An autoethnographic case study of opening a new medical school in the United Kingdom

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Dedication and Thanks

I dedicate this thesis to the individuals who have been the cornerstone of my journey.

To my beloved husband, Daniel, your support has been key to my determination to complete this work. Your encouragement and patience sustained me through the peaks and valleys of the past six years. Your belief in my abilities propelled me forward when self-doubt and external events threatened to derail me.

To our children, Riley and Lucien, you are the heart of my inspiration. Your laughter and joy in life echoed through the late nights, reminding me of the purpose behind the long hours and sacrifices. Your resilience bolstered my own, and your tolerance of my absences was humbling. Your endless curiosity drove me to conduct my own exploration of the world.

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This thesis stands as a testament to the collective effort of my husband, children, supervisors, colleagues, and collaborators. Your influence has left an indelible mark on this academic odyssey, and for that, I am profoundly grateful.

CGH, Canterbury, UK. November 2023.

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Abstract

This Research Based Thesis (RBT) for the award of an EdD is an autoethnographic piece of research which concerns my role as the Founding Dean of a new UK medical between the years of 2018 and 2023.

Background: Opening a new medical school is not a common event in the UK, and little direct evidence about how best to lead endeavours such as this successfully has emerged from other schools that have recently opened. The current evidence is dispersed and disparate. It is highly likely that more new schools will open soon and that this will create new career opportunities for medical educators. Management theories and theories of change management are not always easy to situate in medical education because medical schools have a specific social, moral, professional and vocational purpose as well as a tertiary education purpose. A lot of what has been written by individual medical school leaders has been written in a personal capacity and is not grounded in a scholarly framework.

Methodology: I have used a theory of change leadership in education (Fullan, 2020) to provide the structure for this thesis and my autoethnographic method. I have captured several events which led to epiphanies in my understanding of change leadership and situated these in Fullan's theory. The research draws on a wide range of events and phenomena to reflect the scope of my role, and the large number of stakeholders (institutional and individual) with which I had to interact and incorporates a range of other theories relating to each phenomenon.

Results: The autoethnographic method resulted in new understandings and new perspectives of change leadership in medical education. I was able to compare my perspectives with established theory and build on this to arrive at new conclusions. The work offers a holistic analysis of many of the phenomena associated with opening a new medical school.

Discussion and Conclusions: This single-site, field study of an exceptional occurrence used an uncommon research method in leadership research and produced insights that are relevant for other, similar situations. Change leadership in education relies on successful

social interactions as well as rigorous application of process and management approaches. Every leader's behaviours are influenced by their own personal characteristics, and my methodology also allowed me to consider and contextualise this during the research. This RBT has produced novel insights into the journey of leadership involved with opening a new medical school and highlighted some of the biggest challenges that new medical school deans may face. Some of the successes may be applicable elsewhere, the mistakes I made may also offer opportunities from which others may learn.

Part 1: Getting my bearings

1. Introduction

This Research Based Thesis (RBT) is a personal and scholarly recounting of my leadership of Kent and Medway Medical School (KMMS) during the period 2018 to 2023. In September 2018 I was appointed Founding Dean of Kent and Medway Medical School (KMMS), a new medical school formed as a partnership between two universities in Canterbury – the University of Kent (Kent) and Canterbury Christ Church University (CCCU). This has resulted in some of the most cathartic experiences of my professional life, including some of the very best and some of the worst. There is no manual for how to open or lead a new medical school and I have deployed all my existing leadership skills, not always effectively, and acquired many new ones over the past 5 years. This RBT will focus on some of my critical experiences and analyse some of the implications of these in the hope that they will prove useful for other leaders in medical education.

Context, opportunity and scope

My professional background is in clinical medicine, I qualified in 1997 and am a practising National Health Service (NHS) Consultant in Adult General Intensive Care. I am dual accredited in both Intensive Care Medicine (ICM) and Anaesthetics. During my time as a Doctor, Evidence Based Medicine (EBM) (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996) has become a paradigm of contemporary clinical practice, and my clinical specialties are very grounded in the biomedical sciences and quantitative research. The natural assumption might be that I would have a cultural and personal predisposition towards some sort of quantitative study, or some other methodology which will produce practical and immediate results. This RBT does not follow that assumption.

I became a Consultant soon after completing my Master in Medical Education programme and I forged a portfolio career in ICM and medical education. I became involved with a post-graduate taught (PGT) programme in clinical education and then I was appointed to the position of Deputy Head of Phase 3 of an undergraduate medicine programme at Guy's, King's and St Thomas' School of Medical Education (GKT SoME). The programme was poorly evaluated in the National Student Survey (NSS) at the time, and I was part of a curriculum renewal process at a senior level. After this, I was made Deputy Dean and

became active in the national and international medical education community through roles with regulators, professional bodies and the community of medical educators who became my colleagues and friends. While my career developed and I participated in a diverse range of activities at a variety of senior levels, I formed several perceptions of the medical education community (Box 1).

Just these five personal observations of the medical education community mean that it feels challenging for a novice or an outsider to formulate a coherent picture of the cultural norms of the community and therefore to enter, join and navigate it. Given that the purpose of this community is to educate and to improve the education of a key component of the healthcare workforce, that is doctors, this represented a dissonance for me personally as well as professionally.

1. The medical education community is made up of a diaspora of individuals with and without medical or healthcare qualifications, and it includes many social scientists as well as individuals with a clinical and biosciences pedigree.
2. There is a natural affinity for positivist and data-driven evidence and practice in this community, which is not to say that it excludes other paradigms of research and evidence.
3. There is no consensus about what constitutes good leadership in medical education, nor is the growing evidence-base for what constitutes good leadership in other disciplines well-known or discussed within the community.
4. There are many people who wish to have a substantial career in medical education, but they have limited advice, opportunities and programmes of development available to them. This means that the routes to leadership positions in medical education are often idiosyncratic. This has resulted in a lack of a shared knowledge to support informed debate and discourse in the field.
5. While there is a universal and shared desire to improve healthcare education so that healthcare outcomes and patient experience are improved, a career in education is not always perceived to be a viable route to prestige and prominence in the healthcare professions.

Box 1: My perceptions of the culture of the medical education community

Why do a Professional Doctorate?

In 2015, three years before I was appointed to my role at KMMS and started this RBT, I made the decision to enrol in a professional doctorate (PD) programme in education (Box 2).

I felt that a PD would enhance my personal expertise in the academic grounding of my discipline, it would enhance my credibility in the eclectic community of which I was now a member, and it would further my career opportunities in the future. I reflected on the aspects of my master's programme I most enjoyed and what it was about the portfolio career I had constructed I valued most. I realised that I enjoyed analysing and reflecting on my own personal context and situation and then seeking expertise, evidence and

experiences which could inform adjustments and improvements to my practice. This is a personal characteristic which was highlighted in something called a Hogan Personality Inventory™ (Hogan & Hogan, 2007) which I took in 2020 (Appendix 1), and to which I will return in Chapter 10. I felt that a PD would offer the opportunity to integrate everything that I was doing. I also hoped that there would be synergies in my activities which would support the time-management challenges of taking on this programme of part-time study.

- Purpose – PDs aim to develop the capacity to make a significant original contribution to professional practice through research. They are targeted at experienced professionals and practitioners working in a professional context and, therefore, are a research-based element of professional training and/or development of practitioners.
- Research focus – The research within a PD directly relates to, and is rooted in, the professional practice of the candidate, and its output should not only contribute to knowledge but have a significant impact on professional practice.
- Structure – PD programmes are more structured than many PhD programmes, with taught components as well as supervised and cohort-based experiences. However, this distinction is reducing with the development of other structured doctoral programmes, especially collaborative and cohort-based doctoral training programmes.

