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UNDERGRADUATE LEADERSHIP EDUCATION

Commentary Paper

Undergraduate Leadership Education for Dentistry: Preparing for Practice

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Abstract

This paper seeks to explore the topic of leadership education in undergraduate dental programmes. 'Management and leadership' has been recognised as one of the four main domains in the UK General Dental Council 'Preparing for Practice' document and is identified in the ADEE 'Profile and Competences for the Graduating European Dentist' document under the domain of 'Professionalism'. Many dental schools throughout Europe are now planning for the inclusion of leadership education. Questions are therefore raised about how this might be envisaged: what should undergraduates be prepared for and how should it be done? This paper draws on emerging debates found within the wider, non-dental specific leadership studies literature that challenge traditionally held views of leadership and models of leadership education found currently in dentistry. It is argued that all students should be exposed to distributed and inclusive leadership practices to prepare them for the challenges they will find in their everyday practising careers. It is proposed that there is an opportunity to engage with dental practitioners (at all levels) to encourage the development of experiential, active learning to bring alive leadership in practice for dental students.

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Introduction

This paper seeks to explore undergraduate leadership education for dentistry and asks how we might prepare our students for the leadership challenges they will most likely face in their everyday practising lives. As more interest in this area develops, notably by dental regulatory bodies in Europe and further afield, dental educators need to consider how the design of educational approaches to this important subject may be evidence-based and pedagogically robust.

‘Leadership’ is, of course, not easily defined and this can cause difficulty when attempting to outline the scope and remit of leadership education for dentistry.

Leadership is generally seen to be about setting direction, influencing others and managing change (1). It has been represented in many different ways and we all have our own views about what good leadership looks like. These tend to be influenced by the dominant notion that it relates to the attributes and skills of an individual designated as a leader. There are however more distributed and inclusive understandings of leadership (2) which see it as a relationship or as a social process (3) and that it can be found in routine and mundane everyday working lives, not just at the top levels of large organisations.

What do we mean by leadership and what are the needs of *our* profession? This paper considers the leadership literature in dentistry and dental education and then looks towards the academic field of leadership and organisation studies to help us reconsider our assumptions.

Across professions, the focus of leadership education has, in the past, been to prepare select individuals for leadership roles outside of practice. There has been a focus on abstracted theory rather than the everyday challenges encountered by practitioners and there is a reliance on competency (tick the box) type education. Dentistry is guilty of these paradigms too and it is time to think anew.

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Leadership in dentistry

The discussion surrounding leadership in dentistry is relatively young. In the UK a number of empirical and opinion based papers have been published, predominantly in the British Dental Journal (BDJ), in the past four years. These papers outline the need for leadership to meet the reported challenges facing the dental profession as a whole: government spending policies, health service re-structuring, changes in service delivery and patient perceptions and expectations (4, 5, 6). High profile, UK government commissioned reports: The Darzi Report – High Quality Care for All: NHS The Next Stage Review (7) and in dentistry, The Steele Report – Review of NHS Dental Services in England (8) have helped to stimulate interest and debate. These reviews promote the importance of effective clinical leadership in improving patient care. Another drive for the interest in leadership is the need for dental professionals to be more directly involved in the commissioning and governance of care provision. General dental practitioners are now taking on roles for which many feel unprepared (5). There is therefore an emergent interest in thinking about how dentistry might benefit from better leadership.

As a starting point attempts have been made to identify what leadership in dentistry actually means, who should be involved and what it should do. Morison and McMullen (4) provide a useful overview of current issues and call for a number of developments:

- A rethink of the role that leadership plays in dentistry
- A need to outline the leadership requirements for the profession
- A need to involve the whole dental team
- The development of new approaches to leadership
- A need to develop leadership education at all levels

A number of different approaches to exploring the leadership in dentistry agenda have been adopted by researchers. Willcocks (6) presents an account of the general

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theories, found in mainstream leadership studies, to the dental audience. Personality traits, behavioural style, situational/ contingency theories and transformational leadership are explained. Brocklehurst et al. (5) explore clinical leadership in dentistry and outline their interpretation of developments in leadership theory: from what might be considered the attributes of a 'good leader' (charisma, intelligence, self-confidence) to processual leadership and a description of transformational leadership. As we explore later, such approaches constitute a conventional or traditional consideration of leadership theory. The UK NHS Clinical Leadership Competency Framework (9) is reproduced within their account and its proposed benefits promoted: a consistent approach and universal application to all members of the health-care team.

There is recognition that having effective leaders is essential for the future success of the profession. The 'key informant' research participants within Morison and McMullen's (4) study call for a need to identify potential leaders through education and training. There is seen to be a deficit of leaders within the profession and talk surrounds the need to identify and 'grow' (4) potential leaders.

