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Visions of Leadership

Becoming a leader is serious stuff. Yet what is leadership? Let’s start by suggesting that leadership begins with leading self. A narrative is helpful to set the scene. Rebecca is a health visitor working with a young mother.

She writes: I first meet Tanya when her baby is eleven days old. Discharged from the care of the community midwife on day ten, this is her first health visitor contact. For many women at this stage, this must seem like yet another new health professional to get to know and trust. Before I had had a chance to ring the bell, the front door is opened quickly by a woman who introduced herself as Tanya’s mother. I am ushered into the sitting room with a sense of urgency and then left alone with Tanya. She sits on the sofa surrounded by the paraphernalia of parenthood – muslins, creams, nappies, bottles, pads and wipes. It seems the whole room is taken up by the trappings of a tiny baby. Tanya looks lost and panic stricken in the midst of it all as if she’s been cast adrift on an ocean. I sit beside her and simply ask her to tell me how she’s feeling. Her story tumbles out, and for the next part of that grey, damp afternoon, I listen to an unfolding story of false hopes and broken dreams, expectations that now lie shattered and dissolved in a sea of tears. The planned minimal-intervention water birth that became an emergency caesarean section. The anticipated natural, intense pleasures of breastfeeds that became painful, frustrating and anxious hours, fuelled by the fear of her infant’s poor weight gain. As the rain falls relentlessly against the shiny patio doors, I abandon all planned paperwork and simply listen to the sad tale of a woman who has always had her life so well planned, so controlled, yet now feels so helpless, so lost. I give her very little advice, mindful that once I would have focused on putting things right, on a successful outcome. I am aware of documentation policy and need for standards

(Continued)
but overridden by the needs of Tanya. I have no fear of sanction as I might have had previously.

I am content to allow Tanya to explore her feelings with me, recognising her need to go through this process, even if there can be no happy ending. I suggest that writing down her thoughts and feelings might help her to make some sense of them. She seems surprised at being ‘allowed’ to set agenda; she expected to be ‘told’ what to do. On the way back to the surgery, I smile as I am struck by the parallels of my suggestion to Tanya and my own experience of journaling as a way of exploring contradictions between the desirable and what is actual lived experience. I am conscious of being much more available to Tanya than I have been on similar visits in the past. Why is that? Using the ‘influences grid’ (Johns 2013) helps me to clarify what factors influenced my actions with Tanya. Using the grid creates a space to review myself and reinforce my values. Now, on reflection, I can see that I was mindfully engaged with Tanya, available within the moment, not distant. Using the word ‘engaged’ is profound. I remember reading work by Davies (1995), who had used the same terminology. I look up her work again and see how well it fits with my own practice vision. She argues that nursing is devalued by being seen as feminine (and medicine given dominance by its masculinity); although society values nurses, it devalues the caring act of nursing. Can that still be true? I suspect it is. She suggests a gender-free definition of nursing, with characteristics that are a fusion of both masculine and feminine qualities in a non-gendered profession:

- Neither distant nor involved but engaged
- Neither autonomous nor passive/dependent but interdependent
- Neither self-orientated nor self-effacing but accepting of an embodied use of self as part of the therapeutic encounter
- Neither instrumental nor passive but a creator of an active community in which solutions can be negotiated
- Neither master/possessor of knowledge nor the user of experience but a reflective user of experience and expertise

Davies helps me visualise my role as a leader. It offers substance in that I know better what it is I am trying to do leading myself within my practice.

So how does this brief narrative reflect my leadership? Most significantly, it is about relationship. I shift from being authoritative to (Continued)
facilitative.\textsuperscript{2} I resonate with the idea of creating an ‘active community’ with Tanya and with my other mothers and with my colleagues. Neither did I become so involved with Tanya that the issue became mine, nor so distant that I seemed uncaring, but balanced these two extremes with an active engagement. Pinar (1981: 178) cautions that empathy ‘conceals as it reveals’, potentially creating a political eunuch if over-involvement results in complicity with another’s delusions. Understanding my actions from this deeper, more critical level, embracing organisational and cultural perspectives alongside the aesthetic, helps me deconstruct the experience and recognise ways to sustain it. I could not help but draw comparisons between my responses here, with Cassie in the ‘Troubled Minds’ narrative I wrote some months earlier. When I was not able to ‘fix’ Cassie, control her feelings, I could see no role for myself and quickly withdrew. Here, with Tanya, I was able to stay in the moment, available to Tanya without my own agenda, consciously aware of us together, managing the unfolding moment and supporting her in her crisis. This is true presence – bringing humanness to the moment while simultaneously giving self to the other who is exploring the meaning of the situation (Liehr 1989).

Becoming a leader has been more of an unconscious act – others have seen and noted changes, but I have not been so aware of them myself. It is like a child growing – others see her grow, but the child does not notice. The changes occur daily, imperceptibly tiny, barely there, yet cumulative. Being with Tanya I actually felt myself grow, was actively mindful of the process and could feel the transformation. The reflexive spiral is sometimes a gradual unfolding experience and sometimes a dramatic moment of revelation (Johns 2013) – this was my dramatic moment.

Vision

Rebecca’s story gives insight into her leadership journey at a particular moment. Mindful of her leadership vision she seeks to live it as a reality. This tension between her vision and her reality is the focus of reflection. Theory opens a dialogical space for Rebecca to reflect on in the context of her experience and informs her practice. Through reflection she can assimilate theory into practice.\textsuperscript{3} In this sense, theory adds substance to any leadership vision quest.
Vision gives purpose and motivation to action. Whilst every leader should be very clear about their personal vision, such a vision should not be prescribed or imposed. Working in organisations, the idea that a leadership vision should be truly your own might be problematic if no one else agrees with it. Multiple visions at variance with each other by different team members might see everyone pulling in different directions. Imagine being led under such circumstance. I suspect many readers will know this scenario and its morale-deflating consequence.

In constructing a vision of leadership, leaders like Rebecca are cognizant of ideas about leadership. One approach is simply to adopt one idea, for example Bass’s ideas of transformational leadership. This approach is compelling because such ideas are comprehensive and authoritative. A more constructive approach is to construct an eclectic vision developed from different sources. This approach requires more thinking and perhaps lacks authority. Yet always the leader must ask, ‘What do these theory words mean as something lived?’ Only then can the leader move through ideas into a vision of leadership that is truly her own. And even then, the vision is a moveable feast because it is always shifting in light of reflection on its nature. Reviewing the contemporary health care literature on leadership, the idea of transformational leadership is widely viewed as desirable for health care in stark contrast with the prevailing transactional-type leadership characteristic of health care organisations (Bass 1990, Sofarelli and Brown 1998). Sofarelli and Brown (1998) consider that transformational leadership is the model that will assist nursing to develop into an empowered profession with the potential to be a dominant voice in reshaping the health care system of the future.

However, other ideas of leadership need consideration, notably servant leadership. Servant leadership offers a radically different perspective whereby the leader is servant-first in contrast with leader-first. The role of leadership is to literally service those who deliver the service. Imagine how that type of leadership would shift the nature of relationships within the organisation. Playing with ideas is creative, itself a quality of leadership.

Wheatley writes (1999: 130):

Behaviours don’t change by announcing new values. We move only gradually into being able to act congruently with those values. To do this we have to develop much greater awareness of how we’re acting; we have to become far more self-reflective than normal … little by little, tested by events and crises, we learn how to enact these new values. We develop different patterns of behaviour. We slowly become who we said we wanted to be.

‘Far more self-reflective than normal’ leads into being mindful.
Mindfulness

Kabat-Zin (1994: 76) writes:

*You will need a vision that is truly your own – one that is deep and tenacious and that lies close to the core of who you believe yourself to be, what you value in your life, and where you see yourself going. Only the strength of such a dynamic vision and the motivation from which it springs can possibly keep you on this path year in and year out, with a willingness to practice every day and to bring mindfulness to bear on whatever is happening, to open to whatever is perceived, and to let it point to where the holding is and where the letting go and the growing need to happen.*

Kabat-Zin’s emphasis on mindfulness is key. Goldstein (2002: 32) describes mindfulness as ‘the quality of paying full attention to the moment, opening to the truth of change’. It is the ability to see ourselves clearly without distortion, without judgement. Most of the time our heads are full of ‘stuff’. Our minds are everywhere, we get distracted. We don’t see things clearly. Leaders learn to empty their minds. As Susuki (1999: 21) writes, ‘If your mind is empty, it is always ready for anything; it is open to everything. In the beginner’s mind there are many possibilities; in the expert’s mind there are few.’

Mindfulness involves the capacity to hold the creative tension between a vision of leadership and realising the vision as a lived reality. It is one thing to have an idea of something and quite another to know it as something truly lived. Being mindful is a reflexive self-awareness, a constant and natural self-inquiry and action towards realising one’s leadership values (or vision) as a lived reality. The mindful leader is aware of her assumptions and the way these assumptions influence her perceptions. It is like looking at self in a mirror, warts and all! People undoubtedly smudge the mirror to distort their reflected images to fit in with an ideal self. To see self clearly the mindful leader continuously cleans the mirror even though the images may be uncomfortable. The illusions we hold about ourselves are torn away to reveal the naked self. We wear masks for reasons of sustaining our self-identity. If our masks are pulled away how do we protect our vulnerability? This is the work of reflection, the art of paying attention to self in order to see one’s reality and shift this as necessary to become a true leader. However, accessing, critiquing and shifting one’s assumptions are not easy because they are socially constructed and experienced as normal through patterns of relationships. If I were to shift my assumptions it would impact on others, creating disturbance in the normal flow of everyday practice.