Box 2: Characteristics of PDs described by Careers Research and Advisory Centre (CRAC) (Mellors-Bourne, Robinson, & Metcalfe, 2016, pp. iii-iv)

A PD is intended to be grounded in the ongoing professional activities of the scholar and I completed the first two years of the programme with the same approach to my studies that I used for my master's. By Autumn 2017 I expected to continue to the final stage of the programme and conduct a piece of educational research predicated on my work at GKT SoME. In Spring/Summer 2017 I applied for a new job, and it completely disrupted my portfolio of activities when I was (happily) successful and appointed to a new role at a new university. I felt a pause in my studies was necessary to allow for a period of stabilisation,

and to evaluate what I would focus on for the next stage of my PD. Any semblance of emerging stability was shattered when the project to which I had moved was stopped and I needed to look for another new job. Thankfully, I found my current role and started in September 2018. This role offered the incredible opportunity to lead the creation and opening of a new medical school. It therefore seemed natural to base my RBT in this unique opportunity and professional activity. After a second period of interruption, I began to think about how I could use this to collect the source material for my RBT.

Medical storytelling

Doctors have been telling stories since ancient times. Charon (2006) describes how these stories have fulfilled many purposes over the millennia: to achieve better understanding of the doctor-patient conversation, to share knowledge and expertise with other practitioners, to recover from the traumatic experiences of clinical practice, or to give testimony about what we have done and to bear witness to the suffering of others. Doctors also listen to our patients' stories for diagnostic and therapeutic purposes, and we tell them stories in return to aid their understanding, improve their compliance with therapy, or acceptance of their condition. Despite our affinity for such a non-empirical behaviour, Charon argues that medicine continues to be vexed by failures that are due to its "relentless positivism, its damaging reductionism, its appeal to the sciences and not the humanities in the academy and its wholesale refusal to take into account the human dimensions of illness and healing." (pp. 192-193). In my own clinical practice, I agree that we can lose sight of the person, suffering, amid all that we inflict upon them.

Possibly the most well-known story about medical education for my generation is House of God (Shem, 2009), a more recent story which attracted widespread attention in the UK is Adam Kay's (2017) account of being a junior doctor in London. When it became time to begin the RBT part of my PD I decided that I wanted to tell my own story of transitioning into my role as KMMS. Goffman (1971) famously wrote of the problems of the 'dramatization' of the self in the moment of action. To produce a meaningful story that would be useful to others I was clearly going to have to produce an exposing piece of work. I thought that nothing too painful would come to light. I parsed the timeline of opening KMMS and thought I would only focus on my first year of leadership and initial

bedding into my new role. In the Spring of 2020, I agreed a third period of interruption from my EdD so that I could focus on the task of opening the medical school in the context of a pandemic and contribute to the NHS response to COVID-19. I returned to the programme and my RBT in October 2020, by which time the medical school had opened, I had not taken any leave for nearly 12 months, and the country was entering its second national lockdown. As I am writing these particular words, the UK has just started its third national lockdown and the NHS is facing a surge in patients that may be worse than the first surge in 2019.

Concluding reflections

In this introductory chapter I have described some of my personal context as a practising medical professional and an educational leader. My clinical specialty is very strongly influenced by a biophysical medical model that prioritises positivist and quantitative theory and research. While this is hugely powerful in helping to answer some important questions, it does not adequately reflect my own experience of being a leader concerned with culture and organisational change, nor does it suit my personal affinity for contemporary, person-centred, biopsychosocial models of care (Engel, 1977). I have outlined how I reached a stage in my career where I wanted the challenge of undertaking a piece of doctoral work. I chose a PD because I wanted to do this alongside, and reflexively to, my professional context as an educational leader. By the time I reached the RBT stage I was leading a project that I was very personally invested in, and it was important to me to use this opportunity to catalyse my own personal and professional growth and to produce something which would have utility as a story for future educational leaders.

2. Archetypes of research in education and leadership

In this chapter I shall review some of the major paradigms of research in education and leadership as well as educational leadership. I will also summarise the cultural context of some of the published literature concerning leadership in new medical schools.

Qualitative Research Methodologies

While quantitative research simplifies and codifies the phenomenon under investigation, it ignores and does not interrogate complex, often social, inter-relationships. The development of qualitative research methodologies in the 20th century marked a significant evolution in the field of social sciences, driven by a shift in focus from positivist to interpretivist paradigms. At the turn of the 19th Century, qualitative research began to gain prominence as scholars questioned the applicability of quantitative methods to social phenomena. Influential early figures included Max Weber (1949) and Georg Simmel (1950), whose work emphasized *verstehen* (understanding) and the importance of subjective meaning in social analysis. Weber's interpretive sociology laid the groundwork for later qualitative methods by advocating for the study of social action through the subjective meanings individuals attach to their actions. In the subsequent decades, particularly in the 1920s and 1930s, what became known as The Chicago School of Sociology was instrumental in further advancing qualitative research. Pioneers like Park and Burgess (1969), developed methods such as participant observation, in-depth interviews, and case studies to explore urban sociology and social interactions. Blumer's (1969) symbolic interactionism further refined these methods, focusing on the symbols and meanings individuals create and negotiate within their social worlds. After the Second World War other disciplines began to adopt qualitative research methodologies, and this brought about further diversification and the development of methodologies such as phenomenology and ethnomethodology. Schutz's (1967) phenomenological sociology emphasized the importance of subjective experience and the life-world concept, which later influenced methods like narrative analysis and life history research. Garfinkel's (1967) ethnomethodology introduced the study of everyday social interactions and the methods people use to construct social order, leading to innovative techniques

such as conversational analysis. Glaser and Strauss (1967) developed Grounded Theory, which provided a systematic framework for data collection and analysis, emphasizing the generation of theory from data. There also followed an increased focus on the rigor and validity of qualitative research, with scholars like Lincoln and Guba (1985) introducing criteria for trustworthiness and authenticity.

Fred Nichols Kerlinger was one of the most prominent methodologists in behavioural research in the latter half of the 20th Century. Kerlinger (1986) described four categories of research:

1. Laboratory experiments
2. Field experiments
3. Field studies
4. Survey studies

His taxonomy is incomplete, for example it does not include methodologies such as historical studies or policy analysis, demonstrating that paradigms of research can evolve over time. The utility of Kerlinger's taxonomy is the way in which it considers where the research is occurring (in a laboratory, in the field or by means of a survey) and whether the research is an "experiment" or a "study". Experiments are useful for studying the interactions of variables which may be independent and co-occurring or dependent and correlated, but they may not always be externally valid, and it can be difficult to design experiments which address this. Studies are non-experimental and attempt to identify variables and their inter-relationship. This is also the inherent weakness of studies - researchers have no control over independent variables so the variance in outcome measures cannot be explained. The risk of studies is that researchers or their audience may conflate correlation with causation. This is an even greater risk of studies that gather data using a survey methodology. Kerlinger's classification privileged quantitative research over qualitative research because the classification framed the act of conducting research in ways which suggested that the more objective, statistically controlled and reproducible the phenomenon and accrued data could be the better the resulting analysis.

