DEPARTMENT OF MEDICINE, HUDDINGE
Karolinska Institutet, Stockholm, Sweden

# EDUCATIONAL LEADERSHIP IN HEALTH PROFESSIONS EDUCATION

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Karolinska Institutet

Stockholm 2019

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Published by Karolinska Institutet.
Printed by Eprint AB 2019.

ISBN 978-91-7831-424-9

# EDUCATIONAL LEADERSHIP IN HEALTH PROFESSIONS EDUCATION

## THESIS FOR DOCTORAL DEGREE (Ph.D.)

At Karolinska Institutet to be defended in lecture room de Verdiersalen, Alfred Nobels Allé 12, Huddinge

**Friday 14 June 2019 at 9 AM**

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# ABSTRACT

The aim of this thesis was to explore perceptions and experiences of educational leaders leading educational change and development in health professions and interprofessional education. The sensitising concepts of the thesis were power and resistance and the thesis hence adopted theoretical power perspectives on educational leadership and employed qualitative approaches within the methodological framework of phenomenology. *Study I* explored the experiences of educational leaders leading change and development within an undergraduate medical programme. The educational leaders perceived a lack of authority and status towards their colleagues as a result of an unclear mission, the fact that education had a low level of status at the university as well as a lack of traditional means of power. They also experience meeting resistance towards change and development in the shape of change fatigue, organisational obstacles and conservatism. Their opportunity to use influence towards change and development emerged from a high degree of freedom as well as the creation of vicarious legitimacies connected to research or clinical work, instead of education. *Study II* further explored the experiences of educational leaders in undergraduate medical education and their identity formation. The educational leaders expressed an ambiguity towards their identity as educational leaders as a result of both an unclear educational role as well as the perceived difficulties in leading colleagues towards educational change and development. The educational leaders seldom experienced receiving feedback on their work from higher levels of the institution, which in turn lead them to feel that their role was mostly of a symbolic character. However, the status of being an educational leader was confirmed from time to time by other educational leaders as well as colleagues with a special interest in education. *Study III* explored the experiences of educational leaders leading change and development within a nursing programme. The educational leaders expressed the means of achieving educational change and development as building relationships with colleagues as well as using the elaborate decision-making structures of the programme. Experiences of resistance towards change were perceived as originating from lack of authority, organisational structures and memories and intrinsic avoidance of leadership. *Study IV* explored interprofessional education (IPE) as an example of educational change and development. A comparison of the definition, rationale and presentation of IPE between educational leaders and official policy documents revealed how underlying differences of meaning attached to IPE can create potential difficulties regarding implementation. Successful implementation postulates transparent and clear senior leadership support within an institution. The thesis shows how the findings of study I-IV are important to highlight in connection to research-based faculty development programmes for educational leaders in health professions education; a prerequisite for leading educational change and development successfully.

# SAMMANFATTNING

Syftet med avhandlingen var att utforska utbildningsledares uppfattningar och upplevelser av förändring och utveckling av utbildningsfrågor inom vårdutbildningsområdet samt inom interprofessionell utbildning. De öppnande begreppen kopplade till denna avhandling var makt och motstånd. Teoretiska maktperspektiv har applicerats på fenomenet ledarskap inom utbildningsområdet och avhandlingen återfinns inom det kvalitativa forskningsområdet med inriktning på fenomenologi. *Studie I* utforskade upplevelserna hos utbildningsledare av att leda förändring och utveckling i ett läkarprogram. Utbildningsledarna upplevde att man saknade auktoritet och status bland sina kollegor. Detta var resultatet av att man hade ett oklart uppdrag, att utbildning innehade låg status på det universitet där man var verksam samt att man saknade traditionella maktmedel. Utbildningsledarna upplevde också att man mötte motstånd när man försökte leda sina kollegor mot förändring och utveckling. Motståndet upplevdes i form av förändringströtthet, organisatoriska hinder samt konservatism i utbildningsfrågor. Utbildningsledarnas möjlighet att försöka få sina kollegor att delta i förändring och utveckling av utbildningen var resultatet av att de hade mycket frihet i sin roll samt att de skapade sig ställföreträdande legitimiteter som baserades på resultat kopplade till forskning eller kliniskt arbete, istället för till utbildning. *Studie II* utforskade utbildningsledares upplevelser av identitetsformation i ett läkarprogram. Utbildningsledarna gav uttryck för en tvetydighet gentemot sin identitet som utbildningsledare. Detta var resultatet både av en oklar roll samt upplevda svårigheter att leda sina kollegor mot förändring och utveckling i utbildningsfrågor. Utbildningsledarna upplevde sällan återkoppling eller stöd från högre ledarskapsnivåer på universitetet, vilket i sin tur ledde till att de upplevde att deras roll mest var av symbolisk karaktär. Deras professionella identitet bekräftades dock ibland av kollegor i samma roll eller av kollegor som var särskilt intresserade av utbildningsfrågor. *Studie III* utforskade utbildningsledare upplevelser av att leda sina kollegor mot förändring och utveckling i utbildningsfrågor kopplade till ett sjuksköterskeprogram. Utbildningsledarna upplevde att medel för att leda kollegor mot utveckling och förändring av utbildningsfrågor var att skapa relationer med kollegor samt att använda de tydliga strukturerna för beslutsfattande inom programmet. Motstånd mot förändring och utveckling av utbildningen uppfattades som att härstamma från en avsaknad av auktoritet, organisatoriska strukturer och minnen samt från ett inneboende motstånd mot ledarskap. *Studie IV* utforskade interprofessionell utbildning (IPE) som ett exempel på förändring och utveckling inom hälso- och sjukvårdsutbildningar på ett universitet. En jämförelse mellan definitionen av, den logiska grunden för samt framställningen av IPE hos utbildningsledare och officiella policydokument visade på hur bakomliggande skillnader i uppfattningar om IPE kan skapa problem i en implementeringsprocess. Framgångsrik implementering av IPE förutsätter ett tydligt ledarskap från högre nivåer på ett universitet. Sammantaget visar avhandlingen på hur resultaten från *studie I-IV* är viktiga att lyfta fram i forskningsbaserade utbildningsinsatser för utbildningsledare inom hälso- och sjukvårdutbildningar, för att på så sätt kunna uppnå framgångsrikt ledarskap på vägen mot förändring och utveckling av utbildningsfrågor.

# LIST OF SCIENTIFIC PAPERS

I. **Sundberg K**, Josephson A, Reeves S, Nordquist J.
Power and resistance: leading change in medical education
*Studies in Higher Education*, 2017;42(3); 445-462

II. **Sundberg K**, Josephson A, Reeves S, Nordquist J.
May I see your ID? An explorative study of undergraduate medical education leaders
*BMC Medical Education*, 2017;17(29); 1-8

III. **Sundberg K**, Kitto S, Nordquist J.
The relational leader. An exploration of leading change in nursing education
*Manuscript*

IV. **Sundberg K**, Josephson A, Reeves S, Nordquist J.
Framing IPE. Exploring meanings of interprofessional education within an academic health professional institution
*Journal of Interprofessional Care*, 2019; DOI: 10.1080/13561820.2019.1586658

# LIST OF ADDITIONAL PUBLICATIONS

Nordquist J, **Sundberg K**, Laing A.
Aligning physical learning spaces with the curriculum: AMEE Guide No. 107
*Medical Teacher*, 2016; 38(8); 755-768

Nordquist, J, **Sundberg K**.
Institutional needs and faculty development for simulation
*Best Practice & Research - Clinical Anaesthesiology*, 2016, 29(1); 13-20

**Sundberg K**, Frydén H, Kihlström L, Nordquist J.
The Swedish duty hour enigma
*BMC Medical Education*, 2014, 14(Suppl. 1), S6

Nordquist J, **Sundberg K.**
An educational leadership responsibility in primary care: ensuring the physical space for learning aligns with the educational mission
*Education for Primary Care*, 2013, 24(1), 45-49

Nordquist J, **Sundberg K**, Johansson L, Sandelin K, Nordenström J.
Case-based learning in surgery: lessons learned
*World Journal of Surgery*, 2012, 36(5), 945-955

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| CAIPE | Centre for the Advancement of Interprofessional Education |
| CPD | Continued professional development |
| IPA | Interpretative phenomenological analysis |
| IPE | Interprofessional education |
| UKÄ | Universitetskanslerämbetet (Swedish) |

# 1 PROLOGUE

In 2009 I started a new employment at Karolinska Institutet. I joined Medical Case Centre at the Department of Medicine in Huddinge as a research assistant; my first task was to coordinate the review of the 2007 curriculum of the undergraduate medical programme. I was appointed the role as handling officer of the project.

The review was commissioned by the Board of Education at Karolinska Institutet. The first main aim was to review the programme in relation to the results from the 2007 evaluation report from the national accreditation body, the National Agency for Higher Education (*Högskoleverket*). The second main aim was to review the programme from an international perspective by inviting a panel of national and international experts to conduct the process of the review. The review was thought of as a formative instrument for setting the programme in tune with its original ideas and three main strategies were used to obtain the aims of the review of the programme: 1) establish a working group with national and international expertise in medical undergraduate education and curriculum development, 2) explore internal and external documents and 3) identify and interview students, teachers, administrators, educational leaders and pedagogic researchers of interest. The results were presented in a report (Karolinska Institutet, 2010).

With an academic background in the social sciences and a working background in evaluations within the realm of national and international police education, the world of medical education was intriguing, yet familiar. Fragments of recognition from the world of police education were indeed present, but several things stood out to me as new and interesting. During the fall of 2009 I closely followed, supported and co-ordinated the work of the review panel and had the opportunity to listen to several interviews with educational leaders involved in the undergraduate medical programme at Karolinska Institutet. The long-lasting impression of the interviews was that medical education was a fast-evolving realm, but simultaneously rooted in layers of traditionalism. The teachers that were appointed educational leadership roles such as for example course leaders and theme leaders were trying to manage a complex role. Indeed, the final report of the curriculum review highlighted the fact that critical for turning visions of the curriculum into reality was the implementation capacity of the educational leaders within the medical programme structure; a perceived lack of resources and mandate for the educational leaders to do so was identified (Karolinska Institutet, 2010).

Later, in 2011, I had the opportunity to start my PhD project and I decided to look into educational leadership and leading educational change and development in health professions education from a research perspective. A result of my experiences from the review of the 2007 curriculum of the undergraduate medical programme was the deriving of two sensitising concepts: power and resistance. Another result of my experiences from the review was that additional questions were raised in my mind: what was the situation regarding educational leadership and leading educational change within the nursing programme? Was it the same as in the undergraduate medical programme or something completely different? What was the outcome when the undergraduate medical programme and the nursing programme introduced

joint educational change through interprofessional education projects? The theoretical lens of power and resistance and my interest in finding the answers to my questions were the starting point for the design of this thesis.

# 2 INTRODUCTION

This thesis is written within the scope of the research area of medical education. Medical education is a discipline which could be described as being born out of the meeting between higher educational research and biomedical research. It includes the educational levels of undergraduate, postgraduate as well as continued professional development and inherits a special position among educational research because of its focus on professions education, as well as because of medicine's privileged position in society. Unlike higher education in general, medical education often has the benefit of status as well as separate funding streams and the support of a political lobby (Swanick & Buckley, 2010). Research in medical education aim at deepening the knowledge of teaching and learning within health professions education (Ringsted, Hodges & Scherpier, 2011) and how these processes can improve the education of health professionals and the quality of health care.

In this thesis the term "medical education" refers to education specifically within the undergraduate medical programme and the term "health professions education" refers to all educational programmes designed for health professionals, including both the undergraduate medical programme and the nursing programme. Interprofessional education is in this thesis defined as occasions "when two or more professions learn with, from and about each other to improve collaboration and the quality of care" as according to Centre for the Advancement of Interprofessional Education (CAIPE, 2002).

The thesis takes on the task of exploring the mechanisms operating when educational leaders try to lead educational change and development within health professions education. The context is connected to the undergraduate medical programme and the nursing programme, as well as to the intersection between the two; the arena of interprofessional education. In doing so, the thesis operates within two research realms: research in health professions education and leadership research. Educational leaders are in this thesis defined as important actors on the educational stage that may be found at three different leadership levels within a higher education institution: top level (for example as vice-chancellor or director), mid-level (for example as dean or programme director) and line level (for example as course leader or theme leader). The educational leaders may potentially influence important aspects of content within an educational programme (Bikmoradi, 2009). The thesis is hence focusing on the phenomenon of leading educational change and development which is present within the health professions education environment, but also more specifically on the phenomenon of leadership.

This thesis also supplements the above inquiry through a third research realm, since sociological/social science concepts have been the starting point and the theoretical perspective of the project: the two sensitising concepts of power and resistance derived from the findings of a review of the 2007 curriculum for the undergraduate medical programme. The report of the review highlighted a perceived lack of mandate/power and resources among educational leaders, making it difficult for the leaders to fully implement the new curriculum (Karolinska Institutet, 2010). The concept of power is central within the social sciences such as for example political science and sociology (Haugaard, 2002) and sensitising concepts are often used in social sciences to draw attention to key features of social interaction (Bowen, 2006) as well as background ideas that inform the overall research problem (Charmaz, 2003).

