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Practitioner leadership: a missing link in leadership theory

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Abstract

Purpose – In the collective or distributed leadership models that are now increasingly dominant in the literature about leadership in public services, the role of the "practitioner as leader" takes on powerful significance. The purpose of this paper is to address a gap in this corpus of research, which is a critical analysis of what constitutes the role of the practitioner leader, and the strengths and limitations of these informal leaders as agents of organisational change.

Design/methodology/approach – The paper develops a critical comparative analysis of the role of ordinary teachers and doctors as leaders, as a way of gaining purchase on what comprises and shapes the role of practitioner leader and the potential of this form of leadership to be a driver for quality improvements in the public sectors of education and health.

Findings – Traversing traditional academic divides and comparing medical and teacher leadership provides a clearer picture of how professional and organisational culture strongly influences the roles that practitioner leaders can take up and the influence they can wield. This comparison also shows that building capacity of practitioner leadership in the public services should be approached as an expansion of professional identity, rather than an "added extra" for keen few.

Originality/value – Importantly, this critical comparative review indicates that practitioner leadership is best understood and fostered as a particular ethical stance, rather than a special form of power or knowledge and that it occupies an interstitial space in between formal leadership structures and ordinary practitioners. This is both its strength and its weakness as a form of leadership.

Keywords Distributed leadership, Change agency, Followership, Medical leadership, Practitioner leadership, Teacher leadership

Paper type Conceptual paper

Introduction

The last decade has seen a shift in leadership research, away from studying it as something "done" by individuals in formal roles, towards a more inclusive view of it as something that emerges from the activity of many people within an organisation (Senge, 1990; Spillane *et al.*, 2003; Grint, 2007). Keith Grint describes this shift as a change in perspective, away from leadership as a noun, associated with individuals in formal roles, towards leadership as a verb, which is to do with collective action within organisations (Grint, 2003). Spillane and Diamond (2007) outline this distributed focus as the "leader-plus aspect and practice aspect" (p. 7). The "plus" part of this equation focuses attention on both formal and informal leaders, and the "practice" part foregrounds the way that leadership emerges from the day-to-day practice of leaders and followers based in specific contexts. Perhaps the most specific and empirically grounded definition of effective distributed leadership is that put forward by Fitzgerald *et al.* (2013), which is that it encompasses three levels: "senior leaders with the capability and the interest to support change; second, credible opinion leaders at middle levels, who hold general management or hybrid roles and third, individuals who are willing to engage in change efforts" (p. 1).

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Terminology varies in leadership literature – the concept of distributed leadership is closely related to democratic, collective, or shared forms of leadership (Bolden, 2011; Harris and Spillane, 2008). Notwithstanding differences in emphasis and terminology, what is common to these strands of leadership research is a change of the unit of analysis, away from a spotlight on individuals in formal leadership roles, towards a more diffuse focus on the way informal and formal leaders engage with tasks and influence others in order to bring about organisational improvement and innovation (see, e.g. Brookes and Grint, 2010; Alimo-Metcalfe and Alban-Metcalfe, 2005).

The role of informal practitioner leaders (i.e. front-line staff, who are willing engaging in change initiatives) are foregrounded as being of key importance in these distributed or collective models of leadership, because of their ability to bridge traditional systemic and professional boundaries and engage all workers in change initiatives (Dickinson and Ham, 2008). The models of medical and teacher leadership being promulgated within public services in countries such as the UK, the USA, Canada, Australia, and New Zealand are good examples of this new focus on informal leadership and management as a key driver for organisational and systemic change (Buchanan *et al.*, 2007; O'Reilly and Reed, 2010). Yet, although distributed and collective models of leadership highlight the importance of practitioner leaders, we lack many clear critical analyses of what comprises this role. Indeed, as Bolden (2011, p. 261) points out, most distributed leadership research tends to focus on the "holders of formal positions" which "severely limits opportunities for recognizing the contribution of informal leaders and the manner in which situational factors (physical, social and cultural) impact upon leadership". Although there has recently been more a research focus on practitioner leaders in the public services (e.g. Stevenson, 2012; Fitzgerald *et al.*, 2013), compared with studies of formal leadership, this remains an under-researched area.

In the following paper, we address this lacuna through a comparative analysis of the historical drivers, and organisational and professional contexts which shape the role of teacher and doctor practitioner leaders in (respectively) state schools and public hospitals, in the UK. A comparative approach is particularly helpful, as it draws our attention to the similarities and differences in the way practitioner leadership operates across different public service settings. We then draw out the implications of this critical comparison for our understanding of the way practitioner leaders might best be developed, as well as questioning the extent to which they are likely to be able to live up to the high expectations currently being placed upon them as agents of organisational change in the public services. We begin with a very brief overview of the historical context of teacher and medical leadership in England[1].

Historical background of teacher and medical leadership

Public sector reforms in the UK over the last two decades have seen policy-makers and researchers in the health and education sectors focusing much more attention on the actions and influence of medical and teacher practitioner leaders as pivotal in bringing about reform and innovation in the education and health systems (Buchanan *et al.*, 2007; Dickinson and Ham, 2008; Fitzgerald *et al.*, 2013; Frost, 2012; Gronn, 2002; Spillane and Diamond, 2007). The drivers for this emphasis on practitioner leadership in hospitals and schools have their own distinctive historical patterns.