Late in the 20th Century, reflexivity and postmodern critiques came to the forefront of qualitative research. Reflexivity, the practice of reflecting on one's positionality and impact on the research process, became a cornerstone of qualitative methodologies. This period also saw the influence of postmodernism, a multifaceted concept that challenges traditional notions of objective reality and universal truths. Postmodernism is characterized by a deep scepticism of grand narratives and ideologies, emphasizing instead the subjective and socially constructed nature of knowledge and reality. Scholars such as Geertz (1973) advocated for thick description and emphasized the importance of context and interpretation in understanding social phenomena. While Foucault (1983) developed what he called the genealogical method, which involved tracing the historical development of social practices and institutions. This has been widely adopted in sociological research and helps sociologists to uncover the contingent and constructed nature of social phenomena, revealing how knowledge and power are intertwined in the creation of social reality. Creswell (1994) described four types of qualitative research which are commonly recognised in the postmodern era:

1. Ethnography and anthropology: describing a society by means of data collected during practical field work.
2. Grounded theory: deducing generalisable theory from specific data.
3. Case studies: deliberate and deep scrutiny of data derived from a single, or a small number of, real-world events which demonstrate a specific phenomenon[1].
4. Phenomenological studies such as action research: cooperative interaction between research participants to focus on a specific problem with a view to proposing improvements.

By the end of the Century Baker and Keogh (1995) felt that an analysis of a single, complex, social interaction which seemed to serve no purpose invited, if not demanded, the use of ethnomethodological inquiry.

[1] Case Reports are a common and accepted feature of many professional publications and whole journals are devoted to the publishing of patient-centered medical case reports that are deemed of substantial novel learning value for practitioners.

These varied research methods utilise myriad forms of data, for example, narrative (spoken or written), visual, audible and more. Researchers collect this data by conducting what Kerlinger (1986) would call field studies involving formal interviews, semi-structured interviews, serendipitous observations and participation, performance, artistic and 1-to-1 or group interviews, moderated or not. Silverman (2007, p. 61) describes how one of the key distinguishing features of any type of qualitative data is whether it is derived from a set of instances triggered by the researcher, for example, a researcher-led focus group, or a sequence of events within which the researcher has deliberately located themself, for example by immersing themselves in a specific environment. From the perspective of a field researcher, the major disadvantage of the triggered approach is that it treats the phenomenon discussed in the focus group abstractly, because it is not directly observed by the researcher. Alternatively, by observing naturally occurring events, the researcher can witness the phenomenon directly and make a more informed analysis of how the inputs and context of the phenomenon affect the resulting output.

The utility and utilisation of Creswell's categories (1994) has evolved over time and the conceptualisation of many qualitative methodologies has been reframed. Often this has been an iterative response to the methodologies being applied to ever more diverse situations. For example, van der Meide's (2018) more recent description of phenomenology describes it as an integrative philosophy which directly contrasts with Western scientific thinking because it aims to intertwine polarities such as mind and body or the individual and society which we each individually experience and from which we each construct a personal "lifeworld" (p. 267) based on our analyses of these contextualised experiences.

Challengers to qualitative methodologies have raised concerns about the ambiguity of the various approaches, alleged ethical laxity, the subjective merging of perception and reality, the glamour of novelty, the unreliability of selective or even haphazard descriptions provided by witnesses and the idealisation of fieldwork. Qualitative research also often seems to take quite a lot longer than quantitative research to produce results, and this may be true but may be influenced by the fact that the researchers themselves don't always know when they are finished (Sparkes, 2018). Silverman (2007) cautions

qualitative and mixed-methods researchers that an urgency for practical results, one of Kerlinger's myths, can lead to the dangerous trap of explanatory orthodoxy. Attempts to shorten the time it takes for qualitative researchers to collect data and produce useful output have resulted in data collection methods such as focus groups and exploratory interview studies, but faster data collection still requires thoughtful data analysis. If researchers and those that commission research, make too hasty a rush to an explanation without asking more searching questions about what has been observed then researchers can be tempted to use methods of analysis such as pairing data collected from structured, researcher-led instances with quantifiable population characteristics, such as gender, race, age etc. These can quickly produce statistical associations which may appear to explain the association but miss the complex nature of the behavioural inter-relationships underlying the phenomenon[2].

Qualitative Methods in Leadership Research

Contemporary research in leadership studies also encompasses a wide range of methodologies, each with its own strengths and limitations. Wren (1995, p. X) highlights that the complexity of leadership means that "…because the issues relating to leadership cut across all types of human activity and thought, true understanding of such a complex phenomenon requires a broadly conceived approach.". In fact, leadership research is so complex, contextual and phenomenological that Northouse (2013) required 15 different categories of leadership research in his taxonomy, rendering it what Argyris (2000, p. 37) calls "non-actionable" as a coherent classification.

Stentz et al reviewed current practices in leadership research, and found that of 1179 articles published in a single pre-eminent journal, *The Leadership Quarterly*, between 1990 and 2021, 65% were non-empirical, and of the other 35% (approx. 412 articles) 27% were quantitative, 3% were qualitative and 5% were "potentially" mixed methods (p. 1178). In their opinion this supported the general impression that quantitative methods informed much of what was currently understood about leadership. Antonakis et al. (2004, pp. 57-59) reviewed the sorts of research methodology that could be used in different fora,

[2] See Appendix 2 for an example from healthcare of how qualitative research completely reframed an issue and suggested an adaptive solution rather than a technical one.

analysing the merits and demerits of how different methods performed and expanded Kerlinger's (1986) taxonomy by adding participatory action research to the taxonomy. They described how in leadership research experimental data is mostly obtained by one of the following means:

1. Case Studies: in-depth examinations of one or a few individuals or organizations. Researchers collect and analyse a variety of data sources, such as documents, interviews, and observations, to gain a comprehensive understanding of leadership within a specific context.
2. Content Analysis: systematic examination of written or verbal materials, such as speeches, texts, or communication within organizations, to identify themes, patterns, and trends related to leadership.
3. Interviews: open-ended, in-depth conversations with participants to explore their experiences, perspectives, and insights related to leadership. Semi-structured interviews allow for flexibility in questioning and can provide rich, detailed information.
4. Observational Studies: direct observation of leaders in various contexts to study their behaviours, decision-making processes, and interactions with followers. This method can provide valuable insights into leadership in real-world settings.
5. Surveys and Questionnaires: structured sets of questions that are administered to participants to gather data on leadership practices, behaviours, and perceptions and the responses are then analysed statistically. This approach is useful for obtaining large amounts of quantitative data.

The following methods of data collection were used more rarely:

1. Ethnography: immersive fieldwork in a particular cultural or organizational context to understand leadership practices and dynamics within that context. Researchers often participate in the daily life of the group they are studying.
2. Longitudinal Studies: track leadership development and changes over time. Researchers collect data at multiple points in time to examine how leadership behaviours, styles, and effectiveness evolve.

3. Neuroscientific Methods: functional magnetic resonance imaging (fMRI) and electroencephalography (EEG), can be used to study the neural processes underlying leadership behaviours, decision-making, and social interactions.