Further, the chosen theoretical starting point for this thesis, the sensitising concepts of power and resistance, suggests that the thesis is theoretically driven. Research in health professions education has often been criticised for a lack of connection to theory (Bolander Laksov, Dornan and Teunissen, 2017) but this thesis aim to use theories derived from the world of social sciences both as a starting point as well as applied as perspectives.

Educational leaders engaged in health professions education often hold the task and mission to develop the curricula through initiating, implementing and evaluating educational reforms (Cooke, Irby and O'Brien, 2010); a complex task performed in an environment of several different interest groups (Nordquist and Grigsby, 2011). Still, findings on the role of educational leaders in health professions education are rarely based on the analysis of empirical data and seldom focus on the developmental role of the educational leader (Lieff and Albert, 2010; 2012). This thesis contributes to the closing of this identified knowledge gap.

## 2.1 DEFINING LEADERSHIP

There is some disagreement about the term "leadership" and its precise nature. However, leadership is widely accepted as a real and empirically distinctive entity (Martin and Learmonth, 2010). Leadership is a phenomenon with several definitions within the world of leadership research (Nyberg, Bernin and Thorell, 2005); a research field that has grown and received increased attention since the 1980's (Martin and Learmonth, 2010). Leadership has been described as "a phenomenon that everyone has an opinion on but few of us seem to agree exactly on what it really is" (Jackson and Parry, 2011; Bass, 1981). A widely used definition however, is Kotter's (2001) definition of leadership "as the ability to cope with change in an organisation, setting a direction, aligning people and to motivate and inspire". This is also the definition of leadership that is applied in this thesis. Leadership can also be defined in terms of behaviours, traits and characteristics that are focusing towards a clear vision and the relationship between leaders and colleagues have an influence on both wellbeing and organisational productivity (Avolio et al., 2004).

The research field of leadership research has moved away from research questions such as "who is the leader?" or "what does the leader do?" to focusing more on research questions along the line of "what is going on?" (Jackson and Parry, 2011). Hence, the focus has shifted from leadership as a person or results and towards leadership as a position or a process (Grint, 2005). This trend in the research field signals that leadership is a phenomenon more complex and holistic than the personality traits of leaders or a specific leadership strategy; leadership is also related to relationships and structures.

The somewhat elusive essence of leadership highlights the importance of defining what types of theories we are using when viewing the phenomenon of leadership. Jackson and Parry (2011) suggests five overarching categories that may function as a sorting model when defining what types of theoretical perspectives are being used within the realm of leadership research: leader-centred perspectives, follower-centred perspectives, cultural perspectives, critical and distributed perspectives and leadership with a higher purpose.

**Table 1.** Five overarching categories for theoretical perspectives on leadership research[1]

| Theoretical perspective | Definition |
|---|---|
| Leader-centered perspectives | Research derived from the leader-centred perspectives on leadership focuses on either leader identity or leader behaviour |
| Follower-centered perspectives | The follower-centred perspective on leadership acknowledges the follower in the analysis of leadership – not just the leader. It also moves away from the concept that the follower always plays the passive role in the relationship with the leader |
| Cultural perspectives | The underlying assumptions, frameworks and theories within the cultural perspective on leadership is to highlight organizational context and to see leaders and followers as engaged in an interplay within a context, rather than focusing on just one group or the other. Leadership is seen as a cultural activity – portrayed through aspects such as values and language. The challenge within the cultural perspective is to reveal the role of the context when operationalizing leadership |
| Critical and distributed perspectives | Critical perspectives on leadership challenge the traditional relationship where leaders are people in charge and followers are influenced solely by leaders – all people can be involved in leadership independently of their formal position in an organization. Distributed perspectives on leadership relates to different kinds of collective or dispersed leadership |
| Leadership with a purpose | Perspectives on leadership with a higher purpose are focusing on the nature of purpose and ethics "behind" leadership |

A scoping review of the literature on leadership in undergraduate medical education (Sundberg and Nordquist, 2014) show that only very few studies apply theoretical frameworks to the findings and that only two of the categories of theoretical perspectives suggested by Jackson and Parry (2011) were represented at the time: leader-centred perspectives and cultural perspectives.

## Leadership and management

In the world of leadership research there is an ongoing debate about the relationship between leadership and management. The original take on the matter focused on leadership

[1] Inspired by Jackson and Parry (2011)

and management as two different functions, which often were described as requiring both different skills and different types of people (Zaleznik, 1977; Jackson and Parry, 2011). A later way of viewing the two entities is that they are intertwined (Levy, 2004) and suitable instruments for solving different types of problems depending on their level of complexity (Grint, 2005). Aligned with this way of thinking is the idea that a workplace in today's society needs both leaders who inspires, persuades and challenges status quo simultaneously as it needs managers who assists in the development and maintaining of the functioning workplace (Lunenburg, 2011). Yet another way of framing it is that leadership and management are connected to four different types of processes: leadership, management, governance and command. These four processes are all needed and should be in balance if the goal is to develop a sustainable and vital organisation (Jackson and Parry, 2011).

Change management theory is also a related and recurrent theme in the realm of leadership research which has been defined as a theory that emphasises the description of processes of change processes. However, change management theory is considered to lack contextual considerations, while institutional theory analyses the context of change as well as considers the actors engaged in change as well as their power status. While change management theory focus largely on change on a macro level within organisations, too much theoretical focus on a micro level may lead to a disregard of the wider context (Kuipers et al, 2014). This thesis focuses on educational change and development on a micro and meso level from a contextual perspective. This has been achieved by applying phenomenological approaches and process oriented theories to experience oriented data.

## Educational leadership

The research field of educational leadership is pluralistic and comprises a lack of agreement on the nature of the discipline as well as competing perspectives (Bush, 2007). There is also a disagreement on whether educational leadership should be seen as a branch on the tree of leadership research, or if it is a field of its own with own distinctive features. The view of this thesis is that educational leadership has a character of its own because of its close connection to specific aims of education, which at the same time does not mean that the research field of educational leadership cannot learn from other leadership environments (Bush, 2017).

Educational leadership in health professions education share features with what is referred to as "academic leadership"; a well-established sub-field within the realm of leadership research (Bolman & Gallos, 2011, Kouzes & Posner, 2003, Ramsden, 1998). The existence of the sub-field has proven to be important since findings from more traditional leadership research has been found to not always be of relevance for the academic context (Bryman, 2007). In this thesis the term "educational leadership" is used when referring to leadership issues connected to the educational sphere within health professions education. The focus of the research on academic leadership is often on difficulties within the academic environment, such as adjusting to rapid change and getting other academics/experts to move along in change processes; the phenomenon known as "hearding cats" (Bolman &

Gallos, 2011). Shared features between educational leadership in health professions education and academic leadership are for instance high levels of independence and difficulties to adjust to rapid change and getting other academics/experts to move along in change processes (Bolman and Gallos, 2011; Kouzes and Posner, 2003; Ramsden, 1998). Another example is understanding barriers to change (Mc Rory and Gibbs, 2009). However, the literature connected to the fields of educational leadership in health professions education highlights their own specific characters and challenges, such as the social contract with the public, specific institutional culture and organisational silence (Lee and Hoyle, 2002, Rich, Magrane and Kirch, 2008; Souba, 2010).

## Educational leadership in undergraduate medical education

An overview of the literature on leadership in undergraduate medical education show that it thus far mostly has focused on skills, competencies and leadership styles among educational leaders as well as on cultural aspects of their organisations. Citaku et al (2012) identified core competencies of leadership among educational leaders by showing that the most dominant competency was social responsibility together with justice orientation (following regulations and maintaining safety). Other studies (Yedidia, 1998; Lobas, 2006; Bikmoradi et al, 2010; Souba et al, 2011; Lieff et al, 2013; Saxena, Desanghere, Stobart & Walker, 2017) identify different character traits (able to suspend judgment, be patient with processes), skills (communication, development, emotional intelligence, interpersonal, developing a vision, strategic planning, change management, transformation, team-building, business skill, systems-thinking, politics and knowledge) focus (teaching and research), values (fairness, recognition, trust, respect, shared values and having a positive attitude) and styles (pace-setting, demanding, democratic and coaching) that have been proven successful and effective for educational leadership in undergraduate medical education. Lieff and Yammarino (2017) showed how leadership in undergraduate medical education in later years have moved away from traditional leadership paradigms such as hierarchical and military leadership paradigms, towards more current models such as paradigms based on self, authenticity and networking.

The notion of transformational leadership – leaders who inspire other to excel - was shown to exist among educational leaders in undergraduate medical education by Sanfey, Harris, Pollart and Schwartz (2011); the leaders reported the highest levels of ability on the leadership skills to support and/or care for others and to work in teams. They also reported to have the greatest difficulties to take risks, take care of themselves and bring about organisational change (Sanfey et al., 2011). Cognitive frames used by educational leaders were studied by Lieff and Albert (2010). The study showed how educational leaders were found to most commonly be using the human resource frame, focusing on creating alignment between the interests of the faculty and the interest of the organisation. The use of the human resource frame was closely followed by the use of the symbolic (creating a vision) and the political frames (engaging in diverse stakeholder interests). A new frame was also identified; interpersonal and work style (assessing components to understand how to situate people in the organization to encourage their strengths) (Lieff and Albert, 2010).

Regarding cultural aspects of educational leadership in undergraduate medical education, the theoretical framework of "organisational silence" – originally introduced by Morrison and Milliken (2000) and Milliken, Morrison & Hewlin (2003) - was applied in a study by Souba et al (2011) on organisational silence. Both educational leaders and their colleagues were reported to keeping quiet about misalignment between goals and available resources, as well as ignoring information indicating a performance problem. To create a culture without organisational silence was perceived to be difficult by a majority of the leaders and the leaders reported that non-discussed matters are common within their organisations (Souba et al, 2011). Jippes et al (2013) explored the success factors of adapting to curriculum changes despite strong levels of uncertainty avoidance among the educational leaders. The success factors were identified as: national legislation, strong need for change, visionary change agents and supportive and continuous leadership (Jippes et al, 2013).

The identification of challenges among medical education leaders is a clear theme in research on leadership in undergraduate medical education. Several studies (Yedidia, 1998; Lobas, 2006; Souba and Day, 2006; Bikmoradi et al, 2010; Lieff et al, 2013) have identified challenges on both an organisational level (lack of support, forces in the health care environment, elements of institutional structure, governance and culture as well as an overly extensive set of responsibilities) as well as an individual level (individual resources, difficult people, micromanagement, dysfunctional communication with other leaders and the work-life balance, leadership capabilities, management styles). Another area of challenge is connected to leading change in undergraduate medical education. Educational leaders experience difficulties to engage colleagues in change efforts in a culture dominated by consensus-seeking and collegiality (McGrath, Roxå and Bolander, 2019). Change often triggers resistance among colleagues and as a response the educational leaders engage in different types of tactics to overcome this, such as bargaining (McGrath et al, 2016).

Roles and practices of medical education leaders have also been highlighted in different studies. Lieff and Albert (2012) found that leaders' practices may be systemised as intrapersonal (focusing on the leaders themselves), interpersonal (focusing on the involvement with individuals or groups), organisational (focusing on the educational programme) and systemic (focusing on the world outside the educational programme. Brownfield et al (2012) found that the four main responsibilities of educational leaders in undergraduate medical education were overseeing, expertise, promotion of others and serving but at the same time the leaders were shown to having ill-defined expectations on their role.

Women in educational leadership positions within undergraduate medical education is a field of research that has expanded in later years. Specific barriers toward the possibilities to become female educational leaders have been identified as family obligations, discrimination and bias, lack of skills of envisioning female leaders (Humberstone, 2017, Pingleton et al, 2016, Girod et al, 2016). However, different suggestions of improvements and support have also been presented. Examples of this are twitter networking (Lewis et al, 2018) as well as the possibility of mentorship, career flexibility, faculty development and updating criteria for leadership roles (Humberstone, 2017, Pingleton et al, 2016). Coping strategies to overcome the obstacles in the role of a female educational leader in undergraduate medical education has been identified as downplaying, using humour and using power symbols as for example the white coat, to mark influence (Pingleton et al, 2016).

## Educational leadership in nursing education

An overview of the literature on educational leadership in nursing education reveals that nurses are considered to lead change in nursing, as well as in within nursing education (Nelson-Brantley and Ford, 2017). The development of nursing education through curriculum change processes demands the capacity to lead change and is the result of health care policies (Chowthi-Williams, Curzio and Lerman, 2015). Driven by demands for evidence-based practice as well as information technology, the content of nursing programmes is changing. The demands from nursing students for updated pedagogical models and learning activities as well as the view of nursing education as a service that will provide tools for future employments for students, put demands on nurse educators and their capacity for leading educational change (Stanley and Dougherty, 2010). Curriculum change has become a key feature of nurse education and change management capacity within complex educational organisations that stretches across both educational and health care environments, is needed (Chowthi-Williams, Curzio and Lerman, 2015). A concept analysis conducted by Nelson-Brantley and Ford (2017) to clarify the concept of leading change in the context of nursing, also show that the following five attributes of leading change in a nursing context are present: individual and collective leadership, operational support, fostering relationships, organisational learning and balance.

