Leadership and followership within healthcare teams

Summary

The traditional view of leadership in healthcare often overshadows the importance of followership. Yet, both effective leaders and followers are needed to ensure optimal patient outcomes. The qualities that make leaders and followers effective, the interaction between these roles, and the context in which they operate are central to this thesis.

Chapter 1

This chapter outlines the rationale, need, and intentions of this program of research. I begin by discussing this journey with a personal experience that highlighted the complexities and frustrations of patient care in a healthcare system. My father, diagnosed with cholangiocarcinoma, faced a chaotic and confusing situation during a hospital stay, where the lack of communication and coordination among his various healthcare providers led to a significant confusion for my family. This experience exposed the inefficiencies in team collaboration within healthcare settings and inspired me to explore how leadership and followership dynamics could improve interprofessional healthcare teams (IHTs). Each specialist, acting as a leader in their domain, pursued their diagnostic paths without collaborating with others, leading to mixed messages and a fragmented care plan. This not only compromised the quality of care but also diminished our trust and confidence in the healthcare system. This experience highlights the need for a more integrated approach where leadership and followership are dynamically balanced to enhance teamwork and patient outcomes. The literature on health professions education (HPE) often highlights the development of leaders within IHTs, with less emphasis on the followers. I discuss leadership and followership on IHTs focusing on definitions and theories and how that relates to interprofessional collaboration. This chapter presents the foundational questions of this program of research: What are leader and follower dynamics in IHTs? How do theories of leadership and followership help us to understand these collaborative dynamics? Using a constructivist approach, we recognized that knowledge and understanding are constructed through experience and social interactions. This perspective is particularly relevant in healthcare, where team-based care is increasingly the standard.

Chapter 2

Researchers and practitioners rely on literature reviews to synthesize large bodies of knowledge. Many types of literature reviews have been developed, each targeting a specific purpose. However, these syntheses are hampered if the review type's paradigmatic roots, methods, and markers of rigor are only vaguely understood. One literature review type whose methodology has yet to be elucidated is the state-of-the-art (SotA) review. If medical educators are to harness SotA reviews to generate knowledge syntheses, we must understand and articulate the paradigmatic roots of, and methods for, conducting SotA reviews. We reviewed 940 articles published between 2014–2021 labeled as SotA reviews. We (a) identified all SotA methods-related resources, (b) examined the foundational principles and techniques underpinning the reviews, and (c) combined our findings to inductively analyze and articulate the philosophical foundations, process steps, and markers of rigor. In the 940 articles reviewed, nearly all manuscripts (98%) lacked citations for how to conduct a SotA review. The term "state of the art" was used in 4 different ways. Analysis revealed that SotA articles are grounded in relativism and subjectivism. This article provides a 6-step approach for conducting SotA reviews. SotA reviews offer an interpretive synthesis that describes: This is where we are now. This is how we got here. This is where we could be going. This chronologically rooted narrative synthesis provides a methodology for

reviewing large bodies of literature to explore why and how our current knowledge has developed and to offer new research directions.

Chapter 3

A state-of-the-art (SotA) literature review was conducted to answer: What historical developments led to current conceptualizations of followership in interprofessional healthcare teams (IHTs)? Working from a constructivist orientation, SotA literature reviews generate a chronological overview of how knowledge evolved and presents this summary in three parts: (1) this is where we are now, (2) this is how we got here and (3) this is where we should go next. Using the SotA six-stage methodology, a total of 48 articles focused on followership in IHTs were used in this study. Articles about followership within IHTs first appeared in 1993. Until 2011, followership was framed as leader-centric; leaders used their position to influence followers to uphold their dictums. This perspective was challenged when scholars outside of healthcare emphasized the importance of team members for achieving goals, rejecting a myopic focus on physicians as leaders. Today, followership is an important focus of IHT research but two contradictory views are present: (1) followers are described as active team members in IHTs where shared leadership models prevail and (2) conceptually and practically, old ways of thinking about followership (i.e., followers are passive team members) still occur. This incongruity has generated a variable set of qualities associated with good followership. Leadership and followership are closely linked concepts. For leaders and followers in today's IHTs to flourish, the focus must be on followers being active members of the team instead of passive members. Since theories are increasingly encouraging distributed leadership, shared leadership and/or situational leadership, then we must understand the followership work that all team members need to harness. We need to be cognizant of team dynamics that work within different contexts and use leadership and followership conceptualizations that are congruent with those contexts.