In their opinion, quantitative research of low quality was more likely to be published than qualitative research studying "contextually rich and holistically embedded phenomena" (p. 54). Which is a shame, because Chang (2008) is one of many methodologists who suggest that the qualitative researcher can offer lines of enquiry that might elucidate causation in evidence- and theory-poor situations. Stentz et al. (2012) suggested that the field of leadership research was moving to a more equal use of quantitative and qualitative methods. When they compared their findings in 2012 to an earlier study in the same journal which also looked at trends in the mix of articles published by *The Leadership Quarterly* (Gardner, Lowe, Moss, Mahoney, & Cogliser, 2010), qualitative research was increasing in frequency in the literature, often in the form of mixed methods methodologies. Antonakis et al. (2004, p. 54) suggested that a move to more qualitative research in leadership research was being driven by an increasing recognition that leadership is a complex phenomenon and how strongly affected leaders are by their context. Echoing Wren's (1995) comments, the complex and socially situated nature of leadership with many influencing variables means that it is difficult to study leadership in ways that strictly follow the empirical, positivist and quantitative scientific model. Despite their clear preference for quantitative methodologies, and just like the behavioural researchers Kerlinger (1986) criticised, Antonakis et al. (2004) felt that leadership researchers were not always using quantitative methods properly and degrading the quality of their research as a result. This was consequentially leaving the literature littered with examples of unhelpful research. They distinguished between certain strengths of both approaches and proposed that the strengths of qualitative methods were in theory-generation, while quantitative methods were particularly useful for theory testing. Their description of leadership and the reasons why it is a challenging phenomenon to research will also resonate strongly with educational researchers. Bohl (2019) recognised an ongoing conceptual dichotomy of leadership as the behaviour and actions of a single individual, or a complex social phenomenon involving multiple participants. He critiqued

traditional leader-centric models for their limited scope and suggested that this was a function of the search for reductive, objective and quantifiable "units of measurement" (p. 283) in early research that could be used to analyse this complex aspect of human behaviour. Sutherland (2018) explored the underrepresentation of ethnographic methodologies in Leadership Studies, and the ongoing dominance of positivistic approaches. He critiqued the existing quantitative and qualitative research methods for their lack of nuanced understanding of the complexities of leadership in action. Sutherland's ethnographic investigation illustrated how leadership is performed through argumentation, negotiation, and framing within cultural contexts. The study emphasized the importance of understanding both intersubjective interactions and the broader Discourses that shape organizational life.

Qualitative Research Methods in Education

The debate between the superiority of quantitative and qualitative research methods in education has also been a longstanding and multifaceted one which continues to this day. As a methodologist, Kerlinger was perpetually hopeful that educators would, in his view, improve their research practices. He maintained that research should be designed to ensure that the research question is answered and it should be internally and externally valid (Kerlinger, 1986). He described six myths of educational research (Kerlinger, 1960) which seem to be equally applicable to many of the current practices in both educational and leadership research:

1. Methods: simply "gathering data constitutes research"(p. 149).
2. Statistics: a disregard for statistics as a research tool and a failure to understand the relationship between research design and statistical analysis (Daniel, 1997, p. 104).
3. Measurement: the primacy of evidence, data and facts over "the systemic testing of theoretical and hypothetical propositions" (Kerlinger, 1960, p. 150).
4. Practicality: an assumption that "the purpose of research is to increase knowledge so that… practices can be … improved" (p. 150).
5. Educational research is special and different: this was "the deeper disease of educational thinking, … ignorance, practicality and anti-intellectualism" (p. 151).

6. Action research etc: the development and use of research methods that enhance their legitimacy by the superfluous gathering and use of data and facts so that they meet the requirements of methods-orientated research practitioners.

Kerlinger felt that the methods myth was the most significant in "distorting the research thinking of educators and students of education" (1960, p. 149). Nearly 40 years later, Daniel (1997) reviewed what progress had been made in addressing Kerlinger's methods, practicality and statistics myths. He felt that some progress was visible in ensuring that research design for educational research was being carefully considered to ensure that data was collected in an intelligent and informed manner. Disappointingly, he felt that researchers were focussed on delivering immediate and measurable results but noted that policymakers often demanded immediate results to justify their expenditure of public resource on research. Something which Lincoln and Guba (1985) argued might also be a significant factor influencing publishing choices in the field of leadership research.

Nevertheless, qualitative research methodologies in education have evolved significantly, navigating through various debates, challenges, and advancements. The intrinsic flexibility of qualitative research has supported deeper understanding of the cultural, social, political, and moral phenomena within educational contexts. Sherman and Webb (1988) laid foundational insights into qualitative methodologies in education, focusing on the methods and approaches specific to educational contexts. More recently, authors such as Lichtman (2023) have emphasized virtual and digital data collection techniques, which have become increasingly relevant in today's research environment.

Guba and Lincoln (1994) explored the notion that the fundamental differences in qualitative and quantitative paradigms makes it challenging to reconcile the different methodologies, and emphasized that both have their own strengths depending on the research context and objectives. Cooley (2013) discussed the ascent of qualitative methods in social sciences and their impact on educational research, suggesting strategies to enhance the relevance and impact of qualitative work on educational policies to meet the demands of equality and social justice. Zhou (2022) saw a complementarity in qualitative and quantitative methods and their synergistic utility in educational research. They advocated for an integrated approach called Qualitative

Comparative Analysis (QCA) (Ragin, 1987), which combines the depth of qualitative insights with the generalizability of quantitative data. Ponce (2021) added to this discussion by examining these paradigm wars and the inherent limitations of quantitative methods in capturing the subjective and contextual elements of education, thus arguing for the necessity of qualitative methods. Ponce, Gómez-Galán, and Pagán-Maldonado (2022) revisited these historical debates and underscored the resilience and evolving legitimacy of qualitative research despite political and funding challenges. Qualitative research in education is now considered a legitimate model of scholarly research methodology (Baker & Keogh, 1995; Ponce et al., 2022).

Ethnographic methods have a significant tradition in education research and have been used to great effect in medical education research for at least the past 50 years. Atkinson and Pugsley (2005) describe some ways in which ethnographic methods have been used to study medical student life, including what are probably the two most well-known: Boys in White (Becker, Geer, Hughes, & Strauss, 1977) from Chicago and Making Doctors (Sinclair, 1997), based in London. Atkinson and Pugsley's examples are all anglophone, majority white and male, but medical education ethnographies are starting to use this powerful methodology to tell the stories of non-majority others as well, for example Bintley (2023) used a qualitative, narrative ethnography to research the lived experiences of LGBTQ+ medical students in the UK.

Overall, qualitative research in education has demonstrated resilience and adaptability. It has shifted from being a subject of debate to a robust, flexible methodology that addresses complex educational issues. This evolution is marked by a growing acceptance and integration of qualitative approaches in policy-making and educational reforms, ensuring that diverse voices and perspectives are acknowledged and addressed.

Qualitative Research Methods in Educational Leadership

As in other disciplines, the qualitative methodologies used in research into educational leadership since 1990 have evolved continuously, with researchers focusing on various aspects of leadership, including instructional, transformational, distributed, and ethical leadership. These studies have underscored the critical role of leaders in fostering effective learning environments and leading innovative change. Hallinger and Heck (1998)

reviewed positivist, empirical research concerning the impact that a Principal's leadership had on their school's effectiveness published between 1980 and 1995. They found that Principals only had a small, measurable and indirect effect, but that the methodologies used to investigate the issue were simplistic and produced results of limited reliability and validity. Encouragingly they noted an increase in the use of more sophisticated methodologies; quantitative, qualitative and a blend of the two paradigms.