But the literature highlights several of the vast challenges that nursing education stands before in connection to educational change and development. A shrinking pool of qualified faculty as well as a demand on improvement of nursing education on a program level (Benner et al, 2010; Institute of Medicine, 2011) puts demands on educational leadership within nursing education. Also, to navigate the dichotomy between the two worlds of academia and health care practice (Ross et al, 2013; McNamara, 2009), a shortage of qualified candidates for educational leadership (Adams, 2007) as well as not always being comfortable with viewing themselves as leaders (Stiles et al, 2011) are other specific and highlighted challenges for educational leaders in nursing education. Thompson and Clark (2018) has in addition mapped several of nursing's academic leadership struggles and specifically highlights the existence of "gaslighting" (Sarkis, 2017); the misalignment of actions and words that denies or justifies bullying and harassment in the workplace. The phenomenon reveals behaviour among educational leaders in nursing education that masks inappropriate and unfair conduct towards colleagues as jokes or as the result of line management legitimacy or the department's strategy or mission (Thompson and Clark, 2018). Ethical issues connected to educational leadership in nursing education are explored in a study from 2008 (Gray, 2008). The ethical issues that were found to be the dominating ones were integrity and justice, where integrity was connected to for example honesty and courage to act while justice was connected to fairness. Most of the ethical situations that were brought forward by the educational leaders were connected to struggles of deliberate action such as for example wrestling with decisions in the light of consequences (Gray, 2008).

Leadership identity and the transition of identities from being a nurse leader in a clinical environment to becoming a nurse leader in an educational environment have been explored by Danna, Schaubhut and Jones (2010). The transition allowed the nurse leaders to understand nursing issues from alternative perspectives but a prerequisite for success in the

new environment was mentorship and support from experienced faculty. The unpreparedness of nurse faculty leaders before entering their role is also explored by Young, Pearsall, Stiles and Horton-Deutsch (2011) in a qualitative study on the experiences of becoming an educational leader in nursing education. The most common experience among the educational leaders was to be thrown into a leadership position without any preparation or little time to reflect. Learning to face challenges and to take risks without preparation was considered to be important experiences. However, encouragement and mentorship from colleagues was seen as a prerequisite for transforming into a successful educational leader. The topic of becoming an educational leader in nursing education was also explored in a study by Stiles, Padue, Young and Morales (2011). The study show how the participants become educational leaders by getting involved with colleagues and creating environments for change. However, a common phenomenon was that they did not view themselves as leaders during the process of leading (Stiles et al, 2011). Prerequisites and obstacles for accepting to become an educational leader in nursing education were highlighted in a study by Adams (2007). Conflicts and increased work-load were identified as most likely to discourage someone of becoming an educational leader while variety of work, opportunity to contribute towards change, opportunity to contribute to faculty development and growth as well as mixed job tasks were listed as most likely to encourage the pursuit of becoming an educational leader.

Leadership style is also a topic that has been looked further into within the literature on educational leadership in nursing education. The topic of leadership styles is for example referred to in Shieh, Mills and Waltz (2001) study which focus on the connection between leadership styles among educational leaders and job satisfaction as well as in Mosser and Walls' study (2002) which explores the usage of leadership frames among educational leaders. The study show how the human resource frame (listen to new ideas and foster participation among colleagues) and the structural frame (define goals, coordinate activities and establish roles for colleagues) are much more commonly use than the political frame and the leadership frame (Mosser and Wall, 2002). As a result of emotional intelligence being shown to be an important prerequisite for effective leadership within healthcare, a conceptual model of a connection between emotional intelligence and leadership in nursing education was discussed in a paper by Carragher and Gormley (2017).

## Educational leadership in interprofessional education

The literature on educational leadership in interprofessional education (IPE) points out leadership as an important enabler for implementation. Still, there is an established lack of theory-based research on IPE and educational leadership (Brewer, Flavell, Trede & Smith, 2016) as well as the application of theoretical perspectives on practical problems of deliverance of IPE (Hean et al., 2012). Power perspectives on IPE are also found to be underrepresented in research on IPE (Baker, Egan-Lee, Martimianakis & Reeves, 2011; Paradise & Whitehead, 2015).

The importance of institutional support as well as leadership commitment has been stressed in connection to implementation success regarding IPE. Institutional support is also seen as tool which is helpful when challenging resistance to IPE from different stakeholders

(Steinert, 2005; Ginsburg and Tregunno, 2005; Bennet et al., 2005). Resistance to IPE is a real threat to the implementation of IPE and has been shown to originate from conservative cultures within the field of health professions education (Barker, Bosco, & Oandasan, 2005; Reeves, Levin, Espin & Zwarenstein, 2010). Additional challenges connected to educational leadership in IPE is differing perceptions of IPE, as well as the creation of power hierarchies depending on professional background (Baker et al, 2011). A lack of executive leadership of IPE (Bennett et al, 2011) as well as a lack of leadership support of IPE on different organisational levels (Hammick et al, 2007) have also been shown to exist.

## 2.2 THE POWER PERSPECTIVE

The concept of power does not hold one single definition, but is instead described as a concept of family resemblance. This implies that even though the concept of power may mean and signal somewhat different things in different contexts, the concept always creates a kinship across and regardless of settings and environments (Wittgenstein, 1967). The chosen definition of power in this thesis is focusing on social influence in which (a) individual(s) act to change another individual's or group's attitudes or beliefs (Raven, 2008). Haugaard (2002) describes the same phenomenon as "subsets of relations among social units such that the behaviours of one or more units depend in some circumstances on the behaviour of other units".

French sociologist Foucault declared "Where there is power there is resistance" (Foucault, 1978) which has been interpreted as the nature of power implying the existence and possibility of resistance (Dumm, 1996). The lack of this possibility would in turn have meant that power couldn't have been able to come into play; power relations would not be existing (Armstrong & Murphy, 2011). Within the context of this thesis the relationship between power and resistance implies that it is important not only to take a closer look at mechanisms of power and resistance as separate entities, but to instead choose to highlight the interplay between them. Research on the relationship between power and resistance has shown that resistance may also be found in flexible and complex forms that do not only materialise as a prompt rejection of a dominant discourse (Armstrong & Murphy, 2011). Another way of putting it is that power which is not met with consensus can be met with resistance of different types; both through intentional resistance through active opposition and through frictional resistance which is described as indifference. This in turn does not have to be connected to conflict (Barbalet, 1985). The definition of resistance in this thesis is "a change in the belief, attitude or behaviour of a person (…) which results from the action or presence of another person" (Raven, 1990).

Even though theoretical power perspectives is lacking within research on leadership in health professions education (Sundberg and Nordquist, 2014; Baker, Egan-Lee, Martimianakis and Reeves, 2011; Paradise and Whitehead, 2015) they have been applied on research on leadership in higher education at large. The lack of oppressive top-down power among educational leaders in higher education has for example been highlighted by Lumby (2018). Lundy show how power structures connected to and embedded in social structures are the

most frequently present form of power in higher education environments; academic freedom is key. To step into the role of being an educational leader in a higher education environment is taking a risk to be seen in a negative light by colleagues, as a result of the potential exercise of power it implies (Lumby, 2018). Educational leaders at a mid-level in higher education are also shown by Branson, Franken and Penney (2016) to be a part of a complex network of relationships among colleagues, which they have to learn to both navigate and negotiate. The challenge is to reach balance between exercising power and being collegial with and supportive towards colleagues. Gaining insights on the mechanisms of this specific context has been shown to be the key to successful educational leadership (Branson, Franken and Penney, 2016).

As well as departure from the sensitising concepts of power and resistance this thesis uses theory as a lens to highlight aspects of a phenomenon; leading change and development in health professions education. This is made through the application of power-based theories and models to the findings of study I-IV. Power perspectives offer insights to processes and asymmetries between different types of stakeholders (Jackson and Parry, 2011; Martin and Learmonth, 2010; Mumby and Clair, 1997).

## Models, taxonomies and frameworks of power

As a result of the theoretical power perspective taken in this thesis, power-based taxonomies, frameworks and models have been applied during the interpretative phase in the different studies. The rationale for the choice of the specific frameworks, models and taxonomies of power used are that they are well aligned with the sensitising concepts of power and resistance as well as aligned with and contributing to the overarching research question of the thesis: how does leading educational change in an educational health professions organisation manifest itself through power and resistance? The models, taxonomies and frameworks that have been applied in this thesis are hence exploring different aspects of educational leaders leading change and development in health professions educations, but always with a focus on the specific context and on social processes.

### *Yukl's power taxonomy*

One stream of power research engages in the classification power relations and on different types of power. Within this stream we find the work of French and Raven (1959) whose focus of work is on "social influence" (Gable, 2012); how individuals with power through different processes are able to influence others to act, think and feel (Raven, 2008). Based on these ideas, French and Raven developed a power taxonomy including different primary bases of power (Raven, 2008), which Yukl (1998) in turn later further developed into a taxonomy of five primary sources of leader influence as well as their likely types of outcomes (Green, 1999; Yukl, 1998). The five sources of power included in the taxonomy are reward power, coercive power; legitimate power, expert power and referent power and they are all connected to different type of outcomes when exercised. The outcomes are in turn divided into three categories: commitment, compliance and resistance. The aim of the taxonomy is to

show that the influence tactics of leaders varies and that they are connected to several factors such as the purpose of the influence, the nature of the organisation and the task as well as the status of the so called target person (Yukl, 1998). The power taxonomy functions as a tool to zoom in on sources of power as well as on how different sources of power trigger different types of outcome; the taxonomy holds the potential to provide us with a clearer picture on how leading change and development in health professions education is manifested through power and resistance.

**Table 2**: Power taxonomy – sources of leaders' influence (Yukl, 1998)[2]

| **Source of leader influence** | **Type of outcome** | | |
|---|---|---|---|
| | **Commitment** | **Compliance** | **Resistance** |
| Reward power | Possible—if used in a subtle, very personal way | LIKELY*—if used in a mechanical, impersonal way | Possible—if used in a manipulative, arrogant way |
| Coercive power | Very unlikely | Possible—if used in a helpful, non-punitive way | LIKELY*—if used in a hostile or manipulative way |
| Legitimate power (or "Position power" | Possible—if request is polite and very appropriate | LIKELY*—if request or order is seen as legitimate | Possible—if arrogant demands are made or request does not appear proper |
| Expert power (or "Skill power") | LIKELY*—if request is persuasive and subordinates share leader's task goals | Possible—if request is persuasive but subordinates are apathetic about task goals | Possible—if leader is arrogant and insulting, or sub- ordinates oppose task goals |
| Referent power (or "Friendship") | LIKELY*—if request is believed to be important to leader | Possible—if request is perceived to be unimportant to leader | Possible—if request is for something that will bring harm to leader |

*Gee's identity model*

Identity may be described as the way individuals perceive themselves as well as want to be portrayed within their social context and is recognised by a broader community (Gee, 2001). This is also applicable to the concept of the professional identity. The professional identity is the result of the process of secondary socialisation; when a new member of a profession internalises a joint body of professional knowledge (Berger and Luckmann, 1966). Looking closer at health professions education at large and undergraduate medical education in particular, professional identity formation is an undergoing process not only within the groups of students and teachers, but also among educational leaders. To be able to explore the professional identity of the educational leader in undergraduate medical education from a power perspective, Gee's power-based identity model was used. The model highlights power

[2] Table reproduced with permission of G. Yukl. From his original work *Leadership in Organizations* (1998)

processes and sources of legitimisation connected to four different perspectives on identities. The perspectives are not to be seen as separate from each other, but instead as four different ways to focus on different aspects of how identities are shaped and sustained (Gee, 2001). The model holds the potential to provide us with a clearer picture on how leading change and development in health professions education is manifested through power and resistance.

**Table 3**: Gee's power-based identity model (2001)[3]

| Process | | Power | Sources of power |
|---|---|---|---|
| Nature-identity: a state | *developed from* | forces | in nature |
| Institution-identity: a position | *authorized by* | authorities | within institutions |
| Discourse –identity: an individual trait | *recognized in* | the discourse/dialogue | of/with "rational" individuals |
| Affinity-identity: experiences | *shared in* | the practice | of "affinity groups" |

*Goffman's frame analysis (as applied by Pope and colleagues)*

A frame may be described as something individuals use to identify, perceive, locate and label occurrences with; it is a "schemata of interpretation" (Goffman, 1974; Snow, Rochford, Worden and Benford, 1986). Frame analysis is a concept originally presented by Goffman (1974) that alludes to a process of exploring different elements of an idea to see what is holding the different elements together. By doing this it is then possible to unpack the elements, their meaning and as a result to identify the frame (Creed, Langstraat and Scully, 2002). Pope and colleagues' (2006) application of Goffman's frame analysis is in particular focusing on three different aspects of a frame: definition (the presented defining characteristics of the phenomenon), rationale (the presented purpose of the phenomenon) and presentation (the means by which the phenomenon is represented). By applying frame analysis to a phenomenon of choice, it is possible to explore underlying social processes and power relations in connection to the definition, rationale and presentation of the phenomenon.