In the NHS, there have been a variety of efforts by successive governments to engage doctors in managing and administering the burgeoning system, which has grown in every successive decade to keep pace with growth in an aging population

and rapid advances in medical treatment. These efforts, however, have met with limited success. Thus, since the 1980s, the government has put in place increasingly complex systems of management and administration. In effect, these systems have meant that NHS hospitals are led by two different groups: doctors leading clinical care within small micro-systems, and managers taking more of a macro-view of the needs of the different NHS hospitals in which they are employed (Edmonstone, 2008; Sam and Thomas, 2010). It is important to note that there are organisations and teams in the NHS in which these two groups work together productively to improve services (Kirkpatrick *et al.*, 2007), but spreading this pattern of effective working remains a considerable challenge. Part of this challenge is the longstanding distrust and misunderstanding that exists between doctors and managers. The introduction of neoliberal internal markets in public services, and the subsequent corporate models of clinical governance since the 1990s have exacerbated the belief amongst doctors that their work and those of managers are in pursuit of very different ends. This erosion of traditional patterns of clinical autonomy (Harrison and Ahmad, 2000) and the continuing pressures for large-scale restructuring in the NHS in the 2000s has seen a renewed interest in models of leadership which places doctors are the forefront of change to both the micro and macro levels of clinical services (Ballatt and Campling, 2011). The emphasis in the discourse about medical leadership has shifted somewhat in the last few years – evidenced by the change from a Medical Leadership Competency Framework, to a more generic, Clinical Leadership Competency Framework, which emphasises a shared model of leadership in which all members of NHS staff are considered responsible for the development of services (NHS Institute for Innovation and Improvement, 2010, 2011). Even so, there remains a keen interest by professional bodies in medicine (e.g. Royal Colleges) that all doctors are better prepared through their education (from undergraduate to continuing professional development) to take up roles as leaders of change in NHS organisations.

Similar to the post-welfarist reforms of public services that affected the NHS, the 1980s saw an increased focus on increasing the effectiveness and efficiency of state schools in the UK (Tomlinson, 2001). The means of achieving this was to initially focus on management, via a process of centralising the curriculum, and devolving responsibility for managing finances to individual schools. These reforms continued into the 1990s, but this period also saw a development in the discourse about school change – away from school management towards a transformational leadership (Hall *et al.*, 2011). Transformational leadership was a direct focus on positional leaders whereby the "headteacher became the school leader, the key agent of change made responsible for reform and obliged as a key requirement of his or her role as leader to instigate change" (Hall *et al.*, 2011, p. 5).

By the late 1990s, however, transformational leadership by a single authority figure in the form of the headteacher, already heavily occupied by responsibilities for the general management of the school, had proven to fall short in promoting high achievement standards for all students (Gronn, 2002; Silva *et al.*, 2000; Spillane *et al.*, 2003; Muijs and Harris, 2006). This has become all the more patent since the recent decades, when teachers have been positioned as expert facilitators of learning for the able as well as for the weak and unwilling learner (York-Barr and Duke, 2004). It became increasingly clear that such unfamiliar, multi-level, high-stakes work would need collaboration, coordination, and conversations among all of the stakeholders, and that teachers are powerful players in enacting this kind of change (Frost, 2012; Kruse *et al.*, 1995; Spillane *et al.*, 2003).

A key variation that emerges from this brief overview is the different ways in which medical and teacher leaders have been positioned, by the historical drivers, in their respective public service sector. The overall emphasis in education seems to have been one of creating conditions and incentives for teachers to take on practitioner leadership roles, as a means of helping school systems to meet increased demands to deliver improved student outcomes (Yendol *et al.*, 2000). In contrast, the role of doctors as leaders in the NHS has always been recognised as being a strong force, but increasingly, one that needs to be redirected away from a "lone hero" mindset and more towards a "pit crew" mentality (Gwande, 2010). In other words, whereas teacher leadership is positioned as a latent force to be coaxed forward, medical leadership is viewed more as an active force that needs to be redirected, towards greater engagement with service improvement.

However, there are similarities here too, for it seems that a characteristic of both the teacher and medical leadership movements is the way they are viewed as a means of changing the professional identities of doctor and teachers so that they are much more in alignment with the broader goals of the education and health systems (Brookes and Grint, 2010; Baker and Denis, 2011; Currie *et al.*, 2009). Yet, this expansion of professional identity to encompass responsibility for effecting change and innovation is concurrent with increasing state intervention in the health and education sectors (Hartley, 2007; Little, 2003). The anomaly between decreasing power and increased responsibility for front-line workers in the public services inevitably raises the questions about whether the expectations being placed on teachers and doctors as agents of organisational change are realistic or effective (Connell *et al.*, 2009; Lipsky, 1980; Kirkpatrick *et al.*, 2007). In the following section we move from this historical backdrop to look at the way that practitioner leadership is shaped by contemporary professional and organisational structures.

The situated nature of practitioner leadership

The overarching organisational structure that frames both the work of teachers and doctors has been described as a professional bureaucracy (Mintzberg, 1980). The key features of this organisational archetype is that power is located at the periphery rather than at the centre, within the actions of autonomous professional workers who work in specialised units, in relative isolation from one another. Lam (2005, p. 9) points out that in this organisational setting "individual experts may be highly innovative within a specialist domain, but the difficulties of coordination across functions and disciplines impose severe limits on the innovative capability of the organization as a whole". In other words, in professional bureaucracies, highly skilled professionals work in clusters or small pockets with high levels of autonomy, but low levels of coordinated working. Thus, the actions of doctors and teachers enacting practitioner leadership roles may bring about innovation and change within departments, classrooms, and hospital wards, but a key difficulty is in creating large-scale organisational change, within the whole school, or whole hospital – and even more problematically within entire school systems and health systems (Dickinson and Ham, 2008, p. 20; Scribner *et al.*, 1999). In summary, professional bureaucracies are inclined towards autonomy over collective action, to professional groups clustering together rather than integrating, and to isolated cases of innovation that do not make their way into the broader system of practice.