In relation to undergraduate education, the regulatory body for dentistry in the UK, the General Dental Council (GDC), includes 'management and leadership' as one of four main domains (others are 'clinical', 'professionalism' and 'communication') in their 'Preparing for Practice' (10) document. This document outlines the competences that all UK dental schools must include in their curricula to allow GDC registration. Within the wider European context, the development of 'leadership in clinical dental practice' and 'leading the dental team' form part of the 'Professionalism' domain within the ADEE Profile and Competences for the European Dentist document (11), which demonstrates its perceived importance,

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internationally. Despite these prominent inclusions, there is scant consideration of leadership education in dentistry.

Emergent approaches to undergraduate leadership education can be found in US Dental Schools. One such example (12) describes a programme based around three main themes of knowledge, skills and inspiration. Leadership knowledge is delivered by guest speakers and the issue of a relevant textbook; skills include the practice of public speaking, 360° feedback competency, interaction with fellow students and leaders; inspiration is gained through listening to panel discussions, attendance at a dental association leadership institute and finally dinner with the Dean. These types of activities are found across many business school leadership programmes and are not necessarily designed for the needs of professionals.

It is possible to identify contrasting educational philosophy and delivery methods in two quoted examples in Table 1.

Table 1

Examples of leadership education models used undergraduate dental programmes

	Example 1	Example 2
Aims	“to empower dental and dental hygiene students to envision and promote cultural changes.... those willing to wrestle with global issues facing the dental profession”.	“to enhance the ability of graduates to face the ‘significant challenges’ every clinician and researcher will face within his or her practice with colleagues, staff and patients”
Admission	Selective process	All year 3 students
Requirement	Optional and extra-curricular	Compulsory

13, p.1511

Example one promotes leadership education as preparing selected and interested students to have impact on the world stage, whereas example two proposes that all students must be involved, with emphasis placed on the importance of ‘practice’.

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Student evaluation of these types of programmes is generally positive (14,15) and improvements in confidence, communication, organisational and influencing skills are reported. We shouldn't assume, however, that these reports are universal as negative student evaluations are rarely found in educational literature.

In addition, it is difficult to know whether these skills are translated into everyday general dental practice.

The fact that the majority of graduates work in general dental practice is considered a barrier to the development of leadership post graduation. This environment is apparently too isolated: *"the vast bulk of our profession don't really get exposed to the opportunity to become a leader"* (4, p.3). A self-reflective opinion paper published in the BDJ describes the need for dental professionals to *"get out of the surgery and into the Leadership Academy"* (16, p.222). It may be concluded from these assertions that leadership is only found outside general dental practice and that leadership education is not appropriate for those working in this context.

Interestingly this line is contradicted in Morison and McMullen's concluding remarks when they state: *"there is a need to help future dentists to deal effectively with everyday challenges occurring in a dental practice"* (4, p.5).

It is clear therefore that our profession is not yet sure of what we mean by leadership or leadership education: whom it is for and how we should be doing it.

In summary, this literature reveals some of the current assumptions in relation to leadership and leadership education in dentistry:

- That leadership is seen as a way to meet the many and varied challenges facing the dental profession as a whole
- That the application of conventional or traditional leadership theories is appropriate

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- That there are a number of leadership frameworks and competencies which form a 'regulatory mechanism'
- That there is uncertainty about educational philosophy: what leadership education aims to achieve and what pedagogical methods should be used
- That current examples of leadership programmes in dentistry are based on a generic business school model of leadership education
- That leadership education is not necessarily seen as relevant to those working at the coal face of dental practice

An alternative view

It is useful to look outside of dentistry to find alternatives to the prevailing views and assumptions of the profession. In this case, debates found in the academic field of leadership and organisation studies provide inspiration.

One of the main debates is about who should be involved in 'doing' leadership. The conventional or traditional leadership theories described earlier, it is argued, tend to focus on the distinctive features of individual leaders as being separate and removed from the rest (followers). There is an emerging move away from the individualistic view of leadership towards an understanding of leadership that is more distributed and inclusive where all members of an organisation are perceived to be part of leadership activities (2).

A classic paper by Smircich and Morgan (17) called for the "*dependency*" (p.259) of the traditional leader – follower relationship to be replaced with a "*leaderless*" (p.272) working approach. Rather than focusing on people in defined roles, whether it be as a leader or a follower, it is argued that we can find leadership in the activities and 'practices' that all members of the team take part in. Raelin argues that leadership is "*not an affirmation of the traits and heroics of individual actors, but a practice*" (18, p.4). Raelin defines 'practice' as "*a co-operative effort among participants to choose*

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through their own rules to achieve a distinctive outcome" (19, p.196). Leadership can therefore be considered as being formed by joint understandings and efforts rather than by individually driven actions.

Academics within the leadership studies field are becoming highly critical of leader-focused education. In a review of leadership development, Day (20) distinguishes between the development of 'human capital' as opposed to the development of 'social capital'. The former is about leader development in terms of individual capabilities (leader-focused approaches), the latter considers leadership, the development of interpersonal capabilities (more in line with the emergent leadership approaches described). They deride the aims of "*turning students into inspirational leaders, capable of impacting powerfully and positively on the world*" that is a common aim of many North American business school leadership programmes (21, p.3) and interestingly similar to an example in dental education quoted earlier.

