to validate the findings of the study and also initiate transformative dialogues within and among the medical schools.

Another limitation related to the leadership climate survey is the small sample size (n = 29). The findings might be skewed in terms of institutional representation, with one institution having 15 participants and others represented by only one individual. Generalisation of Likert findings was difficult due to the skewed representation and small sample size, and this hampered statistical analyses. Categorical analyses of the responses of educators, clinicians and scientists were also not feasible due to the multiple-roles of an individual within a particular institution. Best practices were to gain a generalized view of the perceptions of the collective (CONSAMS) and the perceptions of individuals within each institution. Another limitation of the survey is the lack of free text responses, and the ordinal data lacked depth. The addition of free-text responses could have allowed clarification and further elaboration to the responses. Finally, validation of the Likert questionnaire could have been done through the use of a pilot study and using experts to provide feedback on the validity of the data collection instrument.

One of the primary premises of the current study is that leaders are managers and managers are leaders, based on the interchangeability of roles within new medical schools. However, it is important to note that leadership and management are two distinct concepts, as outlined in the literature of the current study. The current study subsequently did not distinguish between the leadership and management. The second premise is that leadership development occurs at all levels due to the situated nature and unique settings of each institution. Leaders and subsequent leadership development in this study did not differentiate between leaders with prior leadership experience and novice and emerging leaders. The contextual complicity and the forces at play were regarded as unique variables that serve as agents of change; forces that catalyse growth regardless of the level of experience. The level of leadership experience was, therefore not accounted for in the current study.

The potential limitations of the semi-structured interviews include: interviewer and interviewee bias, memory, exaggeration by the interviewees, hidden agenda, misunderstanding, lack of skill by the interviewer, incomplete answers, courtesy, biased questions, question order, or appearance (Mackenzie *et al.*, 2012). However, triangulation through a mixed-methods approach, as demonstrated in the current study, can in part mitigate these limitations. Furthermore, the researcher's presence during data gathering, which is unavoidable in qualitative research, can affect the responses. However, this may have been mitigated by the fact that the interview process was conducted virtually through Skype. Issues of anonymity and confidentiality can present problems when presenting the research findings contextually, and the reader might find it difficult to relate the findings in context to a particular institution (Mackenzie *et al.*, 2012).

The title of the current study refers to Africa as opposed to sub-Sahara Africa. However, the findings of the current study could extend beyond the regional representation of the participants and apply to LMICs

generally. These inferences can be warranted by the report of Mullan *et al* (2011), and more recently findings reporting on the impact of COVID-19 on medical education in Africa which show similar issues (Ossai and Ogbuoji, 2021).

The organisational culture, upon reflection, would have provided more insights into the positioning of each leader. This variable could have provided insights into the respective perceptions of leadership development at various levels of seniority. A possible approach to this would have been to consider each participant within their respective organisational charts and former leadership roles. This might have elucidated the aspects of leadership development based on the force of biography at each organisational level. The nationality and cultural background of each leader is another aspect that could influence an individual's development. This is based on factors such as prior schooling, and socio-cultural and religious backgrounds. These factors form part of the lived experiences of leaders. The lived experiences of a western expatriate that relocated to an African medical school would be different to a local within the same establishment (Samuel, 2008). However, the researcher felt that the inclusion of both the organisational structure and nationality of participants might have compromised the anonymity of the participants.

Finally, the conceptualisation of generational differences, historiographies and the impact of colonialism has not been addressed in this study. The impact of these factors on the learnt experience of a leader constitutes the force of biography (Samuel, 2008). For instance, the leaders within each of the new medical schools have different schooling backgrounds that are linked to the political shifts and differences in viewpoints before and after gaining independence. Such factors affect the educational philosophies of leaders and subsequently their practices. This in turn can either drive or hamper their development within a leadership position.

7.5 CONCLUSION

Leadership development in new medical schools in Africa is complex. The complexity arises from the interplay between the leadership, the macro-social context and the leaders within each institution. The findings of the current study led to the development of a framework that serves as a compass to navigate the complexity of leadership development. The framework considers the components of the phenomenon (the individual, the institution and the collective) in order to gain perspectives of the whole, i.e. leadership development in Africa. It stems from the findings of the leadership climate survey (Chapter 4), thematic analysis of the semi-structured interviews (Chapter 5), and the qualitative document review related to the activities of CONSAMS (Chapter 6). The framework further permits scrutiny of the

relationships that are formed between leaders at an interpersonal, organisational and collaborative level. Furthermore, the framework considers the climatic factors that are at play. The conceptual framework that was employed allowed for the identification of the forces that act upon leaders at the level of the individual, the organisation and within a consortium.