Although teachers and doctors both work within professional bureaucracies, this similarity should not mask some other differences – in particular, in how each

group forms relationships with peers and layers of management and leadership in their organisations. Put otherwise, practitioner leadership is also mediated and moderated by distinctive patterns of lateral or horizontal relating within the organisation.

Vertical and horizontal relating

Although school teachers work in a hierarchical structure with formal leaders such as headteachers at the top of the ladder, they maintain very strong lateral affiliations with their peers. This means that when teachers transition into the role of practitioner leader, many experience tension between this extended role and the professional norm of maintaining strong connections with their co-workers (Lieberman and Miller, 1999). Moving into a teacher leadership role, in other words, challenges egalitarian professional norms, because "what was once a comfortable, primary relationship with peers shifts to include implicit or explicit instructional, professional, or organisational expectations" (York-Barr and Duke, 2004, p. 283). Yet, because the hierarchy in the teaching profession is relatively flat compared to other professions, teacher leaders are able to have more direct and regular contact with the formal leaders they work with. This is important as research shows that in schools where there is a productive relationship between teacher leaders and formal school leaders, there is an increased clarity of purpose and communications about change within the organisation (see, for instance, York-Barr and Duke, 2004; Garceau, 2012).

Doctors, in contrast, work in a professional culture that is characterised by resistance to forming close affiliations to the organisations in which they work. These identifications are avoided because they are viewed as an impingement to a doctors' identity as an autonomous healer (Cruess and Cruess, 1997). Medical culture is also characterised by very strong hierarchies – including a ladder of medical specialties and a pecking order of seniority, with "old-timers" holding significant power over "new-comers" (Bate, 2000; Becker *et al.*, 1980; Berwick *et al.*, 1992; Freidson, 2007; Lave and Wenger, 1991). Whilst there are exceptions to this, a general trend in the professional culture of medicine is also one of competition between colleagues, rather than collaboration (Becker *et al.*, 1962). In this way doctors taking on informal leadership roles and tasks are unlikely to experience conflict with peers in the same way as teachers do. Instead, the challenge for medical leaders is to work with colleagues in a way that encourages collaboration, as opposed to competition (Buchanan *et al.*, 2007).

Patterns of working

A key difference in the working pattern of a teacher and a doctor is that whereas teachers are usually in contact with large groups of students for the majority of their day, doctors normally work with individual patients, in succession. Because teachers work with large groups of students most of the time, they are forced to face and manage (for better or worse) the ethical dilemma of meeting the needs of individual versus those of the collective, on a moment to moment basis (Hargreaves, 2000; Lampert, 1999). Doctors, on the other hand, generally encounter their patients individually and, as noted above, have tended to place questions about meeting the needs of groups of patients as something that exists outside their sphere of professional responsibilities (Shale, 2008, 2012). It seems that through leadership education, more doctors are beginning to consider their responsibilities for patient populations, but there is a still a tendency to consider that looking after needs of groups of patients to be the task of the managers in the hospital and out of their locus of control, expertise, or responsibility (see, e.g. Fitzgerald *et al.*, 2006). In this way, we see that the

organisational architecture of schools and hospitals frames a key dilemma at the heart of practitioner leadership: the way in which teachers and doctors manage the inevitable clash and tension between meeting the needs of individual versus groups of students or patients.

As mentioned earlier, the pattern of working in the organisational structure of a school is one of isolated practice because teachers traditionally work alone in their classrooms with large groups of children. There have been changes to teachers' working patterns in the UK, with increased numbers of teaching assistants working in classrooms, for example. Nevertheless, because of the many contact hours teachers spend with students, as well as the time it takes to prepare for instruction, teachers still have very little free time in their working day to collaborate with other teachers. This culture of isolated working has led to a pattern of lack of shared professional knowledge base for teaching (Hargreaves, 2000), and what Griffin (1995, p. 44) refers to as a "privilege of privacy" in that teachers have traditionally shied away from exposing or challenging shortcomings in each other's practice. In contrast to teachers working alone in their classrooms, doctors tend to work in small multi-professional teams or clinical micro-systems for the majority of their working day (Denis *et al.*, 1999; Øvretveit, 2009). Although there are opportunities to interact within these team settings, interactions between teams and professional groups are hampered by what can often seem to be very heavily guarded hierarchical and territorial boundaries (Degeling *et al.*, 2003; Sebrant, 2008). There is also a strong culture of doctors avoiding challenging each other's practice in the clinical setting, especially across different specialities (Srivastava, 2013).

What emerges from this brief comparison is that doctors and teachers both work in professional bureaucracies, and highly value the principle of autonomy in their practice. This reduces collaboration and sharing of practice across the profession. However, we should not overstate similarities between the work of teachers and doctors, as both work and relate to others within their organisations in distinctive ways. In the following section we build on this comparison to look at the similarities and differences in how practitioner leadership capacity is being developed in the fields of education and medicine.