Chapter 4

Effective interprofessional healthcare team (IHT) team members collaborate to reduce medical errors, use resources effectively, and improve patient outcomes, making interprofessional collaboration imperative. Since physicians are often designated as the positional leaders of IHTs, understanding their perspectives on collaboration within IHTs could help to mitigate the disconnects between what is suggested in theory and what is happening in practice. We aimed to explore leader-follower dynamics within medical teams that are commonly working in interprofessional contexts. Using a constructivist approach, we engaged in 12 individual, semi-structured interviews with attending physicians who have led IHTs in perioperative (i.e., pre-operative clinic, operating room, post-operative and recovery unit) or emergency room settings. We analyzed transcripts using inductive thematic analysis. Three themes explained the physician perceptions of IHT leadership-followership dynamics: (1) Physicians are comfortable sharing leadership intraprofessionally; (2) The clinical culture and environment constrain interprofessional followership and shared leadership; and (3) Hierarchical models hold true even while active followers are appreciated, when appropriate. Our data suggest that, in the clinical contexts of the peri-operative and emergency department, shared leadership largely does not occur interprofessionally, but does occur intraprofessionally. Participants suggested that the clinical culture and environment—i.e., legal concerns, hierarchical assumption, and patient care ownership responsibilities—constrained interprofessional followership and shared leadership.

Based on our findings and how they align with previous research, we suggest that future research into interprofessional collaboration and followership roles needs to focus on what factors enable and constrain active followership and shared leadership. Such collaboration can only be achieved when active followership and shared leadership are allowed and promoted. Our findings and others suggest that not all contexts are enabling such kinds of interprofessional collaboration due to legal concerns, hierarchical traditions, and patient ownership considerations.

Chapter 5

The U.S. Military has long been aware of the vital role effective leaders play in high-functioning teams. Recently, attention has also been paid to the role of followers in team success. However, despite these investigations, the leader-follower dynamic in military interprofessional health care teams (MIHTs) has yet to be studied. Although interprofessional health care teams have become a topic of increasing importance in the civilian literature, investigations of MIHTs have yet to inform that body of work. To address this gap, our research team set out to study MIHTs, specifically focusing on the ways in which team leaders and followers collaborate in MIHTs. We asked what qualities of leadership and followership support MIHT collaboration? This study was conducted using semi-structured interviews within a grounded theory methodology. Participants were purposefully sampled, representing military health care professionals who had experience working within or leading one or many MIHTs. Thirty interviews were conducted with participants representing a broad range of military health care providers and health care specialties (i.e., 11 different health professions), ranks (i.e., officers and enlisted military members), and branches of the U.S. Military (i.e., Army, Navy, and Air Force). Data were collected and analyzed in iterative cycles until thematic saturation was achieved. The subsets of data for leadership and followership were further analyzed separately, and the overlap and alignment across these two datasets were analyzed. The insights and themes developed for leadership and followership had significant overlap. Therefore, we present the study's key findings following the two central themes that participants expressed, and we include the perspectives from both leader and follower viewpoints to illustrate each premise. These themes are as follows: (1) a unique collaborative dynamic emerges when team members commit to a shared mission and a shared sense of responsibility to achieve that mission; and (2) embracing and encouraging both leader and follower roles can benefit MIHT collaboration. This study focused on ways in which team leaders and followers on MIHTs collaborate. Findings focused on qualities of leadership and followership that support MIHT's collaboration and found that MIHTs have a commitment to a shared mission and a shared sense of responsibility to achieve that mission. From this foundational position of collective responsibility to achieve a common goal, MIHTs develop ways of collaborating that enable leaders and followers to excel to include (1) understanding your role and the roles of others; (2) mutual respect; (3) flexibility; and (4) emotional safety. The study data suggest that MIHT members work along a continuum of leadership and followership, which may shift at any moment. Military interprofessional health care team members are advised to be adaptive to these shared roles and contextual changes. We recommend that all members of MIHTs acquire leadership and followership training to enhance team performance.