Every experience is unique, a mystery unfolding. It has not been experienced before although the leader may recognise similar experiences.
Once we think we know we only see what we know. The mind closes to possibility.

Whilst being mindful is the quality of paying attention to what is unfolding NOW, it is, however, attached to a sense of both the future and the past. With regard to the future, leadership is purposeful; the leader constantly holds the intent to realise her vision of leadership. With regard to the past, I find the Buddhist word apramada helpful. It means the guardian at the gate of the senses ever alert to threat. Sangharakshita (1988: 148) writes, ‘all the time, inattention and errors are trying to get hold of us, but our mind, keeping alert all the time, is trying to drive them away’. So whilst the mind is purposeful it is also clearing away obstacles to achieving that purpose. Greenleaf (2002: 41) alludes to mindfulness as a quality of leadership – ‘The cultivation of awareness gives one the basis for detachment, the ability to stand aside and see oneself in perspective in the context of one’s own experience, amid the ever present dangers, threats and alarms.’ It is through reflection that the leader becomes increasingly aware of self within her practice, more aware of the way she thinks, feels and responds, more aware of her purpose and more aware of those forces that constrain her achievement. In this way, mindfulness is nurtured.

Transforming and transformational leadership

The founding father of transformational leadership is James McGregor Burns. He coined the idea of a transforming leadership necessary for a just and increasingly complex global society, moving the idea of leadership away from previous theories of leadership based on trait, behaviour or tasks (Northouse 2001) and situational theory (Hersey and Blanchard 1982).

Burns (1978: 20) writes, ‘Transforming leadership occurs when one person engages with others in such a way that the leader and follower raise one another to higher levels of motivation and morality.’ This brief description is inspirational in its clarity and brevity. It opens a path to sensing leadership as something lived as relational, moral and mutually empowering. Every action the leader takes is purposeful towards creating a better world.

Emerging from the foundational work of Burns, Bass (1985) developed transformational leadership that was related more to organisational leadership than to Burns’ wider social agenda. Bass set out four interrelated essential aspects of transformational leadership that offer a dynamic framework to appreciate its fundamental nature:

- Idealised influence – that leadership is based on genuine trust built on a moral foundation.
• Inspirational motivation – that leadership provides meaning and challenge for engaging others in working collaboratively towards shared goals and success.

• Intellectual stimulation – that leadership liberates the creative and responsive spirit in followers to fulfil their individual and collective aspirations towards overcoming problems in realising a shared vision.

• Individual consideration – that leadership invests in each person towards enabling the person to fulfil their potential and needs leading to higher achievement and growth.


This positions leadership as essentially an ontological concern, in contrast with an epistemological concern with ideas and tasks. The rhetoric of empowerment and dominant voice sounds like a holy grail. However, the emphasis on empowerment is pertinent because the ability of nurses, midwives and health visitors to realise leadership may be constrained by a legacy of subordination. A vexing challenge! There have been many interpretations of transformational leadership. In her narrative, Martha utilises Schuster’s approach (see Chapter 2).

Bass contrasted transformational leadership with a transactional type of leadership based on contingent reward in exchange for good performance. Performance is managed in one of three essential ways:

• By exception (active) – Watches and searches for deviations from rules and standards and takes corrective action.

• By exception (passive) – Intervenes only if standards are not met.

• Laissez-faire – Abdicates responsibilities and avoids making decisions.

The transactional nature lies in the exchange – reward in exchange for effort. The supervisory nature of active management by exception reflects the command and control behaviour where the focus is on outcome rather than process. The passive mode reflects a managerial indifference unless outcomes are blatantly not being met, usually noted at times of audit or complaint. It leads to a mediocrity of performance. Both active and passive forms of management are not conducive to good relationships. Such management patterns are essentially mindless and lived on
autopilot, operating on assumptions that have not been challenged for a long time (Gilley 1997).

The transformational and transactional are essentially different ways of being in the world. They are not different hats to wear at different times. Otherwise transformational leadership would be instrumental and inauthentic. Transactional leadership is not a fall-back position for when transformational leadership falters. I must be clear. In my view there is no such thing as transactional leadership. Perhaps ‘commander’ or ‘controller’ would be a more suitable word than ‘leader’ in the transactional world. Command and control are the antithesis of leadership, concerned as it is with producing specific outcomes in contrast with leadership’s quest to enable growth through human relationships.

The transactional pyramid

The transactional organisation is symbolised as a pyramid layered through a rigid set of hierarchical- and bureaucratic-bound levels (Figure 1.1). The pyramid symbolises a top-down approach structured through managerial roles governed by rules of engagement, status and positional power. At its apex, the transactional organisation has a mission statement written as a set of strategic objectives set largely by political demand and wrapped in ideological rhetoric. The vision is interpreted as targets or outcomes. The organisation is either rewarded or punished by its success in meeting these strategic objectives at all costs. Because of this demand, the whole

![Figure 1.1 The transactional pyramid](image-url)
The pyramid is infused with high anxiety transmitted downward through its hierarchical levels. When people are anxious they must try to control their environment in an effort to manage anxiety resulting in command and control behaviour. It demands team players yet sets the rules for team play that constantly change in response to organisational anxiety, often without consultation with those affected by such rules. As often heard, 'the goal posts are always changing'. Little emphasis is given to how these targets or outcomes will be met in terms of process. Inevitably, a strong emphasis on outcomes reduces people to 'resources' to meet targets. It is a dehumanising system that evokes low morale, distrust and compliance to avoid sanction. The whole pyramid functions on elaborate systems that demand adherence. When things go wrong it is blamed on human error rather than the system. The system can be viewed as a complex machine—a Newtonian mechanistic perspective of the world with an emphasis on its own smooth running (Freidson 1970). The transactional organisation does not like assertive people because they may disturb the status quo, sending ripples across its smooth running. Power within transactional organisations such as the NHS has a typical authoritative pattern to ensure a docile and competent workforce (Foucault 1979)—‘docile to the extent that its subordinates do not disrupt its smooth running (Johns 2009: 131)’. Perhaps most of all, its managers believe they are effective leaders. Yet when organisational managers are observed, the delusion of leadership is easily revealed, especially around taking risks and giving away power. Delusion is an immense boulder to shift. It is like asking a nurse if she is caring. To say ‘no’ would be shocking. Locked into its tightly bound systems the transactional organisation cannot let go and unfold into a transformational culture simply because it would destroy itself. This is all about survival. Crippled by its anxiety, the transactional organisation disempowers its staff through its patterns of relationship. People are pawns in a game to be moved around the board at the mercy of the chess master in his or her omnipotence. It projects its anxiety into people, criticising and blaming unreasonably behind an internalised sense of threat that serves to keep people in their place. It is a culture of fear and oppression. It does not realise its impact on others, or if it does, it doesn’t see it as a problem.

Leadership is not management

Let’s get one thing clear—leadership is not management. Management is essentially doing certain sorts of tasks whereas leadership is being a certain sort of person. The shift from doing to being lifts leadership into the human encounter. It is not about what I do, as I am is some sort of object, but who I am in relationship with others. For this reason, leadership does not lend
itself to a reduction into competencies although the quest to know leadership often results in such outcome.

In a world where leadership does not exist it is easy to imagine that management is leadership. Then when you see another view, the realisation drops like a lead weight. Management is getting the job done to an agreed quality in line with targets and resources, including ensuring and managing the necessary resources. It is a business arrangement, a transaction between the organisation and its workers. I wonder, must leaders who are managers necessarily wear two hats? I think not. It does not require different personas. Yet, in positioning themselves within their organisations, the leaders must appreciate the tension between any idealised notion of leadership and the reality of their managerial role.

Luke is a senior nurse working in an accident and emergency department.

He writes: I realise that my initial impression of what constituted leadership was not leadership at all, but rather management. I viewed leadership as someone in a position of power with strong opinions who demanded respect. Examination of the literature on leadership revealed a more appealing, inspirational view of leadership. It is hoped by differentiating leadership from management, the basis for understanding true leadership begins – ‘managers are people who often work in hierarchical organisations and are in positions which have legitimate sources of power with the authority to delegate. The emphasis of their work lies in control, decision making, decision analysis and results’ (Marquis and Huston 1996). Within a hierarchical organisation like the NHS, the manager described above is instantly recognisable where the emphasis is on authority, power, control and decision making.

The transformational organisation

In contrast to the pyramidal transactional organisation, a transformational organisation is represented as a round table where colleagues come together to co-create meaningful work based on a shared vision towards shared success (Figure 1.2).