Building teacher and medical leadership capacity

In both medicine and education the last decade has seen an increasing emphasis on preparing practitioners to act as change agents within their organisation. Schools and hospitals increasingly offer professional development programmes aimed at developing practitioner leadership capacity. In addition, external leadership courses for doctors and teachers by university and other educational providers now abound – many of which are structured around standards or competency frameworks (see for instance, NHS Institute for Innovation and Improvement, 2010; Department for Education and Skills, 2004). It is beyond the scope of this paper to engage in a detailed evaluation of the different competency/standards frameworks used in medicine and education. What it is possible to say is that the emphasis in these frameworks is upon doctors and teachers demonstrating the skills and knowledge necessary to interact with others and engage in instructional or clinical improvement projects (Department for Education and Skills, 2004; Spurgeon and Klaber, 2011). Yet, as Grint (2007) and Edmonstone (2011) point out, competency frameworks may work against the development of greater leadership capacity in organisations. Why? Because such frameworks take too little account of the way leadership practice is a situated

phenomenon which occurs through relationships between people, rather than being a discrete set of skills, attitudes, and knowledge which exists within individuals. Thus, in the words of Bolden and Gosling (2006, p. 8), "contrary to the assumption of most leadership competency frameworks, therefore, there is neither a linear, nor necessarily causal, relationship between competencies and job performance". The effect of targeted leadership programmes on the capacity of individuals to take up informal leadership roles in their organisations is a topic that warrants much more careful, longitudinal study.

Perhaps we get a better view of the ways in which practitioner leadership capacity can be developed if we look to the ways that it is rewarded (or not) within the professions and organisations in which they work. Becoming a practitioner leader in a school or hospital relies heavily on collegial acceptance of such roles – for without followership, there is no such thing as leadership (Degeling *et al.*, 2003; Küpers, 2007). Researchers who have studied the characteristics of informal leaders show that they are not only skilled at influencing and changing the behaviour of others, they are also well recognised amongst their colleagues as being outstanding teachers or doctors (Borbas *et al.*, 2000; Degeling *et al.*, 2003; Katzenmeyer and Moller, 2009; York-Barr and Duke, 2004). Thus, legitimacy and authority as an informal leader is founded in a reputation for being an exemplary practitioner.

Yet, not all good teachers and good doctors necessarily become practitioner leaders. Earlier sections in this paper indicate that the role of organisations (professional and institutional) play a crucial role in determining how readily doctors and teachers take up these informal leadership roles. Crucially, if the senior leadership team in an organisation do not support the roles of practitioner leaders, their motivation and work as change agents will be seriously undermined, from the outset (Lieberman, 2011; Mannion *et al.*, 2005; Neath *et al.*, 2004; York-Barr and Duke, 2004). Other professional and organisational norms influencing role of practitioner leader in teaching and medicine are outlined below.

In terms of professional advancement, although the situation is now changing (e.g. through the advent of the Advanced Skills Teachers scheme in England and Wales), classroom teachers have traditionally had very poor promotion prospects within schools (York-Barr and Duke, 2004). Thus, teachers who incline towards taking a broader responsibility for the development of pedagogy have tended to take on formal leadership roles within a school, rather than staying in the classroom. Coupled with the fact that the teaching profession has tended to socialise teachers to be followers rather than leaders (Hargreaves, 2000; Lieberman and Miller, 1999), and one can see that there are significant organisational and professional obstacles to the expansion of practitioner leadership amongst classroom teachers. In teaching, therefore, part of the challenge also lies in fostering a broader professional acceptance of, and organisational support for, the role of instructional or pedagogical leader – so that teachers do not have to leave the classroom and take on formal leadership roles in order to gain sufficient authority and resources needed to influence teaching colleagues and thereby effect systemic improvements. For example, giving teacher leaders a reduced teaching load to allow them time to engage in relevant leadership activities is an organisational change that supports practitioner leadership and also allows teachers to remain engaged in the practice of teaching. Another example of support involves the headteacher giving up particular practices and giving authority to teacher leaders to carry out those practices such as having teacher leaders compile and analyse assessment data and to meet with year/grade-level colleagues to discuss

the implications of the data (Garceau, 2012; Holmstrom Khorsheed, 2005). At a very basic level, in order for teachers to take on practitioner leadership roles, they need some time released from their usual duties in order to have opportunity to develop a vision, new knowledge and a practice that goes beyond their classroom, and to have time to engage with colleagues and thereby influence their teaching practices. Teacher leadership is also fostered when teacher/principals assume the role of providing strategic direction for the school, and relinquish the role of pedagogical leadership to teacher-leaders (York-Barr and Duke, 2004; Garceau, 2012).

Doctors face a similar and different situation. Similar to teachers, making time in job plans for engagement in leadership activities is also likely to foster practitioner leadership amongst doctors. But different to teachers, for doctors mastery of clinical practice (being a good doctor) is the "principle source of prestige and promotion within the medical profession" (Hargreaves, 2000, p. 22). Moreover, doctors are socialised through their training to be leaders (Ballatt and Campling, 2011) – although this is a form of leadership confined to the clinical micro-systems in which they work, rather than a role which encompasses clinical improvement within the broader organisation (Dickinson and Ham, 2008). In medicine, the challenge is less about making the role of practitioner leader meaningful because doctors have always taken on strong informal leadership roles in the multi-professional teams and systems in which they traditionally work (Freidson, 2007). Rather, the primary task of fostering medical leadership is about getting doctors to broaden their outlook beyond their own clinical teams, looking, for example, at their responsibilities for interacting constructively with other teams and professions in the hospital in pursuit of enhanced patient care and outcomes across the organisation (Degeling *et al.*, 2003; Dickinson and Ham, 2008; Øvretveit, 2009). Moreover, this broadening of vision beyond the parameters of the clinical team needs to be seen as a fundamental aspect of doctors' professional identity, rather than (as is often the case) a viewpoint that marks a doctor as going over the "dark-side" of management (Edmonstone, 2008; Jonas *et al.*, 2011; Nicol, 2012).