Chapter 6

Military Interprofessional Healthcare Teams (MIHTs) are the backbone of modern military medicine. However, these teams face distinct operational challenges, including frequent

personnel rotation, diverse work environments, and the constant possibility of rapid deployment. Serving in dynamic teams that deploy for both military and humanitarian missions, MIHTs face the unique challenge of constant restructuring and reorganization. Consequently, preparing MIHT members to function effectively as a team presents a significant hurdle. This difficulty highlights the limited applicability of existing literature focused on training civilian interprofessional healthcare teams. To address this gap, we conducted interviews with MIHT members to identify training elements that equip them for successful collaboration. By gaining a deeper understanding of their needs, we can improve training programs and ultimately optimize MIHT performance, readiness, and patient care. We conducted individual semi-structured interviews with military healthcare professionals. We employed purposeful sampling to ensure a diverse range of perspectives from individuals with direct experience working in or leading MIHTs. The thirty participants interviewed represented a broad spectrum of MIHT professions. The data used for this study stems from a broader research program on MIHTs conducted between 2017 and 2019. We conducted a secondary analysis focusing specifically on interview data related to education and training. Using Braun and Clarke's six-step approach to Thematic Analysis, we identified themes from the data to build an understanding of MIHT perspectives on training effectiveness. The participants' insights allowed us to identify three critical themes related to the training elements they considered most beneficial for fostering collaboration within MIHTs: (1) MIHT members rely on their own pre-deployment readiness; (2) MIHT contexts require unique, adaptive communication skills; and (3) MIHT training is an ongoing endeavor. We need our MIHTs to be ready to deploy, which involves being clinically, emotionally, physically, and operationally ready. Our findings suggest that MIHT success is linked to CPD—both individual-focused and team-focused continuing professional development (CPD). Participants stressed the role of CPD in maintaining competence and readiness, with a particular focus on collaborative training and experiential learning. The findings advocate for formalizing CPD that emphasizes interprofessional collaboration and experiential learning to ensure MIHTs are prepared for the complexities of military healthcare delivery. Investing in meaningful training empowers MIHTs to continuously adapt, excel, and positively impact patient outcomes.

Chapter 7

This chapter presents a synthesis of the findings of the studies in this thesis to answer the overarching research questions: What are leader and follower dynamics in IHTs? How do theories of leadership and followership help us to understand these collaborative dynamics? Summaries from each chapter with results are provided to help answer the foundational research questions of this thesis. Integrating the findings, my thesis contributes to an understanding of the collaborative dynamics in IHTs, emphasizing the fluidity of leadership and followership roles, active followership, and the importance of communication, trust, and mutual respect. The implications from these studies extend across multiple dimensions of IHT functioning. When we think about how theories of leadership and followership can help us to understand these collaborative dynamics, it leaves three questions to consider: (1) Should leadership and followership be taught together; (2) What are the implications for patient care ownership; and (3) How do we approach hierarchy in healthcare? We begin to address each of these questions, yet all of these larger questions lead to the additional question we have to consider are these research, education, and/or cultural problems? Future research should continue to explore these dynamics in various healthcare contexts to refine our understanding of how best to train and support healthcare teams. This will ensure that they are not only clinically competent but also

proficient in the interpersonal and collaborative skills necessary for high-quality, patient-centered care.