Each person around the table, no matter their role, is viewed as an equal, respected and valued for their particular role within the whole. Although there is a designated leader, the leader is intent on each person who sits at the table becoming a leader in their own right, whereby each person assumes responsibility for his or her own performance towards realising the shared
vision and for ensuring the whole group works collaboratively. It might be expected that an emphasis on responsibility could create increased anxiety. This is mitigated by the impact of team support to create a low-anxiety learning environment that views conflict or difference in views as a learning opportunity in contrast with the transactional blame-and-shame culture. It is the idea of every person taking responsibility that is profoundly difficult when emerging from a transactional climate of subordination. Taking responsibility for self and the group is demanding. It is standing up and being counted. It is a demand for commitment to working collaboratively with others.

Becoming a leader is not a rational process of shifting one’s mindset from a transactional to a transformational perspective. This shift is a culture shock because health care organisations must inevitably resist a transformational-type leadership because it does not fit smoothly within its transactional culture. This creates a tension between a vision of leadership and realising the vision as a lived reality. Understanding and resolving this creative tension is the learning focus for becoming a leader. No easy task for an individual leader given the weight of the organisation. As such, realising leadership is not so much an individual thing, but something that needs to be nurtured within an organisational culture that values and lives leadership as a way of organisational relationship. From this perspective, leadership must be consistently role modelled, establishing a leadership culture that nurtures others to become leaders. As Covey warns (2002: 2), ‘We’ve got to produce more for less and with greater speed than we’ve ever done before. The only way to do that is through the empowerment of people.’

Figure 1.2 The transformational leadership round table
Servant leadership

Discovering servant leadership has profoundly influenced my vision of leadership, moving me beyond transformational leadership into a more practical model of leadership based on the twin ideas of community and service.

In one exercise I ask the leaders to brainstorm the attributes of leadership. Many words are generated:

- inspiring, motivating, charismatic
- mindful, listens well, just, fair, challenging
- authentic, real, vulnerable
- mutual respect, collaborative
- confident yet not arrogant
- available, approachable
- intentional, trusting, responsible
- invests in people, empowering
- caring, visionary, compassionate, humble
- realistic and focused, credible, walks the talk
- getting results that matter (realising organisational objectives)
- moral (towards creating better worlds)
- powerful, charismatic
- patience, wisdom, expert
- human!
- spiritual
- community
- service

I add community and service to the list. The significance of each of the qualities is explored. I ask, ‘Do you have these attributes?’ ‘Do people you work with have these attributes?’ Perhaps, for the first time, the aspiring leaders look into the mirror of self.

The idea of community and service as defining qualities of leadership in a dominant transactional culture is both radical and utter sense. The idea of service is that the leader leads from behind turning upside down the
conventional idea that leaders lead from the front. If taken seriously, it fundamentally shifts the power relationship within the organisation. As Gilley (1997: 41) writes, ‘When leaders take a second, closer look, they see that the lines between groups of people blur. The leaders begin to see that although their employers serve them, they must also serve the employees.’

Where to draw the line? For myself, as leader of a community hospital, the line was drawn by the decision to utilise primary nursing as the mode of care delivery whereby the individual primary nurse takes responsibility for her patients. My role as leader was both to support the nurses to take responsibility for their performance and to enable them to develop that performance. To do so, I had to let go of control (power).

Greenleaf (2002: 13–14) writes:

*The servant leader is servant first. It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead. That person is sharply different from one who is leader first, perhaps because of the need to assuage an unusual power drive or to acquire material possessions. The leader-first and the servant-first are two extreme types. Between them there are shadings and blends that are part of the infinite variety of human nature. The difference manifests itself in the care taken by the servant-first to make sure that other people’s highest priority needs are being served. The best test, and difficult to administer, is: Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants?*

The defining nature of servant leadership is servant-first in contrast with leader-first. Whilst servant leadership has much in common with a transformational leadership, it is radical because it turns the transactional pyramid upside down and shakes out all its power symbols.

The leader-first usually sits at the head of the table whilst the servant-first might sit at the foot of the table, ensuring that all at the table are well served. Both might espouse collaborative intent but would approach it very differently. Servant leadership acknowledges that the most important people are those who deliver care – this is why the organisation exists. It takes leadership into a profound new dimension, one that is not easy to grasp, let alone accommodate within the prevailing transactional landscape.

As a holistic therapist, I can appreciate the idea of being of service as I kneel at the client’s feet with the intention of helping and guiding them towards better health. This is energetic work. Leaders are adept at centring their energy to lift others beyond their normal limits towards greatness. Rael
draws attention to a universal energy that the leader knows how to tune into and utilise. He writes (1993: 88–9), ‘when it [consciousness] begins to lift to a higher level, something dramatic can happen’.

You, the reader, will know this: the way some people lift you and others drain you. It is as if people radiate energy, some infusing, some depleting. Patients also know this: those nurses who lift them and those who do not. I wonder how much better patients would heal if all nurses radiated this lifting energy? How much money would be saved? How much better nurses themselves would feel. Leaders know and nurture this energy. They are the great ‘lifters’. They invest in themselves so they can lift as a natural aspect of their being. It is not a tap to turn on as if an offensive charm. Leaders know how to centre their energy and grow from their exchanges with followers. As I sit around the ‘team table’ I am mindful of ‘who I am’, offering my view, challenging and inspiring others, opening the imagination, moving people towards realising our collective vision of hospice. I visualise myself as a peacemaker. As Jones and Jones write (1996: 135), ‘From a sea full of problems, leaders [peacemakers] find solutions. They honour the trail ahead and know that a path of least resistance exists. They focus on the possible.’

I sense that servant leadership has much in common with Buddhism – essentially, a wise and compassionate response to the other’s suffering in ways that enable the person to grow. It is like a vibration that spreads to embrace the whole organisation, a ripple from around the shared collaborative table. Deep within the idea of service is a sense of humility, in the giving of service asking for nothing in reward. This is not a false humility. Of course, serving is its own reward, in seeing both the other and self grow. With humility there is no pretence. The leader is honest and vulnerable – not anxious that he might be exposed as a fraud. Servant leadership resonates with what Prosser (2010) refers to as post-heroic leadership, reflected in such work as Authentic leadership (George 2003), Leading quietly (Badaraccc 2002) and the qualities of the level 5 leader portrayed in Good to great – such qualities as being modest, inspiring, selfless and praiseworthy (Collins 2001).

In his book Servant leadership Greenleaf sets out the qualities of the servant leader. This work reflects Greenleaf’s anecdotal stance rather than claiming validity for his approach through any research. Perhaps the whole idea of service has a romantic feel in stark contrast with the dominant transactional health care culture. As I say to aspiring leaders, it may be a step too far just now, yet be inspired by it, and yet more and more of the aspiring leaders choose this vision of leadership to guide them. Why? Because it is essentially a mindful approach.
Community

Leaders do not work alone. They create communities based on mutual support and respect, trust, commitment, responsibility and love. The circle best symbolises community rather like King Arthur’s legendary round table or the Native American powwow. Ideally people sit wherever around the table to avoid symbolising one particular place as the power chair. Community is the basis of the collaborative team that works together to realise its collective vision. It is a place of belonging and growth.

Initiative

Leaders take the initiative! They ‘take the risk of failure along with the chance of success’. (Greenleaf 2002: 29). They hold the vision and a sustaining spirit to support the movement towards realising the vision. They are good at pointing the direction. Greenleaf (2002: 29) writes,

They [leaders] are better than most at pointing the direction. As long as one is leading, one always has a goal. It may be a goal arrived at by group consensus, or the leader, acting on inspiration, may simply have said, ‘Let’s go this way’. But the leader always knows what it is and can articulate it for those who are unsure. By clearly stating the goal the leader gives certainty to others who may have difficulty in achieving it for themselves.

Leaders listen. Greenleaf asks, ‘Why is there so little listening?’ Through listening, the leader comes to truly appreciate the situation and can respond rather than react. Listening is one thing, speaking is another. Just being there for others and listening to them is one of the most important capacities a leader can have (Jaworski 1998: 67). The leader is a master of language and imagination. It is the facility in tempting the hearer into that leap of imagination that connects the verbal concept to the hearer’s own experience’ (Greenleaf 2002: 32). Withdrawal is about the leader taking time out to charge energy to keep self at an optimum level of performance. To serve others one has to be in good shape. Service is not sacrifice! Acceptance and empathy indicate that the leader is always open to receive. Acceptance is a tolerance to imperfection, although not an acceptance of lack of responsibility. Empathy reflects the facility and willingness to connect with people’s experience. Only then can the leader understand. Leaders are focused on who they are and what they need to do. They do not get sidetracked into peripheral issues and waste energy on futile actions. Leaders organise life simply because they have the facility to raise the spirit of the people around a clear articulation of necessary action.
The leader throws open the doors of awareness and perception, drawing on all her senses to get the big picture. As Greenleaf writes (2002: 33), ‘The cultivation of awareness gives one the basis for detachment, the ability to stand aside and see oneself in perspective in the context of one’s own experience.’ This idea of awareness and empathy towards self resonates with being mindful, the hallmark of leadership.