A further obstacle to the development of practitioner leadership lies in the schism between how policy-makers and managers in the health and education systems view systemic improvement, and the perception of individual doctors and teachers. For example, the advent of high-stakes testing in the compulsory education sector has created a situation in which teachers are being restricted in their planning and assessment in a way that runs counter to traditional patterns of more authentic assessment and planning for the needs of individual students. Thus, at the same time that teachers are being told they have more responsibility, the testing regimes are effectively reducing their authority as practitioners (Little, 2003). In the health system, doctors are increasingly being told that they need to take a lead in organisational quality improvement projects, but they tend to resist these dictates from policy-makers and managers for several reasons. First, because these calls for leadership are viewed as a dictate from "on high" that impinges on their identity as autonomous clinicians, and second because these quality improvement projects and methods often take little or no account of doctor's concerns and their traditional methods for improving medical quality (Øvretveit, 1996; Weiner *et al.*, 1997). If doctors and teachers are to lead and champion quality improvement projects, greater attention needs to be paid to their concerns, and the ways that they already use formal and informal means for improving pedagogical and medical quality.

A similarity that emerges from this brief review is that fostering practitioner leadership capacity in medicine and education involves challenging traditional

professional norms and habits of practice, to foster a different ethical stance in teachers and doctors. This stance is one where doctors and teachers see themselves as not only accountable for those patients and students in their immediate orbit, but with responsibilities for the overall well-being of colleagues, and patients/students in their organisation. This change in ethical stance is, as commentators have pointed out, not so much about new identity for doctors and teachers, but rather an expansion and development of their existing professional identity (Darling-Hammond *et al.*, 1995; Edmonstone, 2008).

Yet, it is also very important to keep in mind that standing in the space between formal leaders within the organisation and the "rank and file" practitioner is often an uncomfortable place to be; doctors and teachers who take on practitioner leadership roles need support from both sides if the role is to be a desired and rewarding one. From the formal leadership of the organisation they need legitimacy, clarity of role, authority, and adequate resources necessary to make changes in practice. From their practitioner colleagues, they need to be allowed to develop a slightly different skill set and vision for change which extends beyond usual professional and organisational boundaries and norms. This organisational support, both from colleagues and formal leaders, must happen if teacher leaders and doctor leaders are to effect the far-reaching improvements in classroom and clinical practice that is currently being hoped for, by policy-makers, and those "on the ground" in the health and education systems.

Conclusion

In this paper, we have presented a comparative review of ways in which practitioner leadership has been conceived, enacted, and fostered in medicine and teaching. It has helped to reveal a shape to practitioner leadership that remains elusive when one is reliant on studying the literature and practice within a single field. In this final section, we draw out two linked implications of this comparative review, for our understanding of practitioner leadership and the role it can potentially play in systemic improvement.

1. Practitioner leadership is best viewed as a particular ethical stance

The foundation of practitioner leadership is best understood, not as the development of propositional knowledge or skills (as we see in leadership competencies or standards), but as an expansion of the ethical stance of teachers and doctors. In this expanded ethical framework, a teacher or doctor makes a shift from seeing professional autonomy as tied to independent working, towards a view of it as the enactment of practice that best meets the needs of students or patients – both individually and collectively. In other words, as a practitioner leader, doctors and teachers take into account the needs of individual patients or students as members of a broader community, and as a collective. Part of practitioner leadership, we suggest, must therefore involve doctors and teachers working across traditional organisational and hierarchical boundaries, to tussle with and arrive as "best solutions" to these inherent professional dilemmas.

We state this, however, with a note of caution; the ethical stance which we claim marks out a practitioner leader will only be effective if it is accompanied by a change in the broader socio-political structures and organisations in which they work – a change that devolves authority to teachers and doctors in a way that is commensurate with the responsibilities inherent in this wider focus of attention. In other words, if we are serious about building practitioner leadership capacity in teaching and medicine,

we must not ignore the role played by the socio-political environment in enabling (and indeed, in disabling) practitioners to exert their authority in leading change and development (Connell *et al.*, 2009; Ingersoll, 2007).

2. Practitioner leadership occupies an interstitial space in between formal leadership structures and ordinary practitioners. This is both its strength and its weakness as a form of leadership

Past research has concluded that collective leadership is an influential force that occurs through the actions of many and as such cannot be separated for organisational structures and culture (Bolden *et al.*, 2008; Grint, 2008; Spillane *et al.*, 2003; Fitzgerald *et al.*, 2013). Our comparative review suggests that whilst this is true, perhaps the more important characteristic is the way in which the role of practitioner leader exists in an overlap, or interstitial space in between practitioners and formal leadership structures. Teacher and medical leaders occupy this space because they are recognised within the organisation as:

- excellent practitioners;
- having a broader vision of practice that extends beyond the boundaries of their own classroom or clinical microsystem; and
- possessing the ability to engage with and influence others.