Schlechty (1990), an American sociologist, provided a comprehensive guide on leadership imperatives necessary for educational reform, drawing on concepts from marketing and business to analyse change processes. He aimed to equip educational leaders with strategies for effective school restructuring and adopted an early neoliberal stance on what was required to prepare American public-school students for work in the 21st Century. At around the same time, Fullan and Hargreaves (1992) explored the relationship between teacher development and educational change, highlighting the importance of the professional growth of educators and the concept of continuous learning for successful school reform. They divided the period since 1975 into two phases, and noticed the same sort of evolution as Hallinger and Heck (1998), with research initially focussing on the relationship between teacher development and successful innovation, before moving to a more holistic evaluation of the complete teacher and entire school. This evaluation of the complete teacher-school interaction coincided with a resurgence of interest in the teacher-research and practitioner-enquiry movement. This coalesced from four approaches to educational research: the efficacy of research undertaken by teachers themselves, the participation of teachers in research as social action, the emergence of progressive education as a social responsibility of teachers to co-create solutions with students, and a counter-reaction to the hegemony of a university-generated knowledge base for teaching (Cochran-Smith & Lytle, 1999). The resulting discourse emphasized the role of teacher research in professional development and its impact on school reform.

Leithwood (1992)and Leithwood and Jantzi (2005) explored transformational leadership within educational settings, noting its influence on organizational change and teacher motivation. They identified key behaviours of transformational leaders, such as setting high expectations and providing intellectual stimulation. Spillane, Halverson, and

Diamond (2001) described an immersed, grounded, situated and longitudinal approach that they called a distributed perspective to study school leadership practices. They focused on leadership as a set of practices distributed across various individuals, such as other leaders and followers, and contexts, such as artifacts, tools and language, within the school environment.

Three reviews, published in quick succession (Harris, 2004; Leithwood, Louis, Anderson, & Wahlstrom, 2004; York-Barr & Duke, 2004) described how, within a few years, this approach had identified a vison of leadership also described as distributed, especially when the task to be performed is complex and the organisation is knowledge intensive. This approach seemed to bring benefits from shared leadership responsibilities, but required leaders to appreciate the importance of collaborative decision-making processes. Leithwood et al. (2004) found that good leadership in educational environments is "second only to teaching in its impact on student learning" (DeVita, 2004, p. 3) and identified effective leadership practices that contribute to student achievement. They also emphasised the role of distributed leadership and the importance of fostering a collaborative school culture. York-Barr and Duke (2004) identified the critical role that teacher leadership has in both school improvement and student learning. They emphasized the need for structures that support teacher leadership and professional development.

Distributed and transformational leadership emerged as counterpoints to the more longstanding concept of Instructional Leadership; leaders who are strong, directive and goal-orientated with high standards and who lead schools where a greater proportion of students succeed despite the odds. Hallinger (2005) reviewed the enduring significance of this approach in education. He described how the concept of instructional leadership underscored the transformation of schools into learning-centred environments and the idea that a principal has a pivotal role in fostering instructional quality. Hallinger (2005); Hallinger and Heck (1998) highlighted that this approach requires principals to engage deeply with the detail of teaching practices and curriculum development. Robinson, Lloyd, and Rowe (2008) used a comparative meta-analysis methodology to reconcile these leadership styles. They recorded at least one quantifiable effect size statistic for 27

included studies. When they used these to analyse the varying impacts of different leadership styles on student outcomes, they concluded that instructional leadership had a more significant positive effect compared to transformational leadership.

While investigating the impact of education leaders had on the compassion and social justice of their educational establishments, Theoharis (2007) used a blend of empiric, ethnographic and autoethnographic methods to propose a theory of social justice leadership in education. He examined how leaders address inequality and promote inclusive practices, drawing on his own enthusiasm for the works of Freire (1993) and his personal motivations to enact social justice. His study highlighted the challenges and strategies of social justice leaders in creating equitable educational environments.

Bush (2020) reviewed some of the theoretical frameworks underpinning educational leadership in the early 21st Century. He explored the expanding scope of leadership and management, distinguishing between various leadership styles and their impact on educational outcomes. His comprehensive overview of leadership theories included transformational and instructional leadership but found that neither approach was clearly better than the other.

Fullan's theories of leadership in education (Fullan, 2002, 2015, 2016, 2020; Fullan & Hargreaves, 1992) resonate within this landscape of educational reform over the past 30 years. His approach underscores the significance of Moral Purpose, collaboration, and systemic change, and challenges traditional hierarchical models of leadership. He emphasized the need for educators to work collectively towards a shared vision, reflecting the growing interest in transformational and distributed leadership, and a shift towards more inclusive and democratic forms of leadership.

His concept of moral purpose is the cornerstone of his work. In his view, effective leadership aligns with contemporary societal values that prioritize the ethical considerations and social justice as exemplified in Theoharis' work (2007). Fullan demands that educational leaders must be driven by a commitment to the common good, should challenge the status quo and advocate for educational systems that are not only efficient but also just and compassionate.

Collaboration is another key aspect of Fullan's leadership theory. He argues that successful educational change depends on the collective efforts of teachers, administrators, students, and the community. This collaborative approach reflects a cultural movement away from neoliberalism and individualism towards a more communal and cooperative ethos. His emphasis on collaboration also echoes the recognition that complex problems require diverse perspectives and joint efforts to solve.

Fullan's agrees with Schlechty (1990) about the importance of capacity building within educational systems. He argues, like Hallinger and Heck (1998), that leaders must focus on developing the skills and abilities of their staff and foster an environment of continuous learning and improvement. This aligns with the late 20th Century cultural shift towards lifelong learning and adaptability in the face of rapid technological advancements and changing job markets. By promoting professional development and a growth mindset, Fullan's approach prepares educators to navigate and thrive in an ever-evolving educational landscape.

Leaders' aptitude to influence systemic change is a central tenet of Fullan's leadership model. He suggests that leaders should have a holistic approach to reform that addresses the interconnectedness of various components within the educational ecosystem. This perspective resonates with the cultural recognition of the complexity and interdependence of modern societies and the concept of distributed leadership. Fullan's insistence on understanding and leveraging the dynamic interactions within educational systems reflects a broader cultural appreciation for systems thinking, which is increasingly seen as essential for addressing multifaceted challenges. Fullan (2020) suggests three proposals leaders of educational change might want to heed:

1. There aren't as many good leaders as are needed.
2. Leaders need to listen and learn from the outset.
3. Leaders for change spend time developing collaborative leadership cultures that mean they are ultimately dispensable.

Keating, Heslin, and Ashfolf (2017) describe how, with time, focus and discipline, leaders can develop to become highly effective at change management, but they must adopt an

open mindset and willingness to learn to do so. Effectiveness is associated with how expert a leader becomes in their organisation, how courageous they are in getting outside their comfort zones to learn about the issues their organisation faces and how nuanced they are in understanding why context and relationships are important to these issues. This is remarkably similar to Eriksson's model of how expertise is acquired through deliberate practice (2009). This idea, initially popularised by Gladwell (2008), is well understood in medical education as it corresponds with our observations of the acquisition of what are termed craft skills such as surgical procedures or clinical skills which require foundational knowledge, skill acquisition and the contextualised application of these. Ericsson (2009), Fullan (2020), Gladwell (2008) and Keating et al. (2017) all agree that the key is what the expert spends their time practising and learning. For leaders in education these are not routine archetypical behaviours such as chairing a meeting or writing a board paper. Fullan (2020) and Keating et al. (2017) recommend focussing on more metacognitive behaviours such as:

1. Seeking to understand the impact of any proposed change on culture and context.
2. Acting as role-models while making their moral purpose clear and public.
3. Asking questions and practising persuasiveness by always trying to learn about the challenges their teams are facing.
4. Recognising when they have useful expertise and when they need to listen and learn from those who create value.