At an individual level, leaders conceptualise their roles and development differently and are contextually bound and subjective to the institutional climate. Leaders respond to the forces (biographical, programmatic, institutional and macro-social) by either navigating obstacles, hindrances and emergent circumstances, and/or exerting an influence on, or to mitigate the forces. Leadership development at an individual level can be characterised by five archetypes: the leader in front, the strategist, the silenced leader, becoming a leader and the leader as manager.

Individual leadership development, and that at an institutional level, stems from leadership roles and results in their development into five archetypes. The archetypes are interchangeable and manifest based on a specific hindrance, emergent circumstances, institutional turbulence, and the need to take corrective action. Leadership roles translate to being a good captain and a navigator and develops into the *leader in front*. The process of being a leader and soldier represents leadership development into *becoming a leader*. Solving problems represents leadership development into *the strategist*. The *silenced leader* emerges from circumstances where leaders are overwhelmed by the forces associated with the institutional climate. Silenced leaders lose their voice within a climate that does not permit open and frank communication, where collaboration is not encouraged, and where support is not provided. Emergent circumstances are taxing the efforts of the leadership and accounts for the forces that are at play.

Leadership development entails a steep learning curve and learning the hard way. Some leaders experienced a level of detachment within their institutions and experienced little to no guidance. This detachment relates to the bilateral flow of information within the intrapersonal and organisational domains. Furthermore, the alignment of the vision and goals within the collective is distorted by emergent circumstances. Their growth and development were hampered by day-to-day managerial duties. Leaders conceptualise the challenges at varying emotional levels as either small irritations (little hindrances) or as visceral experiences that are expressed as headaches and heartaches.

Leadership roles and development within the consortium are driven by collaborative efforts where knowledge is exchanged at an interpersonal and organisational level. The consortium serves as a dynamic colloquium where northern and southern partners grow together. The northern partners are exposed to the contextual challenges in Africa. However, the micro-contextual forces and the leadership

climate are omitted by these efforts. The 'big picture' approach of the consortium appears to be not in touch with the various institutional climates. The leadership climate within each institution determines the ethos and atmosphere that leaders are exposed to. The climatic factors can be constraining on some instances and leaders who participate within a consortium are removed from institutional constraints. A unique climate is generated within a consortium where leaders are not restricted by emergent circumstances. This unique climate fosters mutual growth where the heterogeneity of the leaders can flourish without institutional constraints. However, it is important to note that this novel climate stems from leaders' interactions and further allows the manifestation of their leadership development archetypes.

7.6 IMPLICATIONS AND RECOMMENDATIONS

In the same way that medical schools in the region should strive towards contextually relevant curricula, so leadership development programmes follow suit. Tailored leadership development programmes that consider the framework presented here might prove effective. There are numerous practical lessons in the day-to-day operations within new medical schools in Africa. These practical lessons and the lived experiences can serve as case studies for the development of context-driven leadership development programmes. The value of establishing mentor-mentee programmes in Africa has potential to bolster leadership activities and development (Burgess et al., 2018). The findings of the current study can direct such efforts in order to establish contextually relevant and tailored mentorship initiatives. Senior leadership within new medical schools might benefit from the framework that has been presented. It will aid in identifying the interplay between the leadership climate and the forces within their respective institutions.

The leader-climate-practice mechanism and cultural competence within medical schools and an African context are in part accounted for by the findings of the study. The framework of the current study permits the examination of the relationships between leadership, cultural aspects (biographies of the leaders), climate, and outcomes (Guerrero et al., 2017). The aspect of cultural competence is extremely relevant within African medical schools, due to the diverse cultural representation of various cultures. The influence of cultural practices and possible linkages to conventional vertical leadership could be highlighted through the use of the current framework. The same holds true for gender equality and socio-political factors, and current and evolving institutional policies.

In addition, leaders' self-regulation and intrinsic motivation can be evaluated by considering the forces they experience, which can shed additional light on leadership development needs within each institution (Carver and Scheier, 2000; Fischer et al., 2019). The effects of emerging circumstances on leaders' self-

regulation can be revealed through the use of the framework at both the level of the individual and that of the institution. This has the potential to further bolster staff development efforts.

Finally, the value of the current findings relates to the strength of diversity of the participants within CONSAMS. This diversity ensures a multifaceted perspective on the needs of each medical school in the region. The use of the current framework can direct the efforts of the consortium to bring about organisational progress within each institution.