Practitioner leaders occupy this space by dint of the way they take on these roles, and are permitted to do so by the colleagues and by formal leaders. In other words, we should see these roles as being framed and shaped through three factors:

- a doctor's or teacher's willingness to take on this kind of informal role;
- collegial acceptance of the teacher/medical leader as a "first amongst equals"; and
- formal leadership recognition and support of the role.

All of these three factors have to come together in the right balance, so that the practitioner leader feels that they have requisite legitimacy and authority in this role, as well as in the eyes of both their colleagues and the formal leaders in the organisation.

The way that the role of practitioner leader exists in the interstitial space between the ordinary practitioner and the formal leader in an organisation is both its strength and its weakness. It is a strength because, with connections and affiliations to both these other groups within the organisation, medical and teacher leaders understand the challenges faced by their colleagues, as well as having a broader organisational vision and thereby an understanding of the complexities that formal leaders have to deal with in their everyday practice. Yet the fact that this role requires all three elements of self-motivation, collegial acceptance, and formal recognition to come together in the right mix is also a weakness of practitioner leadership; there are many ways in which this equation could become unbalanced, and a practitioner leader finding herself thwarted in attempts to engage with programmes of instructional or clinical improvement.

Note

1. We focus here on the UK, but there are these drivers are paralleled in other countries such as the USA, Australia, Canada, and New Zealand.

References

Alimo-Metcalfe, B. and Alban-Metcalfe, J. (2005), "Leadership: time for a new direction?", *Leadership*, Vol. 1 No. 2, pp. 51-71.

Baker, G.R. and Denis, J.-L. (2011), "Medical leadership in health care systems: from professional authority to organizational leadership", *Public Money & Management*, Vol. 31 No. 5, pp. 355-362.

Ballatt, J. and Campling, P. (2011), *Intelligent Kindness: Reforming the Culture of Healthcare*, RCPsych Publications, London.

Bate, P. (2000), "Changing the culture of a hospital: from hierarchy to networked community", *Public Administration*, Vol. 78 No. 3, pp. 485-512.

Becker, H.F., Geer, B., Hughes, E.C. and Strause, A.L. (1962), "Boys in white", *Academic Medicine*, Vol. 37 No. 4, p. 406.

Becker, H.S., Geer, B., Hughes, E.C. and Strauss, A.L. (1980), *Boys in White: Student Culture in Medical School*, Transaction Publishers, NJ.

Berwick, D.M., Enthoven, A. and Bunker, J.P. (1992), "Quality management in the NHS: the doctor's role – II", *British Medical Journal*, Vol. 304 No. 6822, pp. 304-308.

Bolden, R. (2011), "Distributed leadership in organizations: a review of theory and research", *International Journal of Management Reviews*, Vol. 13 No. 3, pp. 251-269.

Bolden, R. and Gosling, J. (2006), "Leadership competencies: time to change the tune?", *Leadership*, Vol. 2 No. 2, pp. 147-163.

Bolden, R., Petrov, G. and Gosling, J. (2008), "Tensions in higher education leadership: towards a multi-level model of leadership practice", *Higher Education Quarterly*, Vol. 62 No. 4, pp. 358-376.

Borbas, C., Morris, N., Mclaughlin, B., Asinger, R. and Gobel, F. (2000), "The role of clinical opinion leaders in guideline implementation and quality improvement", *Chest*, Vol. 118 No. 2, pp. 24S-32S.

Brookes, S. and Grint, K. (2010), "A new public leadership challenge?", in Brookes, S. and Grint, K. (Eds), *The New Public Leadership Challenge*, Palgrave Macmillan, Basingstoke, pp. 1-15.

Buchanan, D.A., Addicott, R., Fitzgerald, L., Ferlie, E. and Baeza, J.I. (2007), "Nobody in charge: distributed change agency in healthcare", *Human Relations*, Vol. 60 No. 7, pp. 1065-1090.

Connell, R., Fawcett, B. and Meagher, G. (2009), "Neoliberalism, new public management and the human service professions introduction to the special issue", *Journal of Sociology*, Vol. 45 No. 4, pp. 331-338.

Cruess, S.R. and Cruess, R.L. (1997), "Professionalism must be taught", *BMJ*, Vol. 315 No. 7123, pp. 1674-1677.

Currie, G., Lockett, A. and Suhomlinova, O. (2009), "The institutionalization of distributed leadership: a 'Catch-22'in English public services", *Human Relations*, Vol. 62 No. 11, pp. 1735-1761.

Darling-Hammond, L., Bullmaster, M.L. and Cobb, V.L. (1995), "Rethinking teacher leadership through professional development schools", *The Elementary School Journal*, Vol. 96 No. 1, pp. 87-106.

Degeling, P., Iedema, R., Winters, M., Maxwell, S., Coyle, B., Kennedy, J. and Hunter, D. (2003), "Leadership in the context of health reform: an Australian case study", in Dopson, S. and Mark, A.L. (Eds), *Leading Health Care Organizations*, Palgrave, Basingstoke, pp. 399-414.

Denis, J.L., Lamothe, L., Langley, A. and Valette, A. (1999), "The struggle to redefine boundaries in health care systems", in Brock, D.M., Powell, M.J. and Hinings, C.R. (Eds), *Restructuring the Professional Organization: Accounting, Health Care and Law*, Routledge, London, pp. 105-130.

Department For Education and Skills (2004), "National standards for headteachers", DfES Publications, Nottingham.

Dickinson, H. and Ham, C. (2008), *Engaging Doctors in Leadership: Review of the Literature*, NHS Institute for Innovation and Improvement, London.