Fullan's work provides a compelling vision for educational leadership that is attuned to the cultural and societal shifts of our time, advocating for a more inclusive, ethical, and effective approach to leading educational change.

Autoethnography

One of the most problematic aspects of Kerlinger's (1986) taxonomy is that he deliberately associates the isolation of both the observer and an observable phenomenon from their real-world context to better quality research. Thirty years before describing his taxonomy he wrote of the benefits of this isolation (Kerlinger, 1957). It was his opinion that researchers, in particular university professors, should conceive theory and experiments

that could be systematised and tested in a controlled environment. He advocated deliberately attempting to isolate an observable phenomenon from its real-world context, because if researchers rubbed shoulders with practising professionals who were trained to practise in a certain way, then their training had usually been informed by some older theory or tradition of practice. He argued that isolated researchers would not visualise the problem to be fixed or the improvement to be made in the context of older theories and doctrines. If they could not do this, it would make it easier for researchers to conceive of new theories. This assumption that people are so heavily influenced by their social situation is referred to as explanatory orthodoxy (Silverman, 2007), whereas the assumption that the researcher will know better than the practitioner is referred to as divine orthodoxy. Kerlinger's divine orthodoxy meant he disapproved of the growing imperative for university researchers to conduct research in the real world and so find real world solutions. He criticised the tendency of academic training programmes to teach educational researchers that practical problems required practical research which would provide practical solutions.

As part of the broader acceptance of qualitative research methods and the increasing value placed on narrative, reflexivity, and subjectivity in scholarly work a distinct qualitative research methodology, called Autoethnography, emerged and evolved during the late 20th and early 21st centuries.

Autoethnography represented a significant methodological innovation, allowing researchers to harness the power of personal narrative to explore and illuminate cultural and social phenomena. It integrates autobiographical writing and ethnographic research, focusing on the researcher's personal experience as both the subject and the method of inquiry and providing a lens to explore broader cultural, social, and political phenomena. The development of autoethnography can be traced through several key stages. Its roots can be found in the broader movements of reflexive anthropology and critical ethnography which challenged traditional, objective notions of ethnographic research, advocating for the inclusion of the researcher's perspective and the acknowledgment of their influence on the research process. Early precursors to autoethnography include Geertz (1973) who emphasized the interpretive nature of cultural analysis, and Turner and

Bruner (1986), who focused on the subjective experiences of individuals within cultural rituals. The term "autoethnography" began to be used more explicitly in the 1980s and 1990s, reflecting a growing recognition of the value of personal narrative in research. This period saw significant contributions from scholars such as Ellis, Adams, and Bochner (2010) who were instrumental in defining and popularizing autoethnography. Ellis and Bochner (2000) describe autoethnography as a contemporary methodology which arose in response to some of the issues thrown up by the growing recognition that any individual's experience of cultural and societal phenomena could not be reduced to a few stable and universal theories and that the relationship between authors and readers was being disrupted by the forms of writing imposed by those paradigms. They argued for the legitimacy of personal experience as a source of data which engaged readers emotionally and intellectually, thereby fostering a deeper understanding of cultural phenomena.

Autoethnography has now gained considerable acceptance within the academic community, particularly within disciplines such as sociology, anthropology, communication studies, education, and health research, and it has been applied to a wide range of topics, such as chronic illness (Chang, 2016), policing (Murphy, 2008), leadership (Deckers, 2021), elementary school education (Tamayo, 2020), medical education (Farrell, Bourgeois-Law, Regehr, & Ajjawi, 2015), pharmacology education (Ramalho-de-Oliveira, 2020) and research methods education (Ibrahim, Weller, Elvidge, & Tavener, 2023). Researchers use their personal experiences to explore and illuminate complex cultural and social issues, offering insights through rich, nuanced accounts that challenge dominant narratives, and which might be inaccessible through traditional research methods. Farrell (2017) delves into the intricacies of employing autoethnography in medical education research. She argues that it is particularly advantageous for clinician educators as it allows them to reflect on and analyse their own experiences in the context of their professional environment. Farrell emphasizes the importance of balancing personal insights with contributions from other participants and literature to avoid excessive self-focus. Ultimately, she argues that autoethnography can provide profound cultural insights and foster a deeper understanding of educational practices within the medical field.

Autoethnographies typically involve a narrative style of writing, emphasizing storytelling, emotion, and reflection. The methodology is characterized by its commitment to authenticity, ethical self-disclosure, and the intertwining of the personal with the cultural. Various forms of autoethnography such as evocative autoethnography (Bochner & Ellis, 2016), which emphasizes emotional resonance and literary qualities, interpretive autoethnography (Denzin, 2014) and analytic autoethnography (Anderson, 2006), which integrates personal narrative with broader social science analysis have followed. Anderson (2006) emphasized the need for autoethnographers to maintain analytic reflexivity, engage in dialogue with informants beyond the self, and make visible the theoretical frameworks guiding their analysis. Murphy (2008) used an autoethnographic approach to examine the complex relationship between emotions, transformational leadership, and organizational culture within a large metropolitan police force. His approach allowed him to integrate his own emotional reactions and experiences during a four-day immersive study with the police force. The study revealed that transformational leaders, who can emotionally connect with their followers, have a significant impact on challenging and reshaping dominant organizational paradigms, but they may invoke fear and insecurity among upper management. He highlighted that, while emotions are generally seen as hindrances in police work, they play a critical role in how leadership is perceived and enacted. He noticed that leaders who aligned with the values of their followers and demonstrated genuine care and commitment were particularly admired, indicating that effective leadership in policing is deeply intertwined with emotional connections and cultural context.

Two authors who used autoethnography to great effect in uncovering and analysing the impact of bad leadership were Beattie (2018) and Skousen (2022).

Beattie (2018) used autoethographic methods to analyse her leadership experiences, both good and bad, across two contrasting socio-political environments. She contrasted the idiosyncrasies of leadership in a Soviet educational establishment and a contemporary UK higher education institution. Her narrative accounts highlighted her move from a system characterized by 'clientilism', where leadership was based on patron-client relationships, to one that emphasizes transformational leadership. She was also able to discuss how

Soviet leaders maintained control through manipulation and bribery, contrasting these behaviours with the collaborative and motivational approaches advocated in the UK. As she described the challenges of adapting to different leadership styles her use of autoethnography helped her to understand the personal and cultural dimensions of leadership. Despite the differences, she noticed that there were strong parallels between current leadership practices in UK higher education and Soviet clientilism, suggesting that power dynamics and organizational pressures continue to shape leadership behaviour regardless of socio-political context.

Skousen's (2022) deep, reflective examination of personal and professional experiences within broader cultural contexts particularly underscores the value of autoethnography in leadership research. This was an exploration of his own journey as a principal opening and leading a new alternative school in the United States (US). He described how important the works of Freire (1993) are to him and critiqued traditional notions of learning, teaching, and leadership, arguing that these often contribute to inequity and injustice in schools. He highlighted the potential for schools to be reimagined as sites of liberation and equity and discussed his efforts to create a school culture based on social justice principles, emphasizing the importance of understanding the lived experiences of students and engaging with their communities. He suggested that school leaders can significantly impact educational equity by fostering a culture of hope and possibility, challenging oppressive practices, and advocating for marginalized students.