The following recommendations for further practice are based on the current findings and is believed to aid the understanding of leadership development within new medical schools:

- Individual leaders might benefit by reflecting on their own archetype of development in light of the forces that are at play in order to direct faculty development programmes.
- Awareness and an understanding of the leadership climate and how it impacts the day-to-day activities of leaders can draw leaders out from isolation and promote collaboration at an institutional level.
- Awareness of the heterogeneity of leaders within each institution will permit the identification of development needs, especially where support is lacking.
- Consortia, such as CONSAMS, should draw on the strength of the diversity of participating members and this requires more representation from various institutions.
- Effective communication and feedback by the consortium are required and can improve institutional efforts to strengthen partnerships and HPE activities, in order to address the healthcare challenges in Africa.
- Consortia, such as CONSAMS, will benefit from using the framework to review the needs of individuals within each institution in order to strategically direct and plan future activities.

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APPENDICES

APPENDIX I: ETHICAL APPROVAL

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 404 7682
Email: nosi.tsama@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

18 April 2018

HREC REF: 751/2017

Prof S Reid
Primary Healthcare Directorate
E47, Old Main Building

Dear Prof Reid

PROJECT TITLE: UNDERSTANDING LEADERSHIP DEVELOPMENT WIHTIN NEW MEDICAL SCHOOLS IN AFRICA (PHD CANDIDATE - DR Q WESSELS)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 April 2019.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the following student will be involved in this study: Dr Q Wessels

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval before the research may occur.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Yours sincerely

pp TBurgess

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

APPENDIX II: PARTICIPANT INFORMATION SHEET

Participant Information Sheet

Dear Professor/Doctor

Study Title: **Understanding pedagogical leadership within new medical schools in Africa**

What is the study about?

The purpose of this study is to develop narrative on your leadership growth or learning as a leader within your particular CONSAMS institution.

Why have I been invited?

Did you know that estimates point towards a total of 100 new medical schools that will be established in Africa within the next decade? As participatory member of CONSAMS and founding members, you are/were uniquely positioned as pedagogical leaders during the inception of your respective medical school. Your valuable contribution has the potential to assist future endeavours in establishing medical schools in Africa in order to address the continent's growing health needs.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part.

What will I be asked to do if I take part?

If you decide you would like to take part, you will be expected to be complete a Likert-based survey (approximately 15 minutes of your time) and a semi-structured interview (approximately an hour of your time).

Will my data be confidential?

The information you provide is confidential and anonymous. We are not collecting names or any personal information that will be directly traceable back to you. You will be assigned a unique identifier that allows the primary researcher to link you to your institution and your name will not be attached to any data set or document. The data obtained by the researcher will thus be strictly confidential.

What will happen to the results?

The results will be summarised, reported and submitted as the findings of a PhD thesis and will later be considered for publication in an academic or professional journal and presented at an international conference.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress during and following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

You may find participating interesting and the reflective practice during the interview might be insightful. You might gain a better understanding of your journey in becoming an academic leader in medical education.

Who has reviewed the project?

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee (UNAM) for the pilot study, and approved by the University Research Ethics Committee at the University of Cape Town for the research project as a whole.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

What if I do not want to participate?
There will not be any consequences for not participating.

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Chairperson of the HREC - Professor Marc Blockman
The Human Research Ethics Committee
Old Main Building
Groote Schuur Hospital, Floor E53, Room 46
Observatory
7925
Tel +27 21 406 6346

Thank you for taking the time to read this information sheet.

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, please feel free to contact the main researchers.

APPENDIX III: LIKERT SURVEY

Likert-Based Survey

1 _ strongly disagree; 2 _ disagree; 3 _ neither agree nor disagree; 4 _ agree; 5 _ strongly agree.

In my institution…	**1**	**2**	**3**	**4**	**5**
1. Leadership is widely shared.					
2. People are kept in the dark about information and decisions.					
3. Subordinates can question their superiors on important issues.					
4. People feel involved with the process of leadership.					
5. The clinical, research, and teaching missions are aligned.					
6. People provide honest feedback to others.					
7. People are not held accountable for their performance.					
8. Constructive conflict is embraced and encouraged.					
9. Communication is driven by hidden agendas.					
10. Information is widely shared across departments.					
11. Everyone can be a leader.					
12. Good performance is rewarded.					
13. People do not collaborate effectively in teams.					
14. Constructive conflict is not tolerated.					
15. Decision making is transparent to those at lower levels.					
16. Leaders are held accountable for their performance.					
17. People do not communicate openly.					
18. Performance expectations are clear.					
19. Decisions are made in secret.					
20. People feel open to disagreeing with others on key issues.					
21. People from different parts of the organisation would give similar answers to the question, “What are we trying to accomplish here?”					
22. Everyone is encouraged to participate in leadership.					
23. Departments have their own agendas, which take priority over the institutional mission.					
24. Institutional values are aligned to meet educational needs.					
25. Educators work together in solving problems.					
26. Poor performers are held accountable.					
27. Competition is the norm between departments.					
28. Information is tightly held by those in power.					
29. Physicians and basic scientists collaborate productively.					
30. Leadership is the responsibility of only those at the top.					
31. Teamwork is practiced widely.					
32. People understand that conflict and debate produce better ideas.					
33. Open, frank communication is the norm.					
34. Physicians, scientists, educators, and administrators share similar values.					
35. Open communication is valued.					