Foresight

Foresight gives leaders their leading edge. Greenleaf (2002: 21–22) writes, ‘[The leader] needs to have a sense for the unknowable and be able to foresee the unforeseeable. Leaders know some things and foresee some things which those they are presuming to lead do not know or foresee as clearly. This is partly what gives leaders their lead, what puts them out ahead and qualifies them to show the way.’

Foresight has a somewhat mystical quality. It resonates with the idea of chaos theory (Wheatley 1999) that somehow the leader can tune into the patterning around meaning and intention. It is about processing what is happening now, informed by the past and anticipating the future. I might call this wisdom the ability to weigh up the situation even before it unfolds and know how best to respond considering the consequences.

Foresight is possible when the leader is able to process information towards making best decisions in both the short and long term. It is not being attached to knowing and being open to the possibility of the moment. Foresight is faith in oneself that followers know and trust. Salzberg (2002: 67) writes of faith,

It doesn’t decide how we are going to perceive something but rather is the ability to move forward even without knowing. In order to deepen our faith, we have to be able to carry things out, to wonder, to doubt. In fact, faith is strengthened by doubt when doubt is sincere, critical questioning combined with a deep trust in our own right and ability to discern the truth.

Persuasion

Although leaders often have positional power as befits their position within the organisational hierarchy, they do not emphasise this type of power and certainly avoid coercion. Instead, they give emphasis to expert and relational power, what French and Raven (1968) describe as facilitative power, whilst reinforcing intrinsic reward by appealing to values and responsibility.
Key principles of servant leadership

Considering Greenleaf’s characteristics I established eight key principles of servant leadership. I added the dimensions of perseverance and poise, qualities I consider vital to leadership but which Greenleaf does not give overt attention. These eight principles are set out in Chapter 4 as a prelude to Alison’s narrative in which she endeavours to realise servant leadership.

Against this theoretical background I will now explore broader, more philosophic ideas of leadership: leadership as chaos, leadership as feminine and leadership as caring.

Leadership as chaos

Chaos theory challenges the idea of an orderly and predicable world upon which the transactional organisation is predicated, reflected in its demand for smooth running as its *sine qua non*. This suggests a Newtonian machine-like mentality. A machine comprises many parts and, as with any machine when it doesn’t function well, the emphasis is on fixing the part or parts that are problematic. Within this machine metaphor, people become part of the machine and are naturally blamed for any malfunction – what might be called the human factor. Management’s primary role is to ensure the smooth running.

In contrast, chaos theory views the world as a whole, mindful of the relationship between parts. Only by seeing the whole can things be understood. This is the leader’s perspective. Chaos theory accepts the world is fundamentally chaotic and not easily predicted within the complexity and uncertainty of everyday human experience. Targets can only ever be speculative and misleading because they have traditionally focused action. Yet everything is always changing. There is an inherent order within chaos framed around the idea of meaning, what are known as strange attractors (Wheatley 1999). From this perspective, the leader can relax control, knowing that things will work out just fine based on practice values. Practice becomes self-organising. There is a creative edge between stability and instability that is important for the leader to read and tread. On this edge everything is in flux, dynamic and changeable. The transactional world, fearful of consequences, clings to stability, leading to a static and sterile work environment. There is a natural synergy between mindfulness and chaos theory – that to tread the creative edge of chaos the leader must be mindful. It won’t work otherwise. Indeed it will be a disaster.
Leadership as feminine

Leadership might be viewed as a feminine approach to organisation in contrast with a more masculine approach that characterises the transactional organisation. The work of Gilligan (1982), *In a Different Voice*, gives substance to this gender contrast. In her research she noted that men and women have different ethical values. From Gilligan’s perspective a feminine leadership is grounded in responsibility and relationships whereas a masculine-type leadership is grounded in justice based on rationality and rules.

Heather was attracted to a transformational leadership because she sensed it resonated with her feminine caring values. She sought congruence between her leadership and being a woman.

She writes: Rosener (1990) writes that women tend to prefer transformational approaches to leadership. Wedderburn-Tate (1999) writes, however, that the current environment of our health care system – finance-driven, performance attainment, short-term initiatives and territorial battles – is not conducive to producing transformative leaders. This seems to suggest that women who desire to be leaders often suffer a sense of conflict between personal and professional expectations. Are female leaders socialised then into behaving in a certain way to ‘fit in’? Barker and Young (1994) write of the continuing domination of patriarchal values and assumptions where competition, control and manipulation are the predominant (transactional) influences in the modern world. They suggest that as the post-modern period develops, there will be an increasing emphasis on feminine values and beliefs, such as caring, nurturing and intuition, to balance patriarchal views. The modern and post-modern world are today operating side by side and in conflict at present. The transition in thinking is slowly happening but is not predicted to be complete for another 10–20 years (Barker and Young 1994). Challenges and tension seemed to lie ahead if I aimed to be true to myself and learn the skills necessarily to provide the desirable practice of transformational leadership that fits comfortably with my own feminist caring ethics of nursing within this harsh, primarily transactional, environment.

Barker and Young’s prediction was written twenty years ago. Since that time I sense no discernible movement towards a more feminine leadership. Perhaps you, the reader, will discern it differently? Perhaps there are more women in senior management, but does that equate with feminine values? Patriarchal
structures are immensely thick, hewn over the years and supported by a government bent on a target approach to health care despite the numerous health warnings of failed care. As such, framing leadership as feminine may not serve the cause of leadership within the dominant patriarchal organisational culture. As Rebecca explored, Davies (1995) argues that nursing is devalued by being seen as feminine (and medicine given dominance by its masculinity); although society values nurses, it devalues the caring act of nursing.

The feminine is often associated with the right side of the brain, the masculine with the left side of the brain (Table 1.1) – Yin and Yang. The transactional world reflects the masculine with an emphasis on rationality, reason, justice and order, whilst the feminine reflects an emphasis on perception, imagination, intuition, creativity, empathy and wonder – all qualities vital for leadership that are nurtured through leadership coaching using humanities and art. It is significant to acknowledge that the transformational is not opposite to the transactional but accommodates it in seeking wholeness.

The leader uses the whole brain and achieves greatness (Woolf 1945). In other words, the leader finds synergy between her masculine and feminine side. Both masculine and feminine qualities are significant for effective leadership. It is interesting to speculate whether one side should mediate the other. Hence men as leaders would naturally lean to the right and women naturally lean to the left. Being mindful, the leader appreciates this interplay. This phenomenon is most visible in men who have undertaken the leadership programme perhaps because women are naturally socialised to embrace the masculine given its domination.

<table>
<thead>
<tr>
<th>Right brain</th>
<th>Left brain</th>
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<tbody>
<tr>
<td>Masculine</td>
<td>Feminine</td>
</tr>
<tr>
<td>Yang</td>
<td>Yin</td>
</tr>
<tr>
<td>Reason</td>
<td>Perception</td>
</tr>
<tr>
<td>Rationality</td>
<td>Imagination</td>
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<td>Justice</td>
<td>Creativity</td>
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<tr>
<td>Order</td>
<td>Intuition</td>
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<tr>
<td>Logic</td>
<td>Empathy</td>
</tr>
<tr>
<td>Balance</td>
<td>Wonder</td>
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**Table 1.1** Contrasting right and left brain qualities
Marge writes: Choosing to become a leader led me to embark upon a voyage of self-examination and self-discovery, arousing feelings of restlessness and impatience, which has driven me to question my previous acceptance and acquiescence in the role of wife and mother. My dual identity as a woman and professional nurse presents me with a personal dilemma, because as a senior nurse and a woman, I find myself working in a male-oriented professional health care system where masculine values, particularly those of doctors and senior managers, appear to be viewed as more significant and dominant and thus attain priority in the primary care trust (PCT) in which I am employed. These attitudes and values are becoming increasingly incompatible with my family life and responsibilities. When I am at work, in my professional persona, I now find myself considering whether as a senior nurse I aspire to have masculine values within the PCT. This causes immense contradiction, in recognition that in doing so, I face continual denial of self and alienation from my nursing colleagues, and yet behaving as the ideal woman and nurse and perpetuating expected perceived norms, I risk experiencing the suppression of voice in my personal and professional life and this leaves me feeling incredibly uncomfortable. This exploration of discomfort and frustration forms the basis of my journey. In recognition that I must be courageous and reveal to my reader who I think I am, at my starting point, I capture the flavours of the text from an early entry from within my reflective journal. I begin with this fearful attempt of looking inwards, to a place of freedom from distraction, as I contemplate self in the turmoil of my work as a senior nurse and as a mother and wife to my family. In my current senior nurse position, where I have been for the past five months, only now that I am standing back can I appreciate how much I enjoyed my previous position in contrast to where I now find self. I question whether where I am is in tune with my values and beliefs, as I am uncertain about my commitment to this role as nurse manager, if it means that I am to be like my colleagues: desiring to be at the centre of the action as ‘the captain’ and expected to work incredibly long hours, to be part of the internal race and to be seen to be the first in the office and the last to leave! Can I cope with only being allowed to be covertly compassionate, ensuring that compassion is not obviously displayed by self as a manager; as it seems that by ‘showing I care’ is a weakness I bring with me? Does caring for others and valuing people stop me from earning the right as a senior to credibly ‘run the show’?