Edmonstone, J. (2008), "Clinical leadership: the elephant in the room", *International Journal of Health Planning and Management*, Vol. 24 No. 4, pp. 1-16.

Edmonstone, J. (2011), "The challenge of capability in leadership development", *British Journal of Healthcare Management*, Vol. 17 No. 12, pp. 572-578.

Fitzgerald, L., Ferlie, E., Mcgivern, G. and Buchanan, D. (2013), "Distributed leadership patterns and service improvement: evidence and argument from English healthcare", *The Leadership Quarterly*, Vol. 24 No. 1, pp. 227-239.

Fitzgerald, L., Lilley, C., Ferlie, E., Addicott, R., Mcgivern, G. and Buchanan, D. (2006), "Managing change and role enactment in the professionalised organisation", report to the National Co-ordinating Centre for NHS Service Delivery and Organisation, NCCSDO, London.

Freidson, E. (2007), *Professional Dominance: The Social Structure of Medical Care*, Transaction Publishers, NJ.

Frost, D. (2012), "From professional development to system change: teacher leadership and innovation", *Professional Development in Education*, Vol. 38 No. 2, pp. 205-227.

Garceau, M. (2012), *Leadership for Instructional Improvement: An Examination of How Principals Share Leadership*, Northeastern University.

Griffin, G.A. (1995), "Influences of shared decision making on school and classroom activity: conversations with five teachers", *The Elementary School Journal*, Vol. 96 No. 1, pp. 29-45.

Grint, K. (2003), "Foreword: why leadership is important (and how to choose the right book on it before 2035)", in Dopson, S. and Mark, A.L. (Eds), *Leading Health Care Organizations*, Palgrave, Basingstoke, pp. ix-xiii.

Grint, K. (2007), "Learning to lead: can Aristotle help us find the road to wisdom?", *Leadership*, Vol. 3 No. 2, pp. 231-246.

Grint, K. (2008), "Wicked problems and clumsy solutions", *Clinical Leader*, Vol. 1 No. 2, pp. 54-68.

Gronn, P. (2002), "Distributed leadership as a unit of analysis", *The Leadership Quarterly*, Vol. 13 No. 4, pp. 423-451.

Gwande, A. (2010), "Health care needs a new kind of hero. Interview by Gardiner Morse", *Harvard Business Review*, Vol. 88 No. 4, p. 60.

Hall, D., Gunter, H. and Bragg, J. (2011), "The strange case of the emergence of distributed leadership in England", *BERA Conference, 6-8 September, London*.

Hargreaves, D.H. (2000), "The production, mediation and use of professional knowledge among teachers and doctors: a comparative analysis", *Knowledge Management in the Learning Society: Education and Skills*, Organisation for Economic Co-operation and Development, Paris.

Harris, A. and Spillane, J. (2008), "Distributed leadership through the looking glass", *Management in Education*, Vol. 22 No. 1, pp. 31-34.

Harrison, S. and Ahmad, W.I.U. (2000), "Medical autonomy and the UK State 1975 to 2025", *Sociology*, Vol. 33 No. 1, pp. 129-146.

Hartley, D. (2007), "The emergence of distributed leadership in education: why now?", *British Journal of Educational Studies*, Vol. 55 No. 2, pp. 202-214.

Holmstrom Khorsheed, K. (2005), "Knowledge resources at work for improving instruction", unpublished dissertation, School of Education, University of Michigan, Ann Arbor, MI.

Ingersoll, R. (2007), "Short on power, long on responsibility", *Educational Leadership*, Vol. 65 No. 1, pp. 20-25.

Jonas, S., Mccay, L. and Keogh, B. (2011), "The importance of clinical leadership", in Swanwick, T. and Mckimm, J. (Eds), *ABC of Clinical Leadership*, Blackwell Publishing, London, pp. 1-3.

Katzenmeyer, M. and Moller, G. (2009), *Awakening the Sleeping Giant: Leadership Development for Teachers*, Corwin Press, Thousand Oaks, CA.

Kirkpatrick, I., Maltby, B., Dent, M., Neogy, I. and Mascie-Taylor, H. (2007), "National inquiry into management and medicine", final report, Centre for Innovation and Health Management, University of Leeds, Leeds.

Kruse, S.D., Louis, K.S. and Bryk, A. (1995), "An emerging framework for analyzing school-based professional community", in Louis, K.S. and Associates, S.K. (Eds), *Professionalism and Community: Perspectives on Reforming Urban Schools*, Corwin Press, Thousand Oaks, CA, pp. 23-44.

Küpers, W. (2007), "Perspectives on integrating leadership and followership", *International Journal of Leadership Studies*, Vol. 2 No. 3, pp. 194-221.

Lam, A. (2005), "Organizational innovation", in Fagerberg, J., Mowery, D.C. and Nelson, R.R. (Eds), *The Oxford Handbook of Innovation*, Oxford University Press Inc, New York, NY, pp. 115-147.

Lampert, M. (1999), "How do teachers manage to teach? Perspectives on problems in practice", in Mintz, E. and Yun, J.T. (Eds), *The Complex World of Teaching: Perspectives from Theory and Practice*, Harvard Educational Review, Cambridge, MA, pp. 255-271.

Lave, J. and Wenger, E. (1991), *Situated Learning: Legitimate Peripheral Participation*, Cambridge University Press, Cambridge.