There are many different labels for work that could be thought of as autoethnographic, and the output does not have to be narrative or scripted, many performance and visual art pieces are recognised as being grounded in autoethnography (Ellis & Scott-Hoy, 2008). The autoethnographic researcher seeks to draw on their personal experience to understand the cultural experience and the relationship between these two experiences. This results in a complex multi-layered reflexivity on the part of the researcher (Short, Turner, & Grant, 2013, p. 1). Holman Jones, Adams, and Ellis (2013, pp. 22-25) describe four characteristics that "bind" all autoethnographies (Box 3).

1. The use of personal experience to examine and/or critique cultural experience.
2. Texts demonstrate knowledge of past research on a topic and seek to contribute to this research.
3. Autoethnographic works present an intentionally vulnerable subject.
4. Autoethnography actively seeks a reciprocal relationship with audiences.

Box 3: Conceptualizing autoethnography

(Abridged from: Holman Jones et al., 2013)

Despite its growing popularity, autoethnography has faced criticism, particularly regarding issues of rigor, validity, and generalizability (Chang, 2016; Deckers, 2021; Edwards, 2021). Critics argue that the highly subjective nature of autoethnography can lead to self-indulgent narcissism or lack of critical distance (Pace, 2022; Sparkes, 2002). In response, proponents have emphasized the importance of methodological rigor, ethical reflexivity, and the potential for autoethnography to offer profound insights and foster empathy and understanding.

Synopsis

The 20th century witnessed the maturation of qualitative research methodologies from their nascent stages to a robust, diverse array of techniques grounded in the interpretivist tradition. These methodologies have fundamentally transformed how social scientists understand and study human behaviour, emphasizing the complexity, context, and subjective experiences of individuals. Qualitative research methodologies have evolved continuously, incorporating techniques from a smorgasbord of disciplines. Visual ethnography, discourse analysis, and narrative inquiry have emerged, expanding the toolkit available to qualitative researchers. This interdisciplinary nature of qualitative research has also facilitated its application across fields such as education, leadership and the health sciences.

Quantitative methodologies continue to have a privileged position in the published educational and leadership research. Several authors advocate that good research design in leadership studies should follow a positivist approach by starting with consideration of a theory and proposing analysis and measurement levels which are correctly specified

and aligned to answer the research question and which account for the context of the forum where the research is taking place. Unfortunately, analyses of the published literature demonstrate that few studies achieve this definition of quality. There is a clear tension between qualitative and quantitative methodologies with some evidence that poor quality quantitative research is more likely to be published than better quality qualitative research. Despite arguing that researchers should use the best methodology for the research question they are asking, some authors, for example Antonakis et al. (2004) continue to perpetuate some of Kerlinger's myths (1960). Quantitative research is appealing because it defines the phenomenon being investigated with absolute clarity and it appears to be able to suggest pragmatic actions that will be quick win solutions for the real world. The mythology of acceptable leadership research which privileges quantitative methodologies as being better may persist because these methods allow the accrual of data and facts which can be used to produce outputs that can be used to make leadership apparently better with immediate effects.

Leadership in Medical Education Literature Review

I conducted a literature search using the search terms "new medical school" AND "leadership" in PubMed and Embase (38 references), Google Scholar (approximately 3340 references) and Microsoft Academic (84 references). When ordered by relevance, only the first 120 reference of the 3340 references identified by Google Scholar were relevant to this piece of work. Microsoft Academic was also used to search for relevant papers authored by the 16 leaders named in Box 4. Some published prolifically in their field of clinical medical research throughout their time opening a new school or published in the medical and healthcare education literature about the pedagogic advances they made in designing the new school's curriculum or approach to student selection but, out of over 100 references, only 4 seemed to concern the impact of their own leadership or the role of a leader. It appears that these leaders tend to move on to other projects without leaving a record of their journey in the published literature. Once duplicates were removed from the combined list of references obtained from the three databases 154 references remained. The date of publication ranged from 1968 to 2020.

The majority of these 154 references originated in North America and focussed on outlining or advising on the typical career pathway of US Medical School Deans, a very different role to that of a UK Dean or Head of School. Others focussed on the application of pedagogical theory to curriculum change or the evaluation of curriculum and programme change, formal training for medical school administration and leadership roles or the general suitability of medical doctors for leadership roles in academic institutions. Only a very few talked about the specific context of new medical schools. As I reviewed the abstracts, looking for content that was specifically about the impact of a leader on the evolution of a new medical school, or on a significant whole of school change process, it became clear that this was rarely the major focus of authors' attention. Only 10 of these references seemed to be relevant to this RBT in this way. Using a snowballing methodology of pursuing references of references and using citation-tracking software, the references and bibliographies for these publications were reviewed for further titles relevant to this work. This identified a further 6 references and saturation was defined as happening when no more new and relevant titles were obtained on screening bibliographies and was reached after six rounds of review.

The 17 references identified by the process outlined above and ranging in publication date from 1997 to 2020, that were most closely aligned to the personal philosophies, role and impact of medical school leaders on new medical schools or as leaders of system-level change are listed in Box 4.

Authors	Country	Methodology
Bassaw (2010)	West Indies	Non empirical discussion paper
P. F. Buckley (2014)	US	Non empirical description of personal experience and key texts
Cole et al. (2018)	US	Literature review and panel discussion followed by analysis of major topics using a variety of theories as lenses
Cookson (2013)	UK	Non empirical summary of personal experience and opinion
Detsky (2011)	US	Non empirical commentary based on personal experience and opinion
Flaer (1998)	US	Doctoral thesis. Self-report from 126 individuals using a validated survey followed by descriptive, correlational and analysis of covariance (ANCOVA) statistical analysis of the data
Hays (2006)	Australia	Non empirical commentary based on personal experience and opinion
Hays, Strasser, and Sen Gupta (2020)[3]	International	Non empirical summary of personal experience and opinion
Lieff and Albert (2010)	Canada	Thematic analysis of 16 semi-structured interviews
Loeser, O'Sullivan, and Irby (2007)	US	Retrospective analysis of a change process using a single model of leadership
Nel (2004)	South Africa	Doctoral thesis. Literature review, 6 structured interviews, thematic analysis and refinement of results using a Delphi process
Petersdorf (1997)	US	Non empirical summary of personal experience and opinion
Rich, Magrane, and Kirch (2008)	US	Literature review
Sachs, Krane, and Kahn (2008)	US	Non empirical summary of personal experience and opinion
Schieffler (2016)	US	Non empirical discussion paper
Stempniak (2016)	US	Non empirical interview of single subject
Yedidia (1998)	US	Thematic analysis of 22 open-ended interviews

Box 4: Research methodology used in previous studies

[3] This was an update of the paper authored by Cookson (2013) with inputs from more authors and a broader range of international perspectives.