(Continued)
And so I question whether my self-esteem has been flattened by coming here, at a time when in the context of my new status I should be respected for who I am and the personal and professional qualities I bring, not my ability to conform with the values of colleagues. I find myself faced with two choices. I can either collaborate with their established ways of relating and be like them or maintain a conscious awareness and sensitivity of dynamics within the organisation, by being mindful and less harsh on self, so that I can behave in tune with my values and beliefs and in doing so begin to redefine my position as a manager within this organisation and live a congruent life, not a façade.

Sharing these words within her leadership community evoked strong feelings and opinions for it seemed to get to the very heart of becoming a leader and the tensions women, in particular, confronted, when they were prepared to face it. It seems that to succeed in a patriarchal culture one must embrace patriarchal values, especially if you are a woman – as if to prove you are serious about management. Not to do so, to turn against the grain, puts you out of kilter and makes you ultimately not management material.

Women’s way of knowing

The feminist perspective can be expanded by appreciating the work of Belenky et al. (1986), who established a typology of different levels of knowing. They framed women’s empowerment through five levels from which women view reality: silence, received voice, subjective voice, procedural voice and constructed knowing (Table 1.2).

<table>
<thead>
<tr>
<th>Constructed voice</th>
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<tbody>
<tr>
<td>Procedural voice – separate and connected voices</td>
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<tr>
<td>Subjective voice</td>
<td></td>
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<tr>
<td>Received voice</td>
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<tr>
<td>Silence</td>
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**Table 1.2** Women’s ways of knowing self through voice
Silence – reflecting how many women in transactional organisations are socialised to be silenced by patriarchal oppression. It is a position of subjugation and powerlessness that constrains the emergence of self-identity. The Cumberlege Report (Department of Health and Social Security, 1986), which reviewed the future of community health care, noted that in meetings doctors filled the front rows and asked all the questions whilst nurses filled the back rows and were silent. Cumberlege noted that if nursing was ever to emerge as a profession it needed to find its voice. How many meetings do you attend where people are silent? What reasons govern such silence?

The received voice – where women speak with a given voice – reflecting that they have no voice of their own. They speak what is expected of them and are not required to think or speak for themselves. How often do people say, ‘Tell me what I need to know?’ How often do health care practitioners endeavour to solve problems for people by telling them what they need to do? The received voice reflects a dominant transmission of knowledge – informing people what they need to know, where knowledge and language constitute power.

The subjective voice – what Belenky et al. (1986: 76) describe as the ‘quest for self’. At this level women express views and opinions that are largely unsubstantiated and hence easily dismissed. This voice is vital and is the voice most expressed as the aspiring leaders commence their leadership journey. It is the voice nurtured within the leadership community.

The procedural voice has two aspects – the separate and connected voices that mirror the right–left brain dichotomy. Returning to the idea of the masculine and feminine, the separate voice is masculine and the connected voice feminine. The patient is reduced to an object subjected to theory rather than remaining a sentient human being. Leadership likewise can be reduced to the application of science and people objects towards meeting predicted outcomes. Both voices are vital for leadership and yet so much emphasis is given within educational organisations to valuing and developing the separate voice. As a consequence people tend to be lopsided and lean to the left side. The two sides of procedural knowing may antagonise each other – the separate knower may disdain the connected self in the belief ‘so that flowers of pure reason may flourish’ Belenky et al. (1986: 109). In a health care culture dominated by a demand for a science of prediction, the connected voice is easily diminished.

The constructed voice is the synthesis of the separate and connected voices (Table 1.3). This voice is informed, caring and assertive although not necessarily heard along the transactional corridors. Hence it must be political and persistent. The constructed voice is the voice of leadership. Being assertive is to know the political game and fearlessly push the boundaries yet without
tripping up and marginalising self as ‘difficult’. In pushing the boundaries the leader teaches, encourages and rewards people to develop a constructive voice necessary for effective dialogue.

**Leadership as caring**

Rebecca drew on the work of Davies to help her visualise her leadership role in being with Tanya. From her reflection, caring emerges as a synthesis of the masculine and feminine; neither one nor the other but a constructed knowing as Belenky et al. (1986).

Perhaps the emphasis on leadership as feminine naturally lends itself to the idea of leadership as caring. Lord Darzi (2008: 11) in the *High quality care for all* report Department of Health 2008: 11 states: ‘High quality care should be safe and effective as possible, with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual.’

Lord Darzi gives some meaning to the idea of caring. The word ‘compassion’ reflects how caring is viewed as a kind of focused love. To be compassion is to have room in your heart for the other’s suffering (Levine 1988), not to be confused with sympathy. However, such is the paucity of compassion in health care that a Scottish project entitled ‘Leadership in Compassionate Care’ was established (Adamson et al. 2009). Perhaps one reason for low morale amongst NHS staff is the inability to be compassionate due to the transactional nature of health care that reduces people to objects, both staff and patients. Is it a failure of leadership if staff lack compassion? I think so.
Rachael writes: I have learnt that leadership is love. As the ego falls away the door of love opens. Wrapped up in self my love had withered as if a vine on a parched tree. Gibran (1926: 35) writes, ‘Work is love made visible’.

He asks, ‘And what is it to work with love?’

He answers, ‘It is to weave the cloth with the threads drawn from your heart, even as if your beloved were to wear that cloth. It is to build a house with affection even if your beloved were to dwell in that house. It is to sow seeds with tenderness and reap the harvest with joy, even as if your beloved were to eat the fruit.’ I recognise the depth of these words, the love, care and nurture required and commitment needed to sustain my passion and create an environment that empowers others to sustain their own passion. If I can work with love, then this will continue to facilitate the learning environment.

Rachael’s words are profound although I am sure many readers shy away from the idea of love, yet embrace the idea of compassion. Indeed health care workers are exhorted to be compassionate as if this is some kind of applied skill rather than something heartfelt.

Mayeroff (1971: 1) considers that ‘To care for another person, in the most significant sense, is to help him grow and actualise himself.’ These words fit well with both transformational and servant leadership – that the key role of leadership is to enable the other person, whether patient or staff member, to grow.

Caring is the attractor working within health care and this must exist at every level of its functioning. If this is true, then working in health care must fundamentally be about caring. When it isn’t, the contradiction is stark, and both patients and staff suffer. Whilst I thought that caring should be natural for health care practitioners, the aspiring leaders generally felt that caring, like leadership, was a rare commodity amongst managers and, more worryingly, at the delivery of patient care. This state of affairs is another reflection of poor leadership, with its managerial focus on filling in paper and meeting targets. It is a simple equation: if commanders treat staff as objects towards meeting outcomes, then staff are likely to respond in similar ways to more junior staff and down the line to patients. This is a huge contradiction for organisations whose business is health care.

All health care practitioners, at every level of the organisation, need to be mindful of self as caring. Leaders work within teams towards a collective vision of health care practice within the wider organisation, whose primary
concern is health care. Leaders create and sustain a creative and moral environment necessary for individual and organisational growth that is care. If an organisation expects its people to care it must also care for those people. It is a simple yet profound equation. And yet everywhere I find that people do not feel cared for within their health care organisations. They feel like objects. It leads to a depersonalisation, and the risk is that they then treat patients like objects. Cared-for people become more inspired, motivated, less toxic, work harder, etc. The list of benefits is endless. If people are not cared for, then the opposite can be assumed.

My partner recently had an angiogram. In the course of the morning we met three nurses; neither one introduced herself by name or acknowledged my presence as her partner. Neither did they inquire as to how my partner was feeling, and let’s face it, an angiogram and possibility of stent insertion is not something to be taken lightly. In contrast, the consultant introduced himself, acknowledged my presence with a firm handshake and inquired into our feelings. The difference was so stark. We felt cared for by the doctor but had no faith in the nurses. They were like robots. Instead of being cared for, we felt uncared for, adding to our suffering (Johns 2014). Why do these nurses respond in this way? The simple answer is lack of leadership. I would like to think that such stories were rare, the exception rather than the rule, but I meet many people who tell similar stories, as if the whole system of health care is infected by its transactional manner. It simply isn’t acceptable, especially when the patient experience is lauded as a quality measure. Without doubt, leadership is grounded in humanness. As Freire writes (1972: 43), ‘It is essential for the oppressed to realise that when they accept the struggle for humanization they also accept, from that moment, their total responsibility for the struggle.’

Mayeroff writes (1971: 2),

In the context of a man’s life, caring has a way of ordering his other values and activities around it. When this ordering is comprehensive, because of the inclusiveness of his caring, there is a basic stability in his life; he is “in place in the world”, instead of being “out of place”, or merely drifting endlessly seeking his place. Through caring for certain others, by serving them through caring, a man lives his meaning of his own life.

Being a leader is being ‘in place in the world’ to lead without contradiction. Being in place the person is able to grow. This can be contrasted with being ‘out of place’ or knowing your place as determined by others within the transactional organisation. It is like being contained within a box slotted into the pyramidal layers. It is restrictive and hinders growth in its demand to conform to rules set by others.
The leadership journey can be viewed as a movement from ‘knowing your place’ to being ‘in place’ as a transformational leader. Mayeroff (1971: 9) reveals the delicacy of such movement so as not to fall into the transactional pattern of imposing direction to shape the person to fit the organisation. In helping the other grow I do not impose my own direction; rather, I allow the direction of the other’s growth to guide what I do and to help determine how I am to respond.