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## 2.3 RATIONALE FOR THE THESIS

Health professions educational leadership has implications for global health; it is crucial for improving the quality of health professionals' skills, knowledge and attitudes (WHO, 2006). Educational leaders engaged in health professions education often hold the task and mission to develop the curricula through initiating, implementing and evaluating educational reforms

[3] Table reproduced with permission of J.P. Gee. From his original work *Identity as an analytical tool for research in education* (2001)

(Cooke, Irby and O'Brien, 2010); a complex task performed in an environment of several different interest groups (Nordquist and Grigsby, 2011). By exploring manifestations of power and resistance among educational leaders in health professions education when leading change and development, this thesis contributes with new light on the complex tasks of the educational leaders. This is done through empirically-based findings interpreted through theoretical power perspectives.

It is also indicated in the literature that even though faculty development programs for educational leaders in health professions education are growing in numbers (Tekian & Harris, 2012), they are seldom based on research findings (Lieff & Albert, 2012). This thesis is hence contributing with knowledge to research-based faculty development programs on educational leadership for educational leaders in health professions education. The results from this thesis has the potential to contribute with important knowledge on how to create quality faculty development programs for educational leaders to support them in their important mission: to turn educational visions into practice, creating better health care for tomorrow.

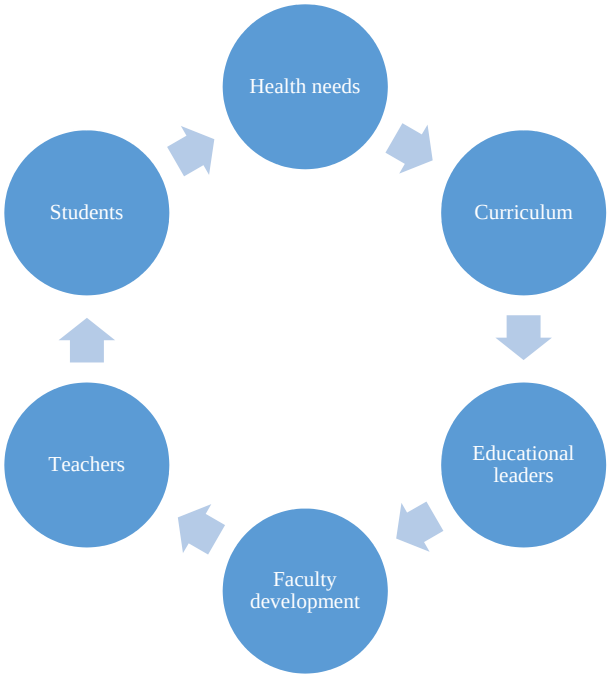


**Figure 1:** Rationale for the thesis

# 3 AIM OF THE THESIS

The overall aim of this thesis was to explore perceptions and experiences of educational leaders leading educational change and development in health professions and interprofessional education. The overarching research question is: how does leading educational change in an educational health professions organisation manifest itself through power and resistance?

The following specific aims were stated in project I (study I-II), project II (study III) and project III (study IV) of the thesis:

Project I: Experiences of health professions leadership in undergraduate medical education

I. To explore the topic of the experiences of educational leaders leading change within an undergraduate medical programme.

II. To explore the topic of medical education leaders and their identity formation; specifically to shed light on the identity of undergraduate medical education leaders

Project II: Experiences of health professions leadership in nursing education

III. To explore the topic of the experiences of educational leaders leading change within a nursing programme

Project III: Experiences of health professions leadership: the interprofessional case

IV. To explore the topic of different meanings attached to IPE within two organisational entities at an academic health professions educational organisation: among educational leaders and among the institution's educational policy documents

# 4 METHODOLOGY

## 4.1 PHILOSOPHICAL POSITIONING

This thesis is based on research using qualitative research methods. In such work, as highlighted by Crotty (2010), it is important to make sure that there is an alignment between the basic elements of the research process: epistemology, ontology, theoretical perspective, methodology and methods. It is crucial to make sure that and present how the different elements of the research process are related, aligned and compatible. To position the choice of methods that have been made for this thesis, it is therefore of importance to clarify within which research paradigm it will be operating in; the underlying assumptions held about the nature of reality, the relationship between the researchers and what is being researched and how to gain knowledge of the world (Guba & Lincoln, 1994; Lincoln, Lynham and Guba, 2011).

The purpose of this thesis and the questions posed to highlight and obtain understanding of the specific experiences of medical educational leaders is with the help of theories and models from the realm of social science. This is made in order to contribute with new perspectives on, and interpretations of, their experiences as educational leaders within a specific context; health professions education. Hence, the thesis aims to understand and map out different truths about leadership and leading educational change, stated subjectively by different persons. The epistemological starting point is that knowledge is subjective and that meaning is socially constructed between the researcher and the educational leaders. The research findings are created as a result of the subjective, personal experiences of the research subjects together with the choice of theoretical perspectives/subjective analysis; the epistemological stance is hence that reality is subjective (Illing, 2010). It is not possible to establish facts about one objective or objectively measured "reality". Therefore, the ontological view connected to this research paradigm is a relativist one, accepting multiple realities that are experientially based and dependent for their form on people/groups (Guba & Lincoln, 1994; Lincoln et al, 2011).

Concerning the results of the analysis of the collected data, the focus will be on offering one or several perspectives on leadership and leading educational change in the realm of health professions education. These perspectives are not the only perspectives on leadership, nor is the thesis claiming to contribute to the field containing of objective "facts" – it is a perspective derived from the subjective application of theory onto the personal experiences of different leaders. Hence, the view on the knowledge that the research results in aligns with the view of knowledge that is connected to the constructivist paradigm (Guba & Lincoln, 1994; Lincoln et al, 2011). The choice of methodology is therefore to adopt a phenomenological approach to explore the subjective experiences of educational leaders within health professions education. Phenomenology is a qualitative research approach that implies in-depth explorations of individuals' experiences and understanding social phenomena from the specific perspectives of those who have experienced it (Husserl, 1931). Another way of defining phenomenology is to describe it as a way to capture the essence of an event which in turn is seen as an abstract and subjective entity (Starks and Brown, 2007). Hence, phenomenology may be viewed as both a family of qualitative research methods and

as a philosophical movement (Gill, 2014). Phenomenology is however a multi-facetted research approach and may be described as a tree with different branches, or schools of phenomenology where this thesis sits on the branch of Husserl's transcendental phenomenology (van Manen, 2006), including Moustaka's variant on the same theme (Creswell, 2013). Transcendental phenomenology is characterised by a focus on knowledge and the constitution of meaning; the methods are descriptive (van Manen, 2006).

Reflecting on this thesis it is quite clear that the experiences/problems I am trying to understand are (inter)subjective experiences/problems of the educational leaders I am interviewing. The direction of my research and the specific questions I am posing is to highlight and obtain understanding of their specific experiences with the help of theoretical frameworks from the realm of social science. This is made in order to contribute with new perspectives on and interpretations of their experiences as leaders. These could in turn be seen as tools to incorporate in future leadership/faculty development to enhance the understanding of leading educational change within a health profession educational environment. Hence, I am not trying to measure the effects of any intervention, nor trying to test any hypothesis. I am operating within a constructivist paradigm trying to understand and map out different truths (Guba & Lincoln, 1994) about leadership and leading educational change, stated subjectively by different persons. Concerning the results of my analysis of the collected data, it is my opinion as a researcher that I will be able to offer one or several perspective on leadership and leading educational change in the realm of health professions education. These perspectives are not the only perspectives on leadership, nor am I claiming that my knowledge contribution to the field contains of objective "facts" – it is a perspective derived from my subjective application of theory onto the personal experiences of different leaders. Hence, my view on the knowledge that my research results in aligns with the view of knowledge that is connected to the constructivist paradigm (Guba & Lincoln, 1994). The research findings are created as a result of the subjective, personal experiences of the interviewees together with my choice of theoretical perspectives/subjective analysis; my epistemological stance is hence that reality is subjective (Illing, 2010).

Since post-positivism to a large extent seems to be dominating the research field of medical education research, I find it interesting to compare my research to this specific research paradigm. As Illing also points out, it is above all the epistemological stance that truly separates the research within the constructivist paradigm from the research within the post-positivistic paradigm: the constructivist epistemology is focusing on subjectivity and knowledge creation between the researcher and the subjects while the post-positivist epistemology is focusing on objectivity (even though research outcomes never can be totally objective or certain) (Illing, 2010). Further, knowledge in the post-positivistic paradigm consist of hypothesis – quite far from the constructivist view on knowledge as relative constructions co-existing with other knowledge constructions (Illing, 2010). And even though I as a researcher, as well as the post-positivistic researcher, both could be using qualitative methods for data collection the researcher is seen as an independent enquirer within the post-positivistic paradigm and as a subjective, actively engaged facilitator in the research process (Illing, 2010).

## 4.2 RESEARCH DESIGN

In alignment with my philosophical positioning, this thesis applies a qualitative research approach. Qualitative research crosscuts subject matters, disciplines and fields; it is considered to be a family concept which includes several approaches and methods. The qualitative researcher is aiming at interpreting and making sense of phenomena in the shape of which they are made meaningful by individuals. He or she is also looking into the reality as a social construction while being closely connected to what is being studied. The focus of research is to look at how social experience is given meaning and is constructed. (Denzin & Lincoln, 2005) Qualitative research is often engaged in systematic collection, ordering, description and interpretation of text-based data sprung from talk, documentation or observation (Kitto, Chesters & Grbich, 2008) Qualitative research does not however connect to a specific paradigm or theory of its own. (Denzin & Lincoln, 2005). As Ringsted, Hodges and Scharpier states (2011), a qualitative research design is used when trying to answer the "why?", "how?" or "what is the nature of…?" questions, for example when exploring complex phenomena. Qualitative research could also be described as rational to use when a topic may be under-studied or if a theories connected to the topic are under-developed. This thesis presents a qualitative research design, which may be defined as follows:

> *Qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that informs the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is both inductive and deductive and established patterns or themes.*
>
> (Creswell, 2013)

A summary of the research design of the four included studies in this thesis is presented as follows:

**Table 4:** A schematic overview of the research design

| Project | Study | Research focus | Research design | Participants | Data collection | Data analysis | Theoretical framework |
|---|---|---|---|---|---|---|---|
| **I** | **I** | Experiences of leading educational change in the undergraduate medical programme | Explorative, qualitative research | Educational leaders within the undergraduate medical programme | 16 semi-structured interviews | Thematic analysis | Yukl's power model (based on French & Raven) |
| **I** | **II** | Experiences of identity formation in | Explorative, qualitative | Educational leaders within the undergraduate | 14 semi-structured | Moustaka's structured phenomenological | Gee's power-based identity |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | connection to leading educational change | research | medical programme | interviews | analysis | model |
| **II** | **III** | Experiences of leading educational change in the nursing programme | Explorative, qualitative research | Educational leaders within the nursing programme | 9 semi-structured interviews | IPA | Yukl's power model (based on French & Raven) |
| **III** | **IV** | Experiences of implementing IPE | Explorative, qualitative research | Educational leaders from the undergraduate medical programme and the nursing programme implementing IPE | 9 semi-structured interviews + 5 documents | Directed qualitative content analysis | Goffman's frame analysis (applied by Pope and colleagues) |

The four studies of this thesis explore the experiences of educational leaders in health professions education leading change (see Table 2). The four studies explore these experiences from a theoretical power perspective. In study I and II different aspects of experiences of educational leaders in the undergraduate medical programme are explored through a qualitative research design. Study III is a qualitative study exploring the experiences of educational leaders leading change in the nursing programme. Study IV may be viewed as qualitative study focusing on experiences of implementation. Implementation of IPE serves as an example of leading change in a common educational project shared by educational leaders from both the nursing programme and the undergraduate medical programme.

## 4.3 CONTEXT AND PARTICIPANTS

The context of this thesis is Karolinska Institutet, a medical university in Sweden established in 1810 and with a strong emphasis on research. Since 1901 the Nobel Assembly at Karolinska Institutet has selected the Nobel laureates in Physiology or Medicine. Karolinska institutet may be described as a prestigious and high-ranking university, both in a national and international context. It is a higher education institution which offers several health professions educational programmes, including the undergraduate medical programme and the nursing programme which are at the focus of this thesis.

At the time of the data collection for the thesis (December 2011- April 2012), the undergraduate medical programme at Karolinska Institutet had a duration of 5,5 years (330 ECTS) and admitted approximately 120 students every semester. The programme resulted in a master's degree and hospital-based attachments started in year 3 of the programme and continued one to year 6. However, the students were exposed to patient contact as early as

semester 1, through primary care attachments. The curriculum at the time was introduced in 2007 and focused on moving away from a traditional preclinical/clinical curriculum towards an integrated and thematic curriculum. There were seven themes present within the curriculum, with the intention to function as facilitators of both progression and integration across the curriculum as a whole. Each of the seven themes consisted of several courses.