APPENDIX IV: SEMI-STRUCTURED INTERVIEW QUESTIONS

During the interviews, participants will be asked to elaborate on the nature of their work, successes and failures, perceived roles and abilities, leadership strategies and recommendations through the following questions (Lieff and Albert, 2012):

1. Introduction: Introduce the research project.
2. Questions:
    2.1 Biographical:
    (a) What do you believe are the things that work when you are trying to get things done?
    (b) Do you have a conviction or set of beliefs that are important in your leading?
    (c) What is the most important aspect of what you do?
    (d) Tell me about any poor decisions that have been made as a leader?
    (e) Tell me about a really great decision that you have made as a leader?
    (f) How do you know when you have truly been successful as a leader?
    (g) How do you know when you have failed as a leader?
    (h) What are the biggest barriers to make things happen? Did you ever face that challenge? What did you do?
    (i) Assume that I want to train myself to take over your job in the next 10 years, what do I need to know?
    2.2 Programmatic, Institutional and Contextual:
    (a) How are decisions made?
    (b) How do you think that your organisation really gets things done?
    (c) What are the things that are necessary to keep things moving in the direction that they need to go?
    (d) When things are not moving along, how do you analyse and address that?
    (e) What are the biggest barriers to make things happen? Did you ever face that challenge? What did you do?
    (f) Hypothetically, what would you recommend that we include in a curriculum on education leadership? Why?
3. Thank them for participating in the interview

APPENDIX V: CONSENT FORM

Study Title: Understanding Leadership Development within New Medical Schools in Africa

We are asking if you would like to take part in a research project that to highlight the narratives on leadership development within new medical schools in Africa. The study will rely on semi-structured interviews to gain an understanding of your personal development as a leader within your institution.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Quenton Wessels.

Please initial at each statement:

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my marks or studies being affected. ☐
4. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication. ☐
5. I understand that the information from my demographical detail will be pooled with other participants' responses, anonymised and may be published ☐
6. I consent to information, audio recordings and quotations from my feedback and participation being used in reports, conferences and training events. ☐
7. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will/may need to share this information with his/her research supervisor. ☐
8. I consent to take part in the above study. ☐
9. I consent to the University of Cape Town keeping the written and audio transcripts for 10 years after the study has finished. ☐

Name of Respondent _____Signature _____Date_____

Name of Researcher _____Signature _____Date ___

APPENDIX VI: EMAIL COMMUNICATIONS

Study Title: Understanding Pedagogical Leadership within New Medical Schools in Africa

Recruitment E-mail

Dear Dean/Professor/Doctor/Colleague:

I, Quenton Wessels, am a PhD candidate in Health Sciences Education at the University of Cape Town.

I am inviting you to participate in a study to understand how pedagogical leadership develops within the CONSAMS (Consortium of New Southern African Medical Schools) group of medical schools amidst the numerous challenges and opportunities. The purpose of the study is to conceptualise, reflect upon and build a collective understanding of pedagogical leadership development within CONSAMS.

The researcher is positioned within one of the young medical schools in sub-Saharan Africa, University of Namibia, School of Medicine. I was part of a small group consisting of five pioneers, tasked with the establishment of Namibia's first medical school in 2009. I have, like you, learnt a lot during the process and I wish to document the institutional and individual leadership-based knowledge gained through your endeavours.

Should you volunteer, you will be asked to complete an online survey and participate in a face-to-face semi-structured interview. Interested individuals can request a Participant Information Pack from the researcher (qwessels@gmail.com)

Thank you very much for your time.

Yours sincerely,
Quenton

Follow-up/Reminder Messages/Appointment

Reminder message about the study

Thank you very much for signing up to participate in this research study. This serves as a kind reminder to complete the online survey. This will be followed by scheduling an interview. If you have any questions, please feel free to contact me (qwessels@gmail.com).

Thank you very much for your time.

Yours sincerely,
Quenton