Joan writes: ‘Knowing your place’ is determined by the organisation within the transactional matrix. Being in the right place is determined by the practitioner in terms of creating the practice conditions to realise desirable practice. The leadership plot is to appreciate and shift into the right place. It is a claim for autonomy based on shared success. Yet my struggle is to know my place within the competing organisational demands let alone find my own place! Perhaps that is my predicament – that I am trying like a good girl to know my place, to satisfy my masters, rather than take over the agenda and find the right place to be in.

**Front foot thinking**

Front foot thinking is about ‘being in place’, taking the initiative and being proactive, rather than being caught on the back foot, reactive, defensive and uncertain. The leader is mindful of being on the front foot, as if leading the dance, rather than on the back foot being led. In leading the dance, the leader guides followers to dance and become leaders through role modelling.

In Table 1.4 I set out indicators of being on the front or back foot. These have been generated through dialogue with aspiring leaders over time and constantly evolve as we better appreciate the idea. Being proactive resonates with foresight, intuitively knowing what needs to be done at what

<table>
<thead>
<tr>
<th>Front foot thinking</th>
<th>Back foot thinking</th>
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<tbody>
<tr>
<td>Views self as a leader</td>
<td>Views self as follower</td>
</tr>
<tr>
<td>Uses initiative/proactive</td>
<td>Waits for others to command/reactive</td>
</tr>
<tr>
<td>Takes responsibility</td>
<td>Shirks responsibility</td>
</tr>
<tr>
<td>Assertive/confident</td>
<td>Non-assertive/hesitant</td>
</tr>
</tbody>
</table>
Mindful of being on the ‘front foot’ | Not aware of being on the ‘front foot’
---|---
Strong sense of purpose/morality/values | Weak sense of purpose/morality/values
Takes initiative | Lets things slide
Alert/is prepared | Not alert/Unprepared
Visible to others | Keeps head down
Recognises own value | Need others to value them
Focuses on strengths | Focuses on weaknesses
Sees the whole picture | Sees only the picture they want to see
Crosses hierarchical lines | Hierarchy bound
Voice is heard | Voice subdued
Expands autonomy | Shrinks autonomy
Foresight | Hindsight
Thinks outside the box/creative | Thinks inside the box/conforming
Dynamic sense of relationship | Confined by normal relationships
Poised | Anxious
‘In the right place’ | ‘Put in place’
Decisive | Prevaricates
Collaborative | Accommodating/avoiding
Bounces back (resilient) | Falls over (fragile)
Engaged | Detached
Yields | Fails
Takes risks/fearless | Plays safe/defensive

**Table 1.4** Front foot/back foot thinking

time. It is being a step ahead, the front foot placed with certainty in front. Front foot leaders weigh up the issues from a moral perspective of ‘what is best or the right way to go’. In other words, as with all leadership perspectives, front foot thinking is a way of being, not a means of doing, an ontological rather than epistemological position.
Table 1.4 is constructed for you to score yourself. There are 26 indicators – so a top score of 260. Go for it! Such tools are useful to revisit from time to time along your leadership journey, to give feedback and remind you of such values.

Personal vision

So, what makes me a leader? Clearly, to know I am a leader necessitates an idea of what leadership is. The literature is resplendent with compelling descriptions: transformational, charismatic, servant, authentic, primal and suchlike. Does leadership reflect an individual’s personality or is it an amalgam of traits that can be learnt? Without doubt, charisma is significant. Perhaps ‘presence’ is a better word. Think of people who have ‘presence’ on the world stage.

My own inquiry explicated the following attributes:

1. Leaders are mindful; mindfulness is the hallmark of leadership.
2. Leaders are visionary (Senge 1990), with shared values congruent with its purpose.
3. Leaders are moral (Bass 1985), acting with integrity towards creating better worlds for others no matter what resistance is encountered, yet yielding graciously as appropriate.
4. Leaders have foresight (Greenleaf 2002); they are always on the front foot and anticipating the next move. Foresight is a reflection of wisdom in simply knowing what to do within a complex and largely indeterminate world.
5. Leaders are of service to enable others to accomplish what needs to be done (Greenleaf 2002) through genuine collaborative relationships that invest in people to enable them to grow and fulfil their potential.
6. Leaders are poised and emotionally intelligent in the face of disturbance and uncertainty, with the ability to sustain self within mutually supportive networks.
7. Leaders are authentic, necessarily transparent for deep trust, mindful of walking the talk of leadership, without being hooked on ego.
8. Leaders are inspirational and energetic; they lift people to higher levels of motivation and achievement within an acknowledged learning community.

Poise

The leader is poised, with the ability to know and manage self within relationships, what Goleman et al. (2002) describe as emotional
intelligence (EI). Emotional intelligence is concerned with expressing and controlling emotions, both requiring a deep self-awareness guided by reflective practice. From the perspective of emotional tension the key aspects of EI are emotional self-awareness and self-control, leading to self-confidence and accurate self-assessment. The other aspects of EI relate to consequences in terms of leadership, thus providing a framework for reflection on leadership ability. The cues within the model for structured reflection nurture the development of poise. 

I only wanted six attributes in my leadership vision but I couldn’t squeeze everything in! No doubt many more ideas could be inserted. For example, I agree with Bolman and Deal (1995) that leadership is a spiritual journey; however, there is something unsatisfactory with listing attributes. It creates an illusion that somehow we can know leadership and projects a reductionist approach whereas leadership is something whole. The risk is that it becomes an abstract model that people struggle to fit into like a suit of undersized clothing. Leadership is much more than a list of attributes. However, we do need signposts to guide us. If leadership is a whole thing, then I need a whole statement. Not an easy task given the complexity of leadership.

_Tentatively_ I offer, ‘Leadership is mindful, insightful and caring, ever vigilant of its authenticity in being of service to others within a community of practice that lifts everyone to higher levels of morality and growth, focused towards achieving shared goals and personal aspiration.’

No doubt, I could use different words. Indeed, I have played around with versions of this statement trying to find the right words to best express leadership. For certain, language is limiting. No matter what words you use, it is vital to reiterate that leadership is a whole thing. The eight characteristics are merely a pattern, ever changing in the light of experience and reflection and gelled through mindfulness.

My vision of leadership reflects my appreciation or appropriation of leadership ideas. The influence of theoretical ideas on my personal vision is very evident.

**Scanning the web**

Scanning the web for current thinking on leadership reveals many ideas that reflect the topical nature of leadership: ideas such as ‘Fourteen things you should do at the start of every day’ (Box 1.1), ‘The most successful leaders do fifteen things automatically every day’ (Box 1.2) and ‘The seven secrets of inspiring leaders’ (Box 1.3). These ideas are useful to spark and
stimulate the leader’s curiosity and reflection – ‘do I do these things?’ They also help make the idea of leadership fun.

Reviewing the various boxes, I must emphasise the significance of ‘take a deep breath’ (Box 1.1) which is the gateway to becoming present and mindful. I know this from my work as a complementary therapist working in a hospice where I take a deep breath before entering any situation in order to bring myself present to that moment. Being present is giving one’s full attention to the situation having dispersed any other concerns. Being present, it then becomes possible to ‘connect with others’ (Box 1.1). Easier said than done. Just pause for a moment and think of how many ideas are spinning in your head at any given moment. How quickly people can let their mind be filled with a hundred things and lose control of self. Losing control creates anxiety and then the problems multiply. As Rinpoche (1992: 59) writes, ‘we are fragmented into so many different aspects. We don’t know who we really are, or what aspects of ourselves we should identify with or believe in. So many contradictory voices, dictates, and feelings fight for control over our inner lives that we find ourselves scattered everywhere, in all directions, leaving nobody at home.’

The idea of positive energy to lift people and to serve others (Box 1.2) reflects the essential character of the leader. In serving others, the leader’s whole perspective of power must fundamentally alter. Ideas such as lead by example, enabling others to feel safe to speak up and facilitating dialogue (Box 1.2) are all powerful expressions of leadership, yet what is significant is that leaders need to be mindful of creating these moments at appropriate times, mindful of the underlying organisational culture and mindful of the potential consequences. Being mindful is being wise and compassionate – as Nelson Mandela said, having a good heart and a good head.

Box 1.1 Fourteen things you should do at the start of every day

(www.forbes.com)

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<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>Arrive on time.</td>
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<tr>
<td>2</td>
<td>Take a deep breath.</td>
</tr>
<tr>
<td>3</td>
<td>Take five – give yourself five minutes to settle in and take a moment for yourself.</td>
</tr>
<tr>
<td>4</td>
<td>Start each day with a clean slate (or don’t start with a hangover).</td>
</tr>
<tr>
<td>5</td>
<td>Don’t be moody.</td>
</tr>
<tr>
<td>6</td>
<td>Organise your day and don’t get distracted; prioritise, but be flexible.</td>
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(Continued)
Be present to connect with others.