At the time of the data collection for the thesis (December 2011- April 2012) the nursing programme at Karolinska Institutet was a 3-year programme that resulted in a bachelor's degree (180 ECTS) and admitted approximately 240 students every year at the Huddinge campus on-site programme. The curriculum at the time was introduced in 2010 with an emphasis on research-driven education and based on 3 themes; one for each year. Every theme consisted of 3-4 courses. Clinical placements were introduced already during the first semester. Both the nursing programme and the undergraduate medical programme were engaging their students in different types of projects and learning activities connected to interprofessional education. The concept of interprofessional education had been implemented actively since 1998 at the institution.

Within the medical programme and the nursing programme, students and teachers are key actors on the educational stage. But there are in addition other actors who are closely connected to the programmes and who potentially may influence the content and the format of the programmes: educational leaders. Educational leaders may in turn be divided into three leadership levels (Bikmoradi, 2009):

**Table 5:** Levels of and responsibilities for educational leaders[4]

| **Educational leadership level** | **Professional responsibilities** | **Examples at Karolinska Institutet** |
|---|---|---|
| Top level | Leadership responsibility for the whole university – both for education and research | Vice-chancellor |
| Mid-level | Educational responsibilities on an overarching programme level | Dean and programme director |
| Line level | Teachers with educational leadership responsibilities within the programme | Theme leaders and course leaders |

As highlighted by Bolander Laksov and Tomson (2016) educational leaders on the line-level are sometimes found working in parallel with the formal power structures of the university, such as for example the department heads. Still educational leaders are in several aspects

[4] Inspired by Bikmoradi, 2009

responsible for the programme delivery (Bolander Laksov and Tomson, 2016). They are also responsible for initiating, implementing and evaluation educational reforms (Cooke, Irby and O'Brien, 2010). In this thesis educational leaders connected both to the undergraduate medical programme and the nursing programme have been interviewed; educational leaders from both the mid-level and the line level are represented in the thesis. However, educational leaders from the top level are not represented since they were not engaged in processes directly connected to the specific aims and research questions of study I-IV included in the thesis.

## 4.4 SELECTION

A purposeful sampling approach was conducted for the thesis as a whole. Purposeful sampling is often a feature of qualitative research; researchers handpick participants based on their typical features/roles/characteristics. The aim is to build a sample that is meeting specific needs; a purposeful sample is chosen for a specific purpose (Cohen, Manion & Morrison, 2011). Educational leaders active on a mid-level and line level (Bikmoradi, 2009) were included in the samples for this thesis. Potential participants were tracked down with the help of the official websites of the programmes and asked by email if they were interested in participating in interviews.

### Study I-II

Study I and II was set within the undergraduate medical programme at Karolinska Institutet. The studies explored educational leaders' experiences of leading educational change and development, as well as their experiences of their professional identity formation. 23 educational leaders on a mid-level and line level were identified and invited to participate in the studies; 16 leaders accepted to be interviewed and were included in the final sample for study I. Out of the 16 leaders, two were active on a mid-level and 14 were active on a line-level. Regarding the gender quota, 11 were male and five were female. The sample for study II however, excluded the two leaders from the mid-level; the final sample for study II hence included 14 leaders from the mid-level. Regarding the gender quota for study II this meant that out of the total of 14 educational leaders, 10 were male and four female. The reason behind the exclusion of the two leaders from the mid-level for study II was the result of not reflecting upon matters regarding professional identity formation during the interviews. Educational leaders from the top level were not included in any of the samples for study I and II, since they were not engaged directly in processes connected to the research questions. One of the educational leaders in the final sample for study I and II was also included in the sample for study III.

### Study III

Study III was set within the nursing programme at Karolinska Institutet and explored educational leaders' experiences of leading educational change. The study explored educational leaders' experiences of leading educational change and development. 10 educational leaders on a mid-level and line level were identified and invited to participate in the study; all 10 leaders accepted to be interviewed and were included in the sample at the

first stage. All 10 were female. During the conducting of the interviews, one of the presumed leaders turned out to not match the profile of a mid-level or line level educational leader. The leader was excluded from the sample, which in the final version consisted of nine educational leaders; two were active on a mid-level and seven were active on a line level. Educational leaders from the top level were not included in the sample since they were not engaged directly in processes connected to the research question. One of the educational leaders in the final sample for study III was also included in the sample for study I and II.

### Study IV

Study IV was set within the context of interprofessional education (IPE) at Karolinska Institutet. The study explored different meanings attached to IPE within two organisational entities: among educational leaders and among educational policy documents. In this study, IPE served as a practical example of educational change. The sample for study IV was derived from the combined samples for study I/II and III. Out of 24 educational leaders active on a mid-level and line-level within the undergraduate medical programme or the nursing programme, nine were engaged in IPE and hence included in the final sample for study IV. Out of the total of nine educational leaders, six were male and three were female. Educational leaders from the top level were not included in the sample since they were not engaged directly in processes connected to the research question. The sample of official documentation on IPE was conducted through the identification of relevant regulatory documents. The identification was made mainly through the study institutional website and the final sample included nine official documents connected to IPE.

## 4.5 DATA COLLECTION

Data for this thesis was collected during December 2011 to April 2012. The interviews were made with educational leaders in connection to the medical programme and nursing programme (study I-IV). Data collection through the collection of official documentation on interprofessional education (study IV) was also conducted. All interviews and the tracing of documents were conducted by me.

As Denzin & Lincoln (2011) states, qualitative research crosscuts disciplines and does not have a distinct or own set of methods that are their very own (Denzin & Lincoln, 2011). However, the main choice of data collection for this thesis has been through interviews. The reason for this choice of method is the alignment with the research question: How does leading educational change in a medical education organisation manifest itself through power and resistance? By conducting semi-structured interviews it has been possible to enter the world of the educational leaders; what are their personal and subjective perceptions and experiences on leading educational change? As Peräkylä & Ruusuvuori (2011) states, interviews are one of two common but different types (the second one being “naturally occurring” materials) of empirical material in qualitative research. Interviews can in this context be described as type of material which exposes the researcher to accounts that he/she is interested in and which otherwise would have been inaccessible. Further, Peräkylä &

Ruusuvouri points out the convenient fact that interviews are very useful for overcoming distances in both space and time (Peräkylä & Ruusuvuori, 2011).

### Study I, II and III

The data collection was conducted through semi-structured interviews. Educational leaders connected to the medical programme on both a mid-level and line level were interviewed for study I (n = 16), educational leaders on the line level within the medical programme were interviewed for study II (n = 14) and educational leaders on the mid-level and line level within the nursing programme (n = 9) were interviewed during December 2011 to April 2012. Each interview lasted approximately 40 – 70 minutes. The semi-structured form of the interviews implies that questions was specified but the interviewer was able to seek both clarification and elaboration on the answers given, as well as probe beyond the answers and engage in a dialogue with the interviewee. (May, 2001).

The interview guide for the interviews was developed around two sensitising concepts derived from the findings of a review of the 2007 curriculum for the undergraduate medical programme: power and resistance in connection to leading change (Karolinska Institutet, 2010). The report of the review highlighted the fact that critical for turning visions of the curriculum into reality, was the implementation capacity of educational leaders within the undergraduate medical programme structure; a perceived lack of resources and mandate for the educational leaders was identified (Karolinska Institutet, 2010).

### Study IV

The data collection was conducted both through semi-structured interviews with educational leaders on a mid-level and line level engaged in interprofessional education (IPE), as well as through the identification and collection of official policy documents connected to IPE. The educational leaders who were interviewed were active within the undergraduate medical programme or the nursing programme. The interviewees all had in common that they in addition were engaged in IPE projects, through different roles (n = 9). The interviews were conducted during December 2011 and April 2012. The average full interview lasted approximately 40-70 minutes. The interview guide was partly (two out of four questions) based on the two sensitising concepts of power and resistance.

The data collection of official documentation on IPE was conducted through the collection of official institutional regulatory documents during December 2011. The identification of relevant regulatory documents was made mainly through the study of the institutional website and the final sample included nine official documents connected to IPE.

## 4.6 DATA ANALYSIS

The audio-taped, semi-structured interviews were transcribed verbatim by me. The data analysis was thereafter conducted through different types of qualitative analysis: thematic analysis (study I and III), Moustaka's structured phenomenological analysis (study II) and directed content analysis (study IV). The analytical process has been a joint effort between

different constellations within the research team, still always involving me as responsible for the process. A crucial step in a qualitative analysis is the interpretation phase; qualitative research without this is just an array of ideas solely applicable to the context where the data were collected (Lingaard and Kennedy 2010). In study I-IV, the core meaning of the data set was identified when considered through the lens of a theoretical power perspective.

## Study I and III

### *The analysis phase*

The data analysis was guided by thematic analysis. Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (Braun and Clarke, 2006). It is a data analysis method which identifies themes that capture central features about the data in relation to the research question. However, the importance of a theme is not always dependent on quantifiable measures and the process is not linear but instead going back and forth between six different phases (Braun and Clarke, 2006): (1) familiarising yourself with your data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes and (6) producing the report. The analysis process in a thematic analysis could hence be described as a recursive process (Braun and Clarke, 2006).

Using Braun and Clarke's own terminology (2006), the coding in study I and III could be described as 'theory driven' rather than 'data driven'. The starting point of the process was the sensitising concepts of power and resistance and the process could be described as abductive. However, the specific data analytical tool used in thematic analysis is thematic mapping, which includes the mapping of main themes, sub-themes and categories. Thematic analysis however share several similarities with for example content analysis, but still has its own specific characteristics. They two schools of analysis differ for example when it comes to the focus of quantification of data in content analysis, which is possible by measuring the frequency of categories and themes. Another difference is that thematic analysis incorporates both manifest and latent aspects of the data, which content analysis does not (Vaismoradi, Turunen & Bondas, 2013).

### *The interpretation phase*

In the interpretation phase the findings from study I and III were viewed and interpreted through a sociological power analysis theory, which classifies different types of power and power relations. The theory was the basis for French and Raven's (1959) power taxonomy which later was further developed by Yukl (1998). The power taxonomy classifies the concept of power into five different types and also includes how different type of power leads to different types outcomes (Green, 1999; Yukl, 1998).

## Study II

### *The analysis phase*

The interviews were transcribed verbatim by me. The data anlysis was guided by Moustakas' structured, phenomenological analysis approach (Moustakas, 1994; Creswell, 2013) Moustakas' structured phenomenological analysis approach is a qualitative instrument for data analysis derived from transcendental phenomenology (Moerer-Urdahl and Creswell, 2004). The analysis process starts by developing a list of significant statements about how the informants have experienced a specific phenomenon i.e. their identity as educational leaders. This process is referred to as horisontalisation of the data. The data is then clustered into larger themes and in the final stage the researcher writes a description of the phenomenon including both what the informants have experienced of the phenomenon (textual description) and how the experience happened (structural description) (Creswell, 2013).

### *The interpretation phase*

To boost the level of transferability of the results of this study, an analytical procedure called "pattern matching" was conducted. It is a strategy for aligning data to theoretical propositions; trying to link the empirical pattern with a theoretical pattern and also to explain why certain components may not match (Moerer-Urdahl and Creswell, 2004). Pattern matching using Gee's (2001) theory of the i-identity was performed. According the Gee, an educational leader should be categorised as an institution identity, an i-identity. Both the theoretical patterns and the empirically found patterns were presented with the help of three headings: perceived identity, identity process and power and identity. The headings were been derived by the research team from Gee's (2001) definition of identity used in this study as well as his power-based identity model (Gee, 2001) used for the pattern matching. The empirically found patterns were exemplified through a textual and structural description including quotes from the informants.

## Study IV

### *The analysis and interpretation phase*

The interviews were transcribed verbatim by me and the analysis and interpretation the findings for study IV was guided by Pope and colleagues (2006) application of Goffman's frame analysis; an approach which in this study guides the exploration and unpacking of three specific aspects of the IPE frame: definition (the presented defining characteristics of IPE), rationale (the presented purpose of IPE) and presentation (the means by which IPE is represented). These three frame aspects were explored both in the interviews and in the official regulatory IPE documents through a directed content analysis. The frame analysis approach can be conducted through different types of data analysis methods; the choice for this study was a qualitative, directed content analysis. The starting point of the directed content analysis was the three aspects of the frames: definition, rationale and presentation.

The concepts were used as predetermined codes when analysing the data both from the interviews and documents, in order to explore and identify frames.