Leadership is seen as something that is abstracted from the immediate working environment. Attendance on these programmes also tends to mean the removal of learners from their own immediate working environments to learn generalised and abstracted leadership skills (21). This decontextualised learning can mean that on return from these programmes they are unable to put much of what they have learned into practice (22).

These generalised and abstracted leadership skills are often formulated into 'competencies'. The UK NHS Clinical Leadership Competency Framework (9) described earlier is an example of this. Competencies can be described as being objective and measurable. Competency based education, based on these principles, are commonly used in dentistry and medicine. Carroll et al. (23, p.365) argue strongly against what they call the '*competency paradigm*' of leadership. In striving to achieve objectivism and measurable assessment of the individual, the collective and relational basis of leadership is overlooked. Denyer and Turnbull James report

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the literature as arguing that “*competencies impose structure, predictability, and constraint at the expense of vitality, life, originality, and distinctiveness that is inherent in leadership*” (24, p.263). The specific practices that are seen within each particular context are also neglected. Interestingly, in the case of the UK NHS Clinical Leadership Competency Framework, its design was based on self-reported data gathered from senior executives and directors yet is applied across all levels of the NHS (25). We need to be careful therefore in the application of competency frameworks as a means of assessment and question their direct relevance to the dental practice context.

Emerging approaches promote the view that leadership can be found in the ‘*everydayness*’ of organisational life, the mundane (26) and often overlooked aspects of leadership practices – what happens at the coal face. Carroll et al. (23) take the definition further, describing how, ‘Leadership-As-Practice’ approaches focus on the routine and mundane occurrences of everyday organisational life – “*the where, when, how and why leadership is done*” (18, p.4). This is in contrast to the traditional approach of seeing leadership as something that is done by individuals only at the highest levels of an organisation.

The ‘*everydayness*’ of leadership and the activities or ‘*practices*’ found here are, of course, extremely variable across different working environments: professions, organisations and workplaces. ‘Leadership-As-Practice’ is seen as being context specific and may therefore be seen as being more valuable and relevant than some of the ‘*generalised*’ and ‘*decontextualised*’ leadership theory that is taught in many leadership development programmes. Leadership-As-Practice offers what has been described as a ‘*bridge*’ (27) between practice and theory. It presents an opportunity to engage with practitioners at a deeper and more meaningful level in considering the ‘*real-world*’ (27) of leadership as it happens in context.

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Leadership education seen with this 'practice' perspective is more experiential where relationships, context and lived experience are brought out. Rather than developing a set of skills or tools in order to pass pre-defined competencies, it is about the use of experiential learning to develop a deeper understanding of how leadership may be found in the collective activities of everyday working life (28).

There are of course challenges and limitations as to how dental educators, situated within dental schools, may successfully produce practice- relevant education. It is here that there is scope to involve and engage dental practitioners, those working predominantly in the practice environment, in the design of leadership education.

The involvement of general practitioners in the design of curricula and the development of teaching materials is rarely seen in dentistry. The collaboration between dental educators and practitioners therefore presents a novel opportunity to develop better informed, practice relevant and pedagogically robust leadership education for dentistry. The authors are currently engaged in exactly this sort of developmental work.

'Leaderless' and 'practice' approaches therefore present an alternative to the theories and educational philosophy that have been applied previously. In looking towards the future, there are some considerations for those involved in planning the inclusion of leadership education within undergraduate dental curricula:

- That effective leadership is best achieved through distributed and inclusive leadership practices rather than exclusively by individuals in designated leadership roles
- That leadership can be found in the 'everydayness' of practice life and that leadership education should not be abstracted from this environment
- That learning outcomes need to be better defined with a clear focus on the needs of practitioners

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- To be mindful that generic business school models of leadership education do not take account of the specific needs of the dental context
- That whilst leadership competency frameworks provide a regulatory model, they can bind and limit the real values inherent in leadership
- That all students should be exposed to leadership education rather than it being limited to selected students or being optional
- That there is opportunity to engage with practitioners to encourage the development of experiential 'real world' learning

Conclusion

This review has asked; what do we mean by leadership and what are the needs of *our* profession? How should we prepare our students for the leadership challenges they will face in their careers? As we have found, it is not entirely clear that we know the answers and that there are contrasting views. The general perception is that better leadership might help to address the growing challenges that the profession faces and that 'growing' leaders is an important part of the solution. In looking towards debates shaping leadership education outside of dentistry it can be seen that the emphasis on individuals as leaders rather than on inclusive leadership practices is becoming outdated and that traditional business school type models cannot provide the contextualised, experiential learning that students require to help them in their practicing careers.

There is an opportunity now to think about the development of leadership education for dentistry. There is a need to involve practitioners (at all levels) in defining learning outcomes, based around their experiences of practice life and involving them in designing experiential, active learning to bring leadership alive for the next generation of dental professionals.

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