Check in with your colleagues – sharing will enable you to achieve substantially what you need to do.

Ensure your workspace is organised.

Don’t be distracted by your inbox.

Listen to your voicemail.

Place important calls and send urgent emails.

Take advantage of your clear head (note time of day best suited for creative exercises).

Plan a mid-morning break (keep the momentum going).

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Box 1.2 The most successful leaders do fifteen things automatically every day

1. Make others feel safe to speak up.
2. Make expert decisions and facilitate the dialogue to empower others; focus on making things happen at all times.
3. Communicate expectations.
4. Challenge people to think.
5. Are accountable to others.
6. Lead by example.
7. Measure and reward performance (not taking others for granted).
8. Provide continuous feedback leading to reciprocal and trustworthy relationships.
9. Properly allocate and deploy talent.
10. Ask questions and seek counsel with a commitment to self-learning.
11. Problem-solve and avoid procrastination (tackle issues head on and learn from and don’t avoid difficult situations).
12. Have positive energy and attitude (motivation).
13. Are great teachers (mentoring and investing in others).
14. Invest in relationships (are lifters not leaches or loafers).
15. Genuinely enjoy responsibility – when you have reached a senior level of leadership it is about the ability to serve others and this cannot be accomplished when you do not genuinely enjoy what you do.
Gallo’s idea of painting pictures (Box 1.3) with a focus on story encourages me, given my approach to leadership development from a story perspective through reflective practice. Stories help people see the bigger picture in ways they can connect with, particularly in relation to their own experiences or stories. As Gallo says ‘stories make connections’. Throughout the book I use reflexive stories as evidence to support my own assertions on leadership.

**Current leadership initiatives within the NHS**

In the foreword to *Inspiring leaders: Leadership for quality initiative* (Department of Health 2009b) David Armstrong, NHS Chief Executive, writes, ‘It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose’ (5). Armstrong aligns leadership with outcomes, for quality is generally measured in terms of outcomes not process – a view reflected in NHS leadership initiatives such as the ‘Inspiring Leaders’ initiative (Department of Health 2009a). It has not been my concern in this book to review the NHS leadership initiatives on offer in the UK. Each region – England, Wales, Scotland and Northern Ireland – does have different approaches which can be appreciated through web exploration. These initiatives suggest that the NHS does value leadership development although these approaches tend to fit within the dominant transactional culture that pervades the NHS and probably health care institutions worldwide.

The need for leadership development was emphasised in *Liberating the talents* (Department of Health 2002a) produced to deliver the reforms set out in the NHS plan (Department of Health 2000). It talks of effective
leadership as corporate, nurturing, encouraging and inclusive, emphasising a leadership role for everyone, whatever their role, wherever they work. This language mirrors the rhetoric of transformational leadership and, in doing so, indicates a significant culture shift for an NHS built on bureaucracy, hierarchy and control. However, it does not make this shift clear, suggesting that such leadership can simply be accommodated within normal organisational patterns.

The NHS Leadership Academy’s leadership model states (http://www.leadershipacademy.nhs.uk):

*The Healthcare Leadership Model has been developed to help staff who work in health and care to become better leaders. It is useful for everyone – whether you have a formal leadership responsibility or not, if you work in a clinical or other service setting and if you work with a team of five people or 5,000. It describes the things you can see leaders doing at work, and is organised in a way that helps everyone to see how they can develop as a leader. It applies equally to a whole variety of roles and settings that exist within health and care. We want to help you understand how your leadership behaviours affect the culture and climate you, your colleagues and teams work in. Whether you work directly with patients and service users or not, you will realise what you do and how you behave will affect the experiences of patients and service users of your organisation, the quality of care provided and the reputation of the organisation itself.*

The health care leadership model consists of nine ‘leadership dimensions’ (Table 1.5). In the second dimension the model states: ‘Having the essential personal qualities for leaders’. The model further notes,

*The way that we manage ourselves is a central part of being an effective leader. It is vital to recognise that personal qualities like self-awareness, self-confidence, self-control, self-knowledge, personal reflection, resilience and determination are the foundation of how we behave. Being aware of your strengths and limitations in these areas will have a direct effect on how you behave and interact with others, and they with you. Without this awareness, it will be much more difficult (if not impossible) to behave in the way research has shown that leaders should. This, in turn, will have a direct impact on your colleagues, any team you work in, and the overall culture and climate within the team as well as within the organisation. Whether you work directly with patients and service users or not, this can affect the care experience they have. Working positively on these personal qualities will lead to a focus on care and high-quality services for patients and service users, their carers and their families.*
<table>
<thead>
<tr>
<th>What is it?</th>
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<tbody>
<tr>
<td><strong>Inspiring shared purpose</strong></td>
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<tr>
<td>Valuing a service ethos; curious about how to</td>
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<tr>
<td>improve services and patient care; behaving</td>
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<tr>
<td>in a way that reflects the principles and</td>
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<tr>
<td>values of the NHS</td>
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<tr>
<td><strong>Leading with care</strong></td>
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<tr>
<td>Having the essential personal qualities for</td>
</tr>
<tr>
<td>leaders in health and social care;</td>
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<tr>
<td>understanding the unique qualities and needs</td>
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<tr>
<td>of a team; providing a caring, safe</td>
</tr>
<tr>
<td>environment to enable everyone to do their</td>
</tr>
<tr>
<td>jobs effectively</td>
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<tr>
<td><strong>Evaluating information</strong></td>
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<tr>
<td>Seeking out varied information; using</td>
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<tr>
<td>information to generate new ideas and make</td>
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<tr>
<td>effective plans for improvement or change;</td>
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<tr>
<td>making evidence-based decisions that respect</td>
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<tr>
<td>different perspectives and meet the needs of</td>
</tr>
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<td>all service users</td>
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<tr>
<td><strong>Connecting our services</strong></td>
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<tr>
<td>Understanding how health and social care</td>
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<tr>
<td>services fit together and how different</td>
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<tr>
<td>people, teams or organisations interconnect</td>
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<tr>
<td>and interact</td>
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<tr>
<td><strong>Sharing the vision</strong></td>
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<tr>
<td>Communicating a compelling and credible vision</td>
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<td>of the future in a way that makes it feel</td>
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<tr>
<td>achievable and exciting</td>
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<tr>
<td><strong>Engaging the team</strong></td>
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<tr>
<td>Involving individuals and demonstrating that</td>
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<tr>
<td>their contributions and ideas are valued and</td>
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<td>important for delivering outcomes and</td>
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<tr>
<td>continuous improvements to the service</td>
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<tr>
<td><strong>Holding to account</strong></td>
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<tr>
<td>Agreeing clear performance goals and quality</td>
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<tr>
<td>indicators; supporting individuals and teams</td>
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<tr>
<td>to take responsibility for results; providing</td>
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<tr>
<td>balanced feedback</td>
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<tr>
<td><strong>Developing capability</strong></td>
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<tr>
<td>Building capability to enable people to meet</td>
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<tr>
<td>future challenges; using a range of</td>
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<tr>
<td>experiences as a vehicle for individual and</td>
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<tr>
<td>organisational learning; acting as a role</td>
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<tr>
<td>model for personal development</td>
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<tr>
<td><strong>Influencing for results</strong></td>
</tr>
<tr>
<td>Deciding how to have a positive impact on</td>
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<tr>
<td>other people; building relationships to</td>
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<tr>
<td>recognise other people’s passions and concerns;</td>
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<tr>
<td>using interpersonal and organisational</td>
</tr>
<tr>
<td>understanding to persuade and build</td>
</tr>
<tr>
<td>collaboration</td>
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**Table 1.5** Nine dimensions of the health care leadership model
It is these personal qualities, notably self-awareness and personal reflection, that I believe are most significant, because without this awareness it will be impossible to become a leader. Personal reflection is the key to developing self-awareness. It is this awareness that ultimately cultures mindfulness.

However, the leader faces another significant challenge to becoming a leader, that of the transactional culture that characterises health care organisations. Hence there is a tension between the idea of leadership and realising its reality in a culture that despite espousing the rhetoric of leadership is antipathetic to it simply because true leadership demands an organisational revolution from the top-down. People are so locked in their unreflective ways that change becomes difficult, wrapped up as they are in bureaucratic hierarchical power relationships and egos. The idea of ‘lead by example’ must ultimately stem from the top down; otherwise aspiring leaders will bang their heads against the hard transactional wall. Without doubt, becoming a true leader is not easy. Understanding and resolving this tension so that the vision of leadership becomes realised is the primary focus of reflective practice.

The desire for genuine leadership shines through the ‘Inspiring Leaders’ paper, yet change fundamentally hinges on the level of existence – can the transactional world radically shift or simply accommodate the idea of leadership to fit into its transactional world? Many leaders are in managerial positions. Rodriguez (1995) describes managers as people who prefer control, stability and exert power through such means as task orientation and quantitative styles. The risk is that the transactional approach becomes more determined and perhaps more ruthless in meeting quality outcomes at a time of severe economic restraint. I am not optimistic. It is not difficult to see that when external agencies set budgets and award stars for good performance against imposed outcome measures, the gaze of management turns towards reaching those outcomes. Leaders emphasise the process, not the product. Loori (2004: 93–4) writes, ‘When we try and reach a goal, we become fixated on it and we miss the process. Process and goal are the same reality. Each step clearly contains the goal.’