## 4.7 USE OF THEORY

There is an increasing demand for researchers in health professions education to position their work to a specific theoretical framework, as well as be able to describe why that specific position has been chosen. Insights from the chosen theoretical framework should then assist the researcher in his or her interpretations of empirical material (Bolander Laksov, Dornan and Teunissen, 2017). This type of use of theory has been applied in this thesis through the application of power-based taxonomies, frameworks and models on findings derived from empirical data. But theory has also been used in alignment with the lighthouse metaphor as described by Bolander Laksov and colleagues (2017); the usage of theory as a specific perspective. The theoretical perspective used in this thesis is the one based on the two sensitising concepts of power and resistance. However, it is also of importance to acknowledge that the use of theory as a specific perspective comes at the expense of flexibility; certain valuable aspects of the topics explored may be ignored (Bolander et al, 2017). This is of course also the case in this thesis; the focus is particularly on the tension between power and resistance and the social processes surrounding it. The usage of other theoretical perspectives would have brought forward other types of findings. However, the choice as power and resistance as the two sensitising concepts of this thesis is based on previous experiences and lessons learned (Karolinska Institutet, 2010) as well as the proven lack of theoretical power perspectives in the literature on educational leadership in health professions education, Therefore the choice could be seen as relevant and legit and has contributed with important findings on the topic, which could be used for example within faculty development programmes for educational leaders in health professions education. One theory is not more legitimate than another, but they are all offering different perspectives on sometimes the same phenomena. This view aligns well with the view of knowledge in this thesis; several truths do exist and several truths can reflect different aspects of the same phenomenon.

## 4.8 ETHICAL CONSIDERATIONS

Evaluative rigour means ensuring that political and ethical aspects of the research are highlighted (Kitto et al., 2013). To account for evaluative rigour connected to this thesis would for example mean describing the process connected to the application and granting of ethical permits. In the initial stages of the thesis project and in connection to the design of the project plan, an application for ethical approval was sent to the local ethics review board for reviewing. The decision was however made by the ethics board that the no ethical permit was needed. Even though the thesis involves interviews which of course in turn implies interaction with humans, the format was not considered to be in need of an ethical permit. Informed consent was however obtained from all participators prior to the interviews. Anonymity toward readers of future studies as well as confidentiality in relation to the authors was guaranteed towards the participants. Since the interviews entailed the exposure of educational leaders' perceptions of colleagues and their behaviours, it was of a high level of

importance that no quotes could be connected to specific individuals. The participants were often very candid and for example mentioned fellow colleagues as different types of examples of leadership, as well as sharing their own personal weaknesses and describing difficult situations that they have had to handle as education leaders. Some of this "openness" could most probably be the result of the fact that they have signed an agreement for informed consent. Names and sensitive personal information has of course not been published at all.

## 4.9 REFLEXIVITY

Reflexivity is about researchers positioning themselves in their writings and being aware of their experiences, values and biases (Creswell, 2013). In qualitative research the role of the researcher is closely connected to the research. He or she is affecting the researcher process as a result of being engaged in and closely connected to the same process. This is why it is crucial in the qualitative context, that aspects of reflexivity are highlighted (Malterud, 2001).

The educational leaders that I interviewed for my thesis were active within the undergraduate medical programme and the nursing programme at Karolinska Institutet. It was also there that I held my employment as a PhD student. As the handling officer of the review of the 2007 curriculum of the undergraduate programme at Karolinska Institutet back in 2009, I gained prior knowledge specifically of the undergraduate medical programme. In connection to the review I also had the opportunity to sit in and listen and take notes during interviews with some of the educational leaders that I later came to interview for my thesis. Hence, there was a potential danger of the educational leaders to feel as my interview for the thesis was an extension of the review interview back in 2009, even though someone else was interviewing them during the review. I was still there and could be identified as a part of the review team. Therefore I felt it as very important to describe the aim of the interviews for the thesis to the participants and that it was not connected to a review of their performance. It was instead an opportunity for them to reflect on their role as educational leaders. Informed consent also became very important. Hence, the power balance between me and some of the educational leaders that I had met earlier was potentially a bit strained. I was not the average PhD student asking for an interview, but instead someone who at an earlier point in time was connected to a project that among other things reviewed their role as educational leaders. In one of the interviews with an educational leader at the undergraduate medical programme I actually felt that I was being questioned for my choice of using a qualitative method of data collection and analysis which made me a bit uncomfortable and probably affected the interview process. The reason for me being questioned about this specific choice in my research design was probably sprung from the fact that the dominating research domain of biomedical research at Karolinska Institutet is more or less totally aligned with the quantitative research paradigm. Hence, my choice of qualitative research was considered odd to such a degree that it obviously became necessary for the participant to comment on. During the research process of my studies it also became important to me to regularly check that I didn't intentionally look for patterns that I had already observed in the review of the 2007 curriculum, but instead trying to keep an open mind during the different stages of interviewing as well as analysing and interpreting the interview data.

When interviewing educational leaders from the nursing programme I was generally unknown to them and I believe that I, as a PhD student at the bottom of the academic food chain, was perceived as coming from a non-threatening place. I also believe this could be the reason behind the fact that all of the approached educational leaders from the nursing programme decided to participate in the interviews.

A reflection on an overarching level is that my background in social sciences and the fact that I was considered as a newcomer at Karolinska Institutet when I conducted the interviews for my thesis also was to an advantage. In this way I could contribute with an "outsider" perspective which could bring new insights and perspectives to the thesis. In addition I have spent a lot of pondering on the subject of the connection between the identification of research questions, choices of research traditions and the mental preferences/capacities of the researcher. Is the fact that my thesis is a research project that uses qualitative research methods the result of the specific research questions I am interested in looking further into or is in fact my mental preferences for qualitative methods what has decided the type of research questions I am interested in? I realise that this type of discussion may be of a "what came first – the chicken or the egg?" type, but I am convinced that my strong interest in research questions connected to the qualitative research paradigm is a result of my mental preferences/capacities. However, it is as important to prove the level of trustworthiness of my thesis regardless.

# 5 FINDINGS

This thesis explores the perceptions and experiences of educational leaders in health professions education (medicine and nursing) as well as in the meeting between the two professions, through interprofessional education. The thesis also highlights the practices of educational leaders leading educational change and development within their organisation. *Study I* and *II* addresses the experiences of educational leaders aiming to lead educational change and development within an undergraduate medical education programme and how their experiences effect their professional identity formation. *Study III* explores the experiences of educational leaders trying to lead change and educational development within the environment of an academic nursing programme. *Study IV* portrays educational development in the shape of implementation of interprofessional education. This is done by looking into perceptions of interprofessional education in connection to two entities: educational leaders from health professions programmes as well as official policy documentation.

## 5.1 STUDY I

The study aimed at exploring the topic of the experiences of educational leaders leading change within an undergraduate medical programme.

16 educational leaders operating at the mid-level and line level within an undergraduate medical education programme were interviewed on their experiences and perceptions of leading educational change and development. The analysis revealed that the overarching theme of *power* was divided into the following sub-themes:

- Lack of authority
- Use of influence

The overarching theme of *resistance* was connected to the following sub-theme:

- Meeting resistance

### Lack of authority

The sub-theme lack of authority emerged from three underlying concepts: *unclear mission*, *lack of status* and *lack of traditional means of power*. The responsibilities of an educational leader were seen in different ways among the group of leaders. Those who felt that they lacked guidance in their mission were not sure if their tasks were regulated in any policy document or not, or what the expectations of an educational leader actually were. On the other hand, there were also educational leaders who felt clearly that they had the responsibility of harmonising the content of the undergraduate medical programme. The uncertainty and the differing views of the content of the mission contributed to a certain feeling of lack of authority; without clear and transparent guidance on their mission as educational leaders the overall perception was that their authority was weakened among their teacher and supervisor colleagues. The lack of being able to influence organisational structures such as for example departmental independence together with the lack of influence over budget and staff resources, was perceived as contributing to the overall lack of authority. Being a leader within the area of education was also perceived as being of lower status than

for example being in a leadership position within the area of research or clinical work. Together, these different elements contributed to a feeling of lack of authority when trying to lead colleagues towards educational change and development within the undergraduate medical programme.

### Use of influence

The sub-theme of use of influence emerged from three underlying concepts: *freedom to make changes*, *creation of alternative means of power* and *unclear mission*. When trying to get access to or create alternative means of influence in the quest towards educational development and change, different methods were used. Gaining expert status through other areas than education, such as research or clinical work, was one method of influencing colleagues. Other ways described were engaging in diplomacy and co-operation projects or to simply let time pass by as a tactic to gain a favourable outcome in the end. There was a perceived low level of control and lack of supervision from higher levels within the educational organisation, as well as an unclear mission of being an educational leader. However, these factors made it possible for the educational leaders to create tools for overcoming the fact that they felt a lack of authority within their role. The educational leaders made use of the low level of supervision from higher leadership levels, with the intention to create their own varieties of influence.

### Meeting resistance

The sub-theme of meeting resistance emerged from three underlying concepts: *culture*, *identity* and *organisational obstacles*. The educational leaders often perceived to meet resistance to educational change and development from their teacher and supervisor colleagues within the programme. Resistance was identified both in the shape of change fatigue as well as acts of "artificial change"; teacher colleagues who portrayed being engaged in educational change and development but instead attending business as usual. Not identifying yourself as a teacher and the fear of integration erasing your identity as a subject/speciality expert, were two factors connected to identity among teacher and supervisor colleagues. Hence, it was the perception of the educational leaders that these factors contributed to resistance to change and development. Organisational obstacles such as the institution not valuing education enough and the lack of shared mental models about education, was also perceived as contributing to manifestations of resistance towards educational change and development among colleagues.

## 5.2 STUDY II

The study aimed at exploring the topic of medical education leaders and their professional identity formation; specifically to shed light on the identity of undergraduate medical education leaders.

14 educational leaders operating on the mid-level within an undergraduate medical programme were interviewed on their perceptions and experiences of their professional

identity as educational leaders. The analysis revealed empirical patterns in connection to three theoretical aspects of their professional identity as an educational leader:

- Perceived identity
- Identity process
- Power and identity

### Perceived identity

The educational leaders had, to a large degree, a feeling of ambiguity towards their professional identity. This was expressed as the result of experiences of having trouble leading teacher colleagues towards educational change and development. The ambiguity was also the result of conflicting roles between being a researcher or clinician on one hand, and an educator on the other. More than identifying themselves as traditional leaders, the educational leaders viewed themselves as negotiators and diplomats trying to communicate and negotiate between different departments, hospitals and cultures connected to the undergraduate medical programme. Identifying oneself as neutral on the scene of educational change and development was seen as important among some of the educational leaders; this was considered to be the key to successful negotiation and mediation between different groups and stakeholders.

### Identity process

The identity of being an educational leader within an undergraduate medical programme was to a great degree perceived as being unofficial. This was in turn the result of the difficulties of trying to lead colleagues toward educational change and development, based on for example a lack of influence over teachers with expert status as well as over different departments.

### Power and identity

Being an educational leader was perceived as being of lower status than being engaged in research at the institution. Perceived evidence of this was the notion that research in medical education was of lower status than other research areas within the institution and that the institution did not have a clear mission and vision regarding education, which was not the case regarding research. The educational leaders did seldom experience that they received feedback on their work from higher levels of the institution, which in turn lead them to feel that their role was mostly of a symbolic character. However, the status of being an educational leader was confirmed from time to time by other educational leaders as well as colleagues with a special interest in education. Few of the educational leaders had received faculty development connected to the specific task of educational leadership offered by the institution. This also contributed to the feeling of a lack of authorisation from the institution, regarding the identity as an educational leader.

## 5.3 STUDY III

The study aimed at exploring the topic of the experiences of educational leaders leading change within a nursing programme.

Nine educational leaders operating at the mid-level and line level within an academic nursing programme were interviewed on the experiences and perceptions of leading educational change and development. The analysis revealed that the category *power* contained two identified superordinate themes:

- Building relationships
- Leading by structures

The category *resistance* contained three identified superordinate themes:

- Lack of authority
- Organisational structures
- Avoidance of leadership

### Building relationships

The superordinate theme building relationships was comprised of two sub-ordinate themes: *creating consensus* and *sense of community*. Building relationships with colleagues through creating consensus and a sense of community functioned as a tool to lead colleagues towards educational development and change. Educational consensus was considered to be a prerequisite for building relationships and trust with teacher colleagues; without it educational development was not possible to pursue. Dialogue, joint projects, diplomacy, the building of support systems within the programme and shared mental models were types of means used to create a feeling of both consensus and community and to encourage colleagues to move along towards educational development and change. The educational leaders perceived that consensus was one of the most important factors for the success of the nursing programme, and that one of its origins was the possibility to gather round the subject nursing instead of being divided between different specialities.

### Leading by structure

The superordinate theme leading by structure was comprised of two sub-ordinate themes: *safety through structures* and *legitimacy through structures.* The somewhat strict organisational structures within the nursing programme was considered to function as a mean for succeeding with educational change and development. The somewhat rigid structures was perceived as offering support and safety to the educational leaders when trying to put matters of educational change and development on the agenda. The organised structures meant that the educational leaders could gain legitimacy in the eyes of their colleagues.