Lieberman, A. (2011), "Laureates speak: can teachers really be leaders?", *Kappa Delta Pi Record*, Vol. 47 No. S1, pp. 16-18.

Lieberman, A. and Miller, L. (1999), *Teachers Transforming Their World and Their Work*, Teachers College Press, New York, NY.

Lipsky, M. (1980), *Street-Level Bureaucracy: Dilemma of the Individual in Public Services*, Russell Sage Foundation, New York, NY.

Little, J.W. (2003), "Constructions of teacher leadership in three periods of policy and reform activism", *School Leadership and Management*, Vol. 23 No. 4, pp. 401-419.

Mannion, R., Davies, H.T.O. and Marshall, M.N. (2005), "Cultural characteristics of 'high' and 'low' performing hospitals", *Journal of Health Organization and Management*, Vol. 19 No. 6, pp. 431-439.

Mintzberg, H. (1980), "Structure in 5's: a synthesis of the research on organization design", *Management Science*, Vol. 26 No. 3, pp. 322-341.

Muijs, D. and Harris, A. (2006), "Teacher led school improvement: teacher leadership in the UK", *Teaching and Teacher Education*, Vol. 22 No. 8, pp. 961-972.

Neath, A., Jones, J. and Buchanan, D. (2004), "Layers of leadership: hidden influencers of healthcare improvement", NHS Modernisation Agency Research into practice report, NHS Modernisation Agency, Leicester.

NHS Institute for Innovation and Improvement (2010), *Medical Leadership Competency Framework: Enhancing Engagement in Medical Leadership*, 3rd ed., NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, University of Warwick, Coventry.

NHS Institute for Innovation and Improvement (2011), *Clinical Leadership Competency Framework*, 3rd ed., NHS Institute for Innovation and Improvement, University of Warwick, Coventry.

Nicol, E.D. (2012), "Improving clinical leadership and management in the NHS", *Journal of Healthcare Leadership*, Vol. 4, August, pp. 59-69.

O'Reilly, D. and Reed, M. (2010), "'Leaderism': an evolution of managerialism in UK public service reform", *Public Administration*, Vol. 88 No. 4, pp. 960-978.

Øvretveit, J. (1996), "Medical participation in and leadership of quality programmes", *Journal of Management in Medicine*, Vol. 10 No. 5, pp. 21-28.

Øvretveit, J. (2009), *Leading Improvement Effectively: Review of Research*, The Health Foundation, London.

Sam, N. and Thomas, B.M. (2010), "A brief history of the NHS", in Stanton, E., Lemer, C. and Mountford, J. (Eds), *Clinical Leadership: Bridging the Divide*, Quay Books, London, pp. 27-37.

Scribner, J.P., Cockrell, K.S., Cockrell, D.H. and Valentine, J.W. (1999), "Creating professional communities in schools through organizational learning: an evaluation of a school improvement process", *Educational Administration Quarterly*, Vol. 35 No. 1, pp. 130-160.

Sebrant, U. (2008), "The impact of emotion and power relations on workplace learning", *Studies in the Education of Adults*, Vol. 40 No. 2, pp. 192-206.

Senge, P. (1990), *The Fifth Discipline: The Art and Science of the Learning Organization*, Doubleday, New York, NY.

Shale, S. (2008), "Managing the conflict between individual needs and group interests-ethical leadership in health care organizations", *The Keio Journal of Medicine*, Vol. 57 No. 1, pp. 37-44.

Shale, S. (2012), *Moral Leadership in Medicine: Building Ethical Healthcare Organisations*, Cambridge University Press, Cambridge.

Silva, D., Gimbert, B. and Nolan, J. (2000), "Sliding the doors: locking and unlocking possibilities for teacher leadership", *The Teachers College Record*, Vol. 102 No. 4, pp. 779-804.

Spillane, J.P. and Diamond, J.B. (2007), "Taking a distributed perspective", in Spillane, J.P. and Diamond, J.B. (Eds), *Distributed Leadership in Practice*, Teachers College Press, New York, NY, pp. 1-15.

Spillane, J.P., Diamond, J.B. and Jita, L. (2003), "Leading instruction: the distribution of leadership for instruction", *Journal of Curriculum Studies*, Vol. 35 No. 5, pp. 533-544.

Spurgeon, P. and Klaber, B. (2011), *Medical Leadership: A Practical Guide for Trainees & Tutors*, BPP Learning Media, London.

Srivastava, R. (2013), "Speaking up – when doctors navigate medical hierarchy", *New England Journal of Medicine*, Vol. 368 No. 4, pp. 302-305.

Stevenson, H. (2012), "Teacher leadership as intellectual leadership: creating spaces for alternative voices in the English school system", *Professional Development in Education*, Vol. 38 No. 2, pp. 345-360.

Tomlinson, S. (2001), *Education in a Post-Welfare Society*, Open University Press, Buckingham.

Weiner, B.J., Shortell, S.M. and Alexander, J. (1997), "Promoting clinical involvement in hospital quality improvement efforts: the effects of top management, board, and physician leadership", *Health Services Research*, Vol. 32 No. 4, p. 491.

Yendol, D., Gimbert, B. and Nolan, J. (2000), "Sliding the doors: locking and unlocking possibilities for teacher leadership", *Teachers College Record*, Vol. 102 No. 4, pp. 779-804.

York-Barr, J. and Duke, K. (2004), "What do we know about teacher leadership? Findings from two decades of scholarship", *Review of Educational Research*, Vol. 74 No. 3, pp. 255-316.

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