It’s not difficult to realise that if staff are respected and valued and feel involved then they will perform better: work harder, put in the extra effort when necessary, take more responsibility and use their initiative, have higher motivation, and be happier and less stressed. You do not need statistical evidence to make this point. Just open your minds. Put like this, you must wonder at the failure of organisations to invest in effective leadership development. I do not mean two- or three-day workshops, such as the Leading Empowered Organisations (LEO)\(^1\) programme, that barely scratch the surface of leadership yet create illusions of leadership investment.
Della, a deputy director of nursing, writes: The Leading Empowered Organisations (LEO) training promises to provide nurses with the skills they need to be effective leaders and to challenge status quo within health care, by supporting staff at all levels to lead and effect change in organisations and providing a basis for developing healthy relationships, skilled problem solving and confident risk taking. On the basis of understanding that leadership skills cannot be taught (Senge 1990) and certainly cannot be developed on a three-day course, my reader should not be surprised to learn that personal experience of LEO training (delivered by senior nurses who are considered to be ‘leading lights’ within today’s NHS in England) is not entirely positive. Taking three days out of practice was beneficial in enabling me to stand back and reflect on my role as leader; however, most of the material used was already familiar to me, having being exposed to it via previous senior management training. Not surprisingly, the focus of training was not inquiry as the literature suggests but on problem solving and advocacy skills concerned predominantly with meeting predetermined national course objectives, namely:

- Supporting nurses to challenge authority
- Enabling nurses to accept responsibility for reducing levels of administration and bureaucracy by challenging the status quo
- Encouraging nurses to challenge misuse of resources
- Encouraging nurses to influence change in front-line services
- Enabling nurses to improve access to services

The course content focused around these topics was delivered via a workbook with pre-prepared questions and answers in order to maintain consistent message delivery across England. Only now can I comment on the absence of learner input and flexibility, as I have come to appreciate how stability, structure and sameness (Porter O’Grady 1992) are the basis of the teaching and how, from this, culturally induced behaviours are likely to reflect the course values and perceptions when and if implemented into practice. Cynically, I use the metaphor of nurses as robots and question the hidden agenda that lies behind this leadership package.

Freire writes (1972: 23), ‘One of the basic elements of a relationship between oppressor and oppressed is prescription.’ I now consider the imposition of this teaching. For the majority of the thousands of nurses who have accessed this training, like myself, it would have been ‘sold’ as a liberating opportunity, as indeed I have ignorantly sold it to others, and as such, being chosen to attend is in itself a privilege.
Kelly writes: As well as having a nurse practitioner role, I had been elected by my colleagues to serve as the board nurse member for a local Primary Care Group (PCG). Like those who elected me, I believed that my extensive knowledge of primary care and willingness to speak out were the qualities to lead changes in the way services were delivered. However, it soon became clear to me that leadership was much more than willingness to have a voice. Reflecting back on those PCG meetings I can now see how ill-prepared my nurse colleagues and I were for this important role. This became evident with the new agenda for nurse executives that required us to engage with staff and lead changes. Without adequate training and understanding of the skills required, many PCG nurse members struggled to engage and lead (Wilkin et al. 2001).

Repeated requests for help from the PCG management team resulted in several workshops around leading and managing. The PCG management team, like the nurses, were of the opinion that leadership could be taught. Although the workshops were very interesting and gave us insight into project management, communication and leading change, none of them ever addressed the personal qualities needed for leadership. There was a general belief that anyone who used the techniques outlined in the training would become a good leader.

As a nurse executive member I was immediately enrolled on the Leading Empowered Organisations (LEO) course, which was one of the Department of Health courses that was to create nurse leaders in three days. The course was to create empowered and visionary nurses who would be valued and nurtured towards becoming effective leaders (Faugier and Woolnough 2003). However, in reality, all it achieved was frustrated staff who felt empowered but became demoralised when they returned to the work place and realised how little control they actually could achieve (Rippon 2001). This was evident in my own role as a nurse executive member where despite my senior position I found my ideas blocked and my enthusiasm for change dampened by more senior nurse managers in the organisation. I began to question why I was experiencing such difficulties in bringing about change. Was it because I lacked effective leadership skills? Or was it because those in more senior positions also lacked effective leadership skills and were unable to cope with this new way of working? After all, many nurse managers have traditionally evolved into these roles and were somehow expected to develop leadership
skills along the way. Critchley (2001) supports this view, stating that there is a false assumption that those in senior positions are already effective leaders by virtue of their status in the organisation. It soon became clear to me that their defensive behaviour may have been due to their own lack of leadership. Although the LEO course had made me more aware of the need to develop personal leadership skills, it also made me realise how little influence I had within the NHS. Faugier and Woolnough (2003) identified that this was a common feeling amongst senior nurses who reported feeling like a ‘cog in the wheel of a very large organisation’ (25). Many of them described leadership within their organisations as driven by senior managers to establish order and control.

For the first time since becoming a nurse over twenty years ago, I began to question my own style of leadership. I always believed I was a natural leader as all through my life I had taken leading roles. At school I was always games captain, the elected student lead, and in my nursing career I had quickly progressed to becoming a ward sister.

Without question I would have described myself as a leader, someone who had never flinched from responsibility and was always willing to stand up and be counted. But did this make me a leader or just someone who likes to be in control? Kerfoot (2002) suggests that the old style of command and control has been a strong component of leadership within the culture of nursing for many years. It was uncomfortable to think of myself as a controller but the more I reflected on this issue, the more I became aware of times when indeed I had controlled situations. I justified my actions by a need to ensure that patients received the best possible care. After all I had come into nursing with the desire to care for others, and I was willing to put everything into achieving the highest standards of care. Delivering a quality standard of care was something I took pride in.

Taking some control and managing other staff was something that I had thought was part of the role of a senior nurse, and although it was always carried out politely there was little real thought for my colleagues. Sofarelli and Brown (1998) would suggest these are the actions of a manager concerned with achieving outcomes to meet service needs. Although I was not employed as a manager there was an element of management within my workload that of course required me to meet organisational goals. Looking back, I am aware
that I was occasionally so focused on meeting the goals of the organisation that I had encouraged and directed others to go along with my plans without really understanding their needs. This again stems from my competitive nature of achieving goals effectively and not being seen to fail. Covey (2002) suggests that this is poor leadership, as concern for the people you manage tends to become less important than meeting organisational targets.

The more I questioned myself, the more I realised that leadership was much more than just pushing staff in the right direction. The LEO course had been sparse in its content but it did make me question my view of leadership. I spent time trying to work out what made individuals good at leadership. I thought about those individuals I had worked with who had taken leading roles such as ward sisters and departmental managers. There had been a mixture of good and poor leaders, but the odd few had stood out in memory as exceptional leaders and people I had enjoyed working with. I began to reflect on what bit it was about those individuals that had made such an impression on me. They were all different people with different ways of working but the key thing that stood out was how they made me feel valued and empowered.

Conclusion

I have surveyed some ideas on leadership that inspire the aspiring leaders to create a vision of leadership. Of course, these are only some ideas. I expect readers will google leadership to reveal an extensive literature and deepen their theoretical sources to inform their leadership journeys.

Reflection

• Write your personal vision of leadership. You may wish to complete reading the book and return to this exercise. You may want to explore leadership literature more widely and deeply to be better informed.
• Share your vision with colleagues. How do they react?
• Consider how this vision can become a reality? What obviously constrains me?
Notes

1. See Appendix A1 for details of the ‘Influences grid’ within the Model for Structured Reflection.
2. Rebecca alludes to types of power, following French and Raven (see Figure 5.3).
3. I term this dialogue between theory and practice as known through reflection as the third
dialogical movement of narrative construction. See Appendix 2.
4. The MSc Health Care Leadership programme module ‘Alternative perspectives on leadership
assignment’ — the leaders were required to shadow and observe leaders in practice. Many of
the leaders asked these leaders to score themselves against used Schuster’s ten attributes of
transformational leadership. These leaders scored themselves as transformational on every at-
ttribute except two – ‘you share power with others’ and ‘you risk, experiment and learn’ (see
Figure 3.1). See also Appendix 1 for programme outline.
5. See Figure 5.3.
6. See Department of Health guidance paper — A consultation on strengthening the NHS constitution
published in November 2012. The paper noted that the main changes proposed include a ‘new
responsibility for staff to treat patients not only with the highest standards of care, but also
with compassion, dignity and respect’.
7. See Appendix 1 figure.
work-day/ (Accessed 10 October 2014).
automatically-every-day/ (Accessed 10 October 2014).
9 October 2014).
11. Leading an empowered organisation programme. See Developing excellence in leadership within
urgent care: Tomorrow’s nurse leaders today (Department of Health (2003)). It states, ‘Develop-
ing leadership is an integral part of the Government’s Modernisation Agenda and the NHS
Plan. Effective leadership is crucial for improving the quality of care for patients, for developing
staff and for creating the vision to take the modernisation agenda forward.’
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