### Lack of authority

The subordinate theme lack of authority was comprised of two subordinate themes: *lack of resources* and *unclear mission*. The educational leaders experienced manifestations of resistance which at times hindered themselves and their colleagues to engage in educational change and development. The educational leaders did for example perceive to lack a clear mandate and mission for their role, but also support from higher leadership levels at the institution. This in turn made it difficult to gain legitimacy among colleagues.

### Organisational structures

The superordinate theme organisational structures was comprised of two subordinate themes: *rigid structures* and *organisational memory*. The rigid structues for decision-making within the nursing programme that on the one hand has been described as creating legitimacy for matters regarding educational change and development, was also perceived at time as obstacles for change. The time consuming processes for decision-making was perceived as hindering for example more spontaneous suggestions for educational development and change. A joint collective memory of a failure of the nursing programme in the past was also described as an obstacle for development and change among some.

### Avoidance of leadership

The superordinate theme avoidance of leadership was comprised of two subordinate themes: *self-image as a leader* and *the risk of challenging relations*. There was a tendency among some of the educational leaders to view themselves negatively in the role as a leader. This originated both from previous experiences of failing as a leader, having witnessed bad leadership and from the notion that a successful leader should be more authoritarian than they perceived themselves to be. Leadership could also be seen as threatening since it was perceived to be challenging the sense of community and consensus with the colleagues; a prerequisite for educational change and development.

## 5.4 STUDY IV

The study aimed at exploring different meanings attached to interprofessional education (IPE) within two organisational entities at an academic health professions educational organisation: among educational leaders and the institution’s educational policy documents.

Nine educational leaders engaged in projects connected to IPE were interviewed on their perceptions of the definition, rationale and presentation of IPE. The educational leaders were active within the undergraduate medical programme or the nursing programme. A document analysis of five official policy documents on IPE was also conducted with the intention to identify the definition, rationale and presentation of IPE from an official, institutional viewpoint.

### Definition of IPE

While the official policy documents on IPE stated that it was seen as important and prioritised, no formal definition of IPE was stated. The educational leaders from both

programmes also viewed IPE as important, but the strategy for implementation was described as a bit more forceful in the undergraduate medical programme, than the nursing programme. This was perceived as the result of the undergraduate medical programme being less willing to adopt to educational innovation, being more protective of specific subjects and as a more male and hierarchical environment. IPE was seen as an element of educational change and it also was perceived as competing with several other "additional subjects" such as for example sustainability, gender, equality etc. IPE was also identified by some educational leaders as a threat to the professional role of the physician as well as something tending only to the needs of nurses and nursing education.

### Rationale of IPE

Among the five official policy document connected to IPE, only one provided a clear rationale for IPE. The rationale focused on the results of IPE as better health and more effective care and rehabilitation. However, among the educational leaders the rationale for IPE was described in several ways: patient safety, decrease of errors, efficient problem solving across professional boundaries and a tool for avoiding silo mentality between the professions etc. To engage in IPE tasks were often experienced as meaningful and important but some educational leaders within the undergraduate medical programme, IPE tasks were considered not high-fidelity enough or as interrupting clinical work. IPE was often perceived as important on an idea level but it was often quite hard to sort out practical and logistical problems between the educational programmes to get joint IPE projects to work in practice.

### Presentation of IPE

Presentation of IPE was only identified in one out of five official policy documents connected to IPE, and it was found in the shape of three learning outcomes. The three learning outcomes focused on the following aspects connected to IPE: identifying and describing the competencies of other health professions, cooperating with other health professions for better health and care and reflecting on how the cooperation between health professions can contribute to increased patient safety and improved health. Among the educational leaders the presentation of IPE was mostly perceived as present in actual IPE learning environments and activities as well as in learning outcomes. However, some obstacles to the implementation of IPE were also perceived, for example logistical problems such as scheduling privileges for the medical students as well as silo mentality, tribalism and change fatigue within the institution. Other problems were the lack of support of IPE within official documentation, as well as from senior leadership levels at the institution.

# 6 DISCUSSION

The overall aim of this thesis was to explore perceptions and experiences of educational leaders leading educational change and development in health professions and interprofessional education. The two sensitising concepts of the thesis have been power and resistance. The thesis contributes with new knowledge on how leading educational change and development is manifested through power and resistance within an educational health professions organisation. Theoretical power perspectives have contributed to revealing some of the complexities regarding the challenges of leading educational change and development in health professions education and interprofessional education. The four qualitative studies included in the thesis are all designed within a phenomenological framework and contributed with complementary perspectives on educational leadership in health professions education, more specifically within undergraduate medical education (Study I and II), nursing education (study III) and interprofessional education (study IV).

## 6.1 THE IDENTITY OF THE EDUCATIONAL LEADER

Based on the findings of this thesis the identity of an educational leader in health professions education is often perceived as somewhat vague. This experience is shared between the educational leaders within the undergraduate medical programme and the nursing programme and is in alignment with earlier research on educational leadership focusing on ill-defined expectations of the role as an educational leader (Brownfield et al, 2012) as well as the experience of being thrown into a leadership position without any proper preparation (Young et al., 2011) However, the experience of vagueness has been portrayed as two-folded among educational leaders in medical education: an unclear mission has been viewed both as a problematic sign of lack of authority towards colleagues but also as a possibility for creating space to engage in change initiatives of one's own without the supervision of higher leadership levels. Among educational leaders in nursing education the unclear mission has however only been perceived as problematic and contributing to a lack of authority among colleagues when trying to lead educational change and development. The identity of the educational leader in nursing education is also portrayed as a somewhat hesitant one, based on negative intrinsic feelings and personal experiences of leadership. Not viewing one-self as a leader during the process of leading has been reflected earlier in the literature (Stiles et al., 2011) but this thesis also brings light to tendencies of self-negativity towards viewing oneself in a leadership role. This is explained as the result of previous negative experiences of leadership as well as the thought of leadership as authoritarian which does not resonate well with the self-image among educational leaders in nursing education. Ambiguity towards the leadership role is however also seen among educational leaders in medical education but instead as a result of not feeling recognised by higher leadership levels at the university. This is perceived as being manifested both through the fact that education has a lower status than research at the university level, as well as through a perceived lack of feedback on efforts and a lack of purposefully designed programmes for continued professional development (CPD). Hence ambiguity towards the identity as an educational leader seems to stem mostly from external factors in the case of educational leaders in medical education and from internal factors in the case of educational leaders in nursing education.

## 6.2 MANIFESTATIONS OF RESISTANCE

Resistance towards educational change and development has been observed in the literature on educational leadership in health professions education on earlier occasions. Themes such as difficulties in bringing about educational change (Sanfey et al., 2011) and change as a trigger of resistance (McGrath et al., 2016) are examples of this. In this thesis manifestations of resistance were reported in different shapes and from different parts and levels of the educational organisation. The organisational culture was perceived as a source of resistance and can be divided into three elements: organisational structures, organisational memories and organisational attitudes. Organisational structures was mostly highlighted in the nursing programme where the clear structures for dealing with educational matters often created obstacles for change as a result of long waiting times. This in turn became an obstacle for the encouragement of more spontaneous suggestions for educational change and development. Organisational memory was considered to trigger resistance and was identified in the shapes of change fatigue and as memories of historical setbacks for the educational programme Educational leaders from both programmes experienced resistance in the shape of the organisational attitude of conservatism; colleagues who resisted educational change and development per say.

Triggers of resistance were also closely connected to the challenging of consensus. However, consensus had different meanings in the undergraduate medical programme and the nursing programme. Resistance as a result of challenging consensus meant in the nursing programme that resistance rose when the community of nursing teachers felt threatened as a group by change or when consensus among them could no longer be achieved. Educational change and development was often perceived as a threat in this setting. However, challenging consensus had a different connotation within the undergraduate medical programme; when strong professional identities as subject experts or specialists were threatened among teachers by for example projects focusing on integration. Even identifying oneself as a teacher and engaging in or accepting educational change and development was seen as a threat to the identity as a physician and hence a threat of consensus. The mechanisms of disturbing consensus were hence at play among both groups of educational leaders, but challenging consensus held different meanings. Consensus seeking among educational leaders in medical education (McGrath, Roxå and Bolander, 2019) and the fostering of relationships among colleagues in connection to nursing education (Nelson-Brantley and Ford, 2016) has been acknowledged in the literature before, but not the differences between the two versions that seem to be co-existing in health professions education. Manifestations of resistance towards interprofessional education (IPE) as an educational phenomenon of change and development also became obvious in study IV. It was in the shape of a threat to the professional identity of the physician and to the power balance between nurses and physicians that IPE triggered the biggest resistance, also as shown by Barker and colleagues (2005) as well as Reeves and colleagues (21010).

## 6.3 RESISTING RESISTANCE

The thesis show how despite different types of resistance to educational change and development the educational leaders in both the undergraduate medical programme and the

nursing programme found strategies to work around it; to resist the resistance. Educational leaders within the two programmes came up with creative ways of creating their own strategies that were very similar in some aspects and very different in others. Strategies to fight resistance that shared aspects of similarity were the ones mentioned earlier which connected to engaging in co-operation and diplomacy as well as involving stakeholders. This emphasis on consensus within the professional community and relationship building were found among educational leaders within both programmes (McGrath el al., 2019; Nelson-Brantley and Ford, 2016) even though it was expressed more explicitly within the nursing programme. Interesting enough, educational leaders within the undergraduate medical programme in addition created yet another tactic which differed from the thoughts focusing on consensus and of creating community. Since educational leadership encountered resistance and knowledge on educational matters was not perceived to be appreciated on neither a university level nor among colleagues who were resisting engaging in educational change and development, something had to be done. The solution was the creation of a vicarious legitimacy; a use of power symbols which were not connected to the realm of education but instead to the arenas of research and clinical work. By portraying oneself as an expert within the fields of either research or clinical work, the educational leaders could gain access to legitimacy in the world of education. In the same way as women in educational leadership positions had been forced to using power symbol as overcoming the obstacles of a male environment (Pingleton et al., 2016), educational leaders were forced to use power symbols disconnected from education but instead connected to the two worlds that really mattered among colleagues within the undergraduate medical programme: research and clinical work.

The differences and similarities between educational leaders' experiences of leading change and development in health professions education and interprofessional education are important to identify. This thesis has done so by applying theoretical power perspectives to the findings of study I-IV. By exploring differences and similarities in the results between educational leaders from two different health professions programmes it becomes evident that faculty development programmes for educational leaders in health professions education must be research-based and must take into account that it is possible to engage in educational leadership in different manners. Different educational programmes share some of the cultural aspects connected to them but they also differ between programmes. It has also become evident through study IV that an educational phenomenon that is implemented with the intention to contribute to educational change and development through the bridging of professional borders (interprofessional education), instead may be perceived as a threat to a specific profession or the power balance between professions. The antidote towards these types of mechanisms of resistance is shared mental pictures across programme and professional borders of what the advantages of educational development and change are. The perfect arena for sharing is through research-based faculty development programmes for educational leaders from all types of health professions programmes (Lieff and Albert, 2012).

Together we have the potential to change and develop health professions education into the future.

## 6.4 METHODOLOGICAL CONSIDERATIONS

To review the quality of qualitative research, positivist quality terms such as validity, reliability and objectivity have been replaced with terms such as credibility, transferability and dependability. These quality aspects of qualitative research may jointly be referred to as the trustworthiness of the research (Denzin and Lincoln, 2005). Another way of making sure that qualitative research live up to the proper quality criteria is to touch upon a number of areas connected to different quality domains while focusing on making the strategies for achieving trustworthiness of the research transparent: sampling in connection to the research question, data collection, data analysis, transferability, ethical issues including reflexivity and overall clarity (Kuper, Lingard and Levinson, 2008).

### Credibility

Credibility refers to the focus of the research and the confidence in how well data and processes of analysis are aligned with the intended focus (Graneheim and Lundman, 2004). Regarding the sampling of the participants for the interviews for study I-IV, a purposeful sampling approach was used. All the identified educational leaders within the undergraduate medical programme and the nursing programme were initially identified through the programme websites and thereafter asked to participate in the interviews through an email invitation. The choice was made to include educational leaders operating on a mid-level and line level in the sample, but to exclude educational leaders on a top level. The reasoning behind this decision was that only the educational leaders at the mid-level and line level had a connection to the overarching research question of the thesis. Hence, the choice of sample was aligned with the concept of credibility; the purposeful sample reflected truthfulness. However, since a sample should be broad enough to include different aspects of a phenomenon (Kuper et al, 2008) it could have been an alternative to also include educational leaders at the top level and hence used a maximum variation sample instead. The maximum variation sampling should focus on sampling as many perspectives as possible to capture a wide range of experiences (Kuper et al., 2008).

Regarding the data collection through interviews, the method of interviewing holds its strengths but also harbours certain weaknesses. When interviewing people, they are of course presenting their perceptions and lived experiences – this is one of the strengths of the method which points towards credibility. At the same time, the same characteristics could be considered a weakness. Though interviews is indeed an empirical material, it cannot be defined as a "natural occurring" material. This implies that the interviews are not the actual material being researched – it is instead what has been said in the interview that is being researched, the accounts. Hence, the object of research is not studied directly, which could be considered a weakness (Peräkylä,& Ruusuvuori, 2011) Factors such as the information being filtered through the memory of the interviewee as well as being influenced by the social context of the interview are factors that also could work to the disadvantage of the method

(Reeves et al, 2006). However, the interviews were conducted in an organised and systemised manner through the usage of interview guides created on the basis of the two sensitising concepts of the thesis, power and resistance, which in turn inspirits credibility.

Both the data analysis as well as the data interpretation conducted in the thesis was conducted by following structured models of analysis and by application of theoretical perspectives. This made it easier for the researchers in the team to follow along and participate in different steps of the processes of analysis and interpretation. By using researcher triangulation the credibility of the data analysis was enhanced (Thurmond, 2001). Credibility is also connected to the way that transparency is obtained regarding similarities within and differences between themes and categories during the analysis. This was obtained by exemplifying the findings through representative quotes from the transcribed interviews in study I-IV (Graneheim and Lundman, 2004).

### Transferability

Transferability in the context of qualitative research is not the equivalent of generalisability in the realm of quantitative research. Transferability instead implies that the results of a qualitative study may be transferable to other contexts and that readers can assess the applicability to their settings and contexts (Kuper, Reeves and Levinson, 2008). One way of achieving this is by the application of a theoretical framework to the findings which will enhance the chances of transferability of the results (Ringsted, Hodges and Scherpier, 2011). The application of theoretical frameworks was conducted in study I-IV included in the thesis. Another aspect that enhances the possibilities of transferability is the clear description and transparency of all the steps of the research process together with a clear description of the culture and context of the study. In combination with a rich presentation of the findings joined by appropriate quotes, this will encourage transferability (Graneheim and Lundman, 2004). It has been the bench mark of this thesis to achieve this in study I-IV by describing the contexts, the different steps of the research process and by sharing a thick description of the findings.

### Dependability

Dependability refers to if data is stable over time and if the researcher's decisions changes during the analysis (Graneheim and Lundman, 2004). Data collection through interviews was conducted during a limited period of time (December 2011 – April 2012) and the researchers of the team could jointly follow and/or engage in the different steps of the process of the analysis and interpretation, which are prerequisite for achieved dependability. The data was collected by one person (me) and the research team has strived to keep the steps of the research process transparent within the team as well as describing them in a transparent and clear manner in study I-IV.

# 7 CONCLUSIONS AND IMPLICATIONS

My contribution to the medical education research field through this thesis is found both within the empirical frame and the theoretical frame. Within the empirical frame I have shown the parallels and differences between the prerequisites and results of leading educational change and development within an undergraduate medical programme and a nursing programme. I have also shown what happens when educational leaders from both programmes lead educational change in the shape of interprofessional education. The parallels and differences between educational leadership within undergraduate medical education, nursing education and interprofessional education must be acknowledged when designing and implementing research-based faculty development programmes for educational leaders in health professions education. How can we visualise the differences and similarities and how can educational leaders as well as high level institutional leadership learn jointly from these experiences? The visualisation of these experiences may contribute to the strengthening of educational leaders in their roles as well as approve the quality of health professions education. Within the theoretical frame, this thesis has contributed to a refinement of power-based theories/models (for example through the introduction of the concept of “vicarious legitimacy”) in the light of the empirical phenomenon of educational leadership in health professions education.

## 7.1 FUTURE RESEARCH

A suggestion for future research derived from this thesis is research on educational leadership in connection to additional educational programmes within health professions. Data collection from multiple institutions would also be of interest as well as the use of other sources for data collection than interviews and policy documents. Examples of such sources could for example be observations.

# 8 POPULÄRVETENSKAPLIG SAMMANFATTNING PÅ SVENSKA

Avhandlingen i din hand heter *Ledarskap i hälso- och sjukvårdsutbildningar*. Den fokuserar på hur en särskild grupp av lärare på ett läkarprogram eller ett sjuksköterskeprogram på ett universitet har fått i uppdrag att jobba med att implementera olika delar av en utbildningsplan och/eller av kursplaner. Ibland möts även lärarna över programgränserna i projekt som är kopplade till det som kallas interprofessionell utbildning – utbildning där två eller flera yrkesgrupper lär av varandra. Dessa lärare kallas i avhandlingen för utbildningsledare. Utbildningsledarna kan verka på toppnivå som exempelvis rektor, på mellannivå som exempelvis dekanus eller programansvarig eller på linjenivå som exempelvis kursledare.

Syftet med avhandlingen har varit att utforska utbildningsledarnas uppfattningar och upplevelser av förändring och utveckling av utbildningsfrågor inom hälso- och sjukvårdutbildningsområdet. Detta har gjorts med hjälp av olika maktperspektiv som har applicerats på resultaten och på så sätt har hjälpt till med att vaska fram intressanta kopplingar mellan utbildningsledarnas upplevelser och olika typer av makt och motstånd som de stöter på i sin vardag.

*Studie I* utforskade upplevelserna hos utbildningsledare av att leda förändring och utveckling i ett läkarprogram. Utbildningsledarna upplevde att man saknade status och inflytande bland sina kollegor. Detta var resultatet av att man hade ett uppdrag som var oklart, att utbildning hade låg status på det universitet där man jobbade och att man saknade traditionella maktmedel som pengar och resurser. Utbildningsledarna upplevde också att man stötte på motstånd när man försökte leda sina kollegor mot förändring och utveckling. Motståndet upplevdes i form av förändringströtthet, organisatoriska hinder och konservativa attityder i utbildningsfrågor. Utbildningsledarnas möjlighet att försöka få sina kollegor att delta i förändring och utveckling av utbildningen byggde på att de hade mycket frihet i sin roll och att de fick visa för sina kollegor att de var duktiga på forskning eller kliniskt arbete, istället för på utbildning. Utbildning hade nämligen inte lika hög status som forskning och kliniskt arbete.

*Studie II* utforskade utbildningsledares upplevelser av hur de formade sin identitet som utbildningsledare i ett läkarprogram. Utbildningsledarna kände sig dubbla gentemot sin identitet som utbildningsledare. Så var fallet eftersom de hade en oklar roll och tyckte det var svårt leda sina kollegor mot förändring och utveckling i utbildningsfrågor. Utbildningsledarna upplevde inte återkoppling eller stöd från högre ledarskapsnivåer på universitetet så ofta, vilket i sin tur ledde till att de tyckte att deras roll mest var symbolisk. Deras identitet som utbildningsledare bekräftades ibland av kollegor i samma roll eller av kollegor som var särskilt intresserade av utbildningsfrågor.

*Studie III* utforskade utbildningsledare upplevelser av att leda sina kollegor mot förändring och utveckling i utbildningsfrågor kopplade till ett sjuksköterskeprogram. Utbildningsledarna upplevde att sätt att leda kollegor mot utveckling och förändring av utbildningsfrågor var att

skapa relationer med kollegor samt att använda de tydliga vägar för beslutsfattande som fanns inom programmet. Motstånd mot förändring och utveckling av utbildningen tycktes komma från att man saknade inflytande, från strukturer och gemensamma minnens som fanns i organisationen och från ett eget motstånd mot ledarskap.

*Studie IV* utforskade interprofessionell utbildning (IPE) som ett exempel på förändring och utveckling inom hälso- och sjukvårdsutbildningar på ett universitet. En jämförelse mellan hur man beskriver och uppfattar IPE bland utbildningsledare och i officiella policydokument visade på hur skillnader mellan dessa kan skapa problem i när man försöker jobba med IPE-projekt tillsammans. För att kunna få IPE att fungera så krävs det bland annat en samsyn på vad IPE är och stöd från högre nivåer på ett universitet, som till exempel från rektor.

Sammantaget visar den här avhandlingen på att utbildningsledares upplevelser av hur det är att försöka förändra och utveckla hälso- och sjukvårdutbildningar är viktiga och att det är viktigt att kunna prata om dem när man går på kurs för att bli en bättre utbildningsledare. Särskilt viktigt är det att prata om dessa upplevelser kopplat till ämnena makt och motstånd eftersom väldigt få har gjort det tidigare och det kan leda till att man förstår sitt jobb bättre och i sin tur kan utföra sitt uppdrag bättre.

# 9 ACKNOWLEDGEMENTS

First of all, I would like to thank the educational leaders who participated in the studies and shared all your valuable experiences with me. Thank you!

**Jonas Nordquist**, my principal supervisor. Thank you for believing in me and for giving me the opportunity to embark on my PhD journey. Without you this wouldn't have been possible. Thank you also for introducing me to the world of health professions education and sending me out into the world to learn new things, meet new people and make friends for life. Your capacity to analyse the political aspects of every situation as well as your high standards when taking care of guests and arranging events, is unprecedented. Watching you shine when you teach and lecture has even inspired an introvert like me to stand in front of an audience and lecture and present. Your knowledge and example has been of such great value to me both during my PhD journey and in my working life. Thanks to you I have truly grown as a person, both professionally and personally. I am forever grateful.

**Scott Reeves**, my co-supervisor. Even though you are no longer with us, I would like to expresses my sincere gratitude towards you. No-one has taught me more about research, the research process and academic writing than you. Always encouraging, always taking time from your busy schedule and always challenging me to learn new things; thank you from the bottom of my heart. I am confident that you are watching over us all while smiling that friendly smile of yours. We miss you.

**Simon Kitto**, my co-supervisor. Thank you for offering to step in when Scott left us so suddenly and unexpected. I couldn't think of a better and more worthy replacer. Thank you for your support!

**Anna Josephson**, my co-supervisor for the first part of my PhD journey. Thank you for your support and encouragement and for teaching me how to let loose and think more "hip hop" during the analysis process.

**Ed Peile**, my mentor. Thank you for all your wisdom and support since we first met back in 2009, and thank you also to **Linda Peile** for your kindness and hospitality.

**Lars Kihlström Burenstam Linder**, Residency Director at Karolinska University Hospital. Thank you for believing in me and taking me under your wings at the Residency Training Office. Your support has been a prerequisite for the success of this PhD project.

**Jan Bolinder**, Head of the Department of Medicine, Huddinge. Thank you for supporting me as the first doctoral student at the Medical Case Centre.

**Sari Ponzer**, former Dean of Education, Karolinska Institutet. Thank you for trusting me with the task to coordinate the review of the 2007 curriculum of the undergraduate medical programme at Karolinska Institutet, as the handling officer of the project. The experience marked the start of my introduction to the world of health professions education as well as my PhD project, a few years later.

Thank you to my colleagues over the years at the Medical Case Centre: **Linda Johansson**, **Hanna Wijk** and **Teresa Sörö**. Thank you for your support and for creating, discussing, analysing, travelling and laughing together with me. You are all true bad-ass ladies! Also, a big thank you to **Eva Johansson** for making me feel right at home at the Residency Training Office at the Karolinska University Hospital.

Thank you to all my PhD colleagues at Karolinska Institutet during the years. A special thank you to **Matilda Liljedahl**, **Linda Barman**, **Hanna Lachmann**, **Katri Manninen**, **Carina Georg** and **Susanne Kalén** for sharing different parts of this PhD journey together with me. A very special thank you to the fantabulous **Per Palmgren** for reading and providing me feedback on my kappa and for chairing my public defence seminar. Thank you also to **Charlotte Silén** for teaching me so much about methodology and research methods during your excellent PhD courses.

Thank you to all my colleagues at Stockholm Business School for rooting for me during this PhD journey, especially to **Nina Wennberg**. A special thank you for supporting me to the Head of School, **Maria Frostling**, and the former Heads of School, **Thomas Hartman** and **Tommy Jensen**.

Thank you to all my beloved friends for your love and support during this process. Thank you especially to **Anna** and **Åsa** for being there for me through thick and thin for all these years. Also, a special thank you to Anna's parents **Maj-lis** and **Jörgen** for inspiring me to choose the artwork for the cover page of this thesis. Thank you to my dear Jubilee Ladies for your true friendship even though we all live far apart from each other: **Linda, Ann Kristin**, **Anna S**, **Anna A** and **Sofia**. And to my beloved Uppsala team - **Marie**, **Linda, Sigrid** and **Jenny** – you mean the world to me. I couldn't have finished this project without your support and friendship.

To my family for continuous love, encouragement and support – thank you! Thank you to my father, **Gustaf- Adolf**, who has waited patiently a very long time for me to finish this project: Dad, I finally made it! And to my late mother **Birgitta**: thank you for always believing in me. I miss you Mum, and I wish you were here. Thank you also to my sister **Ulrika** and her family, **Magnus**, **Victoria** and **Sofia,** as well as to my sister **Helena** and her family, **Hanna** and **Jos**. Love you lots! And to **Thomas**: lots of kisses and thank you for taking such good care of me during the final stage of this process with equal parts love, support, pampering and encouragement. Ända in i kaklet, baby!

And last but not least: thank you to my children **Linnea** and **Malcolm**. All the love, laughs, and goofiness we share mean everything to me. I love you to the moon and back!

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