Commentary on the 17 papers from literature review

Petersdorf (1997) was a Distinguished Professor of Medicine when he gave a lecture to the US Council of Deans. He explored the evolving role of medical school deans since 1940, amid rapid changes in medical education and healthcare. He identified several key themes that seemed to characterize successful deanship during this period: adaptability, vision, and the ability to foster a collaborative environment. He emphasized the need for deans to balance traditional academic responsibilities with the increasing demands for innovation, financial acumen, and external stakeholder engagement, and discussed the challenges faced by deans in maintaining the quality of education and research while also addressing external pressures such as healthcare policy changes and financial constraints. He also highlighted the importance of continuous professional development and support systems for deans to navigate their complex roles effectively. He concluded with some personal recommendations for developing leadership programs tailored to the needs of academic leaders in medical education, in which he suggests that such programs should focus on strategic planning, communication skills, and emotional intelligence to equip deans with the tools necessary to lead effectively in a changing environment. Seventeen years later, P. F. Buckley (2014) reviewed a limited range of sources published between 1991 and 2013, again focussing on the role of deans in the US. He also acknowledged that the historic nature of the role, as a privileged, elected peer who would hold the position for a significant duration of time, had changed dramatically to that of an appointed manager of a team who is also the de facto leader and Chief Academic Officer. Both Petersdorf and Buckley highlighted the interpersonal skills required for a successful Deanship. Schieffler (2016) offered a third historical overview of the evolution of the role of medical school dean in the US, this time over the past 200 years. He too described how the role of the dean has transformed significantly, mainly adapting to the complexities of the US healthcare system. Initially, deans functioned as patriarchal figures overseeing guild-like educational systems. With the introduction of Medicare and Medicaid, and the growth of the National Institutes of Health, deanship evolved into a CEO-like role by the year 2000, where deans had substantial control over mission, strategy, and financial management. The most recent evolution is the concept of a "System Dean", where the dean functions within a larger healthcare system, focusing on collaborative leadership

and integration with broader health missions. This model emphasizes a team-based approach, where the dean's role is influenced by external health system leaders, aligning educational objectives with clinical enterprise goals. Schieffler's review highlights that this evolution reflects broader changes in organizational culture, educational philosophy, and healthcare system integration, pointing towards a future where deans will need diverse skill sets including business acumen and strategic negotiation.

Bassaw (2010) was a Senior Lecturer and Head of a clinical academic unit in the University of the West Indies with a personal interest in medical education when he published his non-empirical literature review and discussion paper exploring the multifaceted roles and essential qualities required for effective leadership in medical faculties. He drew on a mixture of sources ranging in publication date from 1970 to 2009, plus personal communications and anecdotes. He brings the same triple perspective of medical school dean as Buckley's (2014) description, which was based on personal experience; a Physician, an academic and a contemporary leader-manager. Bassaw describes these diverse skills and responsibilities as:

- maintaining high standards in teaching and research
- fostering external collaborations
- ensuring financial prudence to be successful
- ability to influence and manage change
- ability to evoke respect

Sachs et al. (2008) provided another detailed, personal account of the transformative leadership strategies employed by Dr Benjamin Sachs upon becoming the Dean of Tulane University School of Medicine in the aftermath of Hurricane Katrina. The paper outlines three core principles that guided Dr Sachs' approach: hitting the ground running, promoting community involvement, and gaining a common vision for the future. Dr Sachs prioritized immediate, decisive actions to stabilize the faculty and rebuild the institution. Community involvement was central to his strategy, as evidenced by initiatives like establishing neighbourhood health centres to address public health crises and improve healthcare access. The authors emphasize the importance of developing a shared vision, encapsulated in a new mission statement, which reflected the institution's commitment

to community service and rebuilding efforts. Dr Sachs' leadership during this critical period highlights the significance of proactive engagement, strategic partnerships, and a strong, unifying vision in successfully navigating institutional recovery and growth.

Another personal perspective is recounted in an interview with Dr Christine Cassell (Stempniak, 2016) as she joined the leadership team of Kaiser Permanente School of Medicine, which was due to open in 2019. In the interview, Cassel, a renowned figure in geriatric medicine and former president of the American College of Physicians, outlines her transition from leading the National Quality Forum to joining the leadership team at Kaiser. She emphasized the innovative approach the new school intended to take and highlighted the importance of personalized approaches to education, ensuring student wellness, and adopting adult learning principles to enhance engagement and retention. During the interview she also reflected on the challenges and opportunities of creating a medical school that aligns with contemporary healthcare needs, emphasizing the importance of patient-centred care and the use of performance measures to drive improvements in healthcare quality and delivery.

Hays (2006) offered ten principles for developing regional medical education programs in an Australian university based on his own experience. Cookson (2013) and Hays et al. (2020) all wrote for the same journal 7 years apart with a single UK perspective initially and a more global perspective in 2020, focussing on the skills and attributes of a leader tasked with setting up a new medical school and the key decisions that they would need to take on that journey. Box 5 demonstrates that there was a lot of broad agreement between the authors of the three articles.

Hays (2006)	Cookson (2013)	Hays et al. (2020)
Ensure a strong community, professional and political support to develop a relevant and achievable mission	Agree on the overall aim of the school Decide what the medical school is going to concentrate on first	Choose carefully the vision/mission/market position
Develop the most appropriate structure to deliver the mission	Decide who 'owns' the course Engage closely with the parent university from the outset	Engage the communities, professional groups, and local individuals Engage early with accreditation bodies
Design a curriculum with the appropriate content and process, including assessment processes that reinforce learning relevant to the mission	Agree on the type of pedagogy to be employed Ensure good alignment between the aims, outcomes, learning framework and assessment Plan the assessment along with the rest of the course	Select the education design model that will address this vision Develop assessment philosophy and practices
Recruit faculty who are positive role models for regional/rural practice	Appoint the right staff	Recruit educators with educational expertise Recruit clinicians who understand and support the programme

Select students who have the best potential to achieve the mission		Select students most likely to respond to the chosen vision and mission
Ensure high quality learning in both campus-based and clinical teaching facilities, with the latter ideally dispersed across the region of need in a range of communities	Make sure the school facilities are sufficient and appropriate to support the aims of the course Plan the co-ordination between the university and the health service at all levels	Plan for required clinical placement activity
Ensure that graduates have opportunities for relevant and desirable postgraduate training		
Facilitate research development in areas of the mission	Plan the research programme early	
Build in sustainability through succession planning, maintenance of the mission, and managing expectation		Develop the business plan and secure the necessary funding
Evaluate the development and disseminate the results		Contribute to the medical education scholarship literature Build in evaluation
	Communicate, communicate, communicate	

Box 5: Tips from Hays (2006), Cookson (2013) and Hays et al. (2020) (abridged)

Loeser et al. (2007) detailed the process of comprehensive curriculum reform as opposed to setting up a new programme at an institution that has not previously delivered a medical education programme. Their study was at the University of California, San Francisco (UCSF) which was faced with criticism for a lack of innovation and curriculum oversight at the time. UCSF undertook a five-phase reform process which correlated with Kotter's eight-step leadership model (Kotter, 1996). The phases included establishing a need for change, envisioning a new curriculum, designing and obtaining approvals, developing courses, and implementing and evaluating the new curriculum. Key strategies included creating urgency, building a guiding coalition, developing and communicating a vision, empowering broad-based action, generating short-term wins, consolidating gains, and anchoring new approaches in the institution. This structured approach led to significant curricular innovations, integration of basic and clinical sciences, and the establishment of an Academy of Medical Educators to support teaching faculty and promote educational scholarship. The reform emphasized leadership, stakeholder engagement, continuous communication, and a commitment to educational excellence.

Staying with the theme of how medical education leaders overcome adversity, Yedidia (1998) provided an in-depth analysis of the various obstacles faced by 22 former and current US medical school deans. Through detailed, 90-minute interviews the study identified several critical challenges that hinder effective leadership in medical schools. Key issues included the increasing complexity of the healthcare environment, the balancing act between academic responsibilities and financial management, and the need for strategic vision and adaptability. Deans had to navigate institutional politics, manage diverse stakeholder expectations, and foster collaboration among faculty, staff, and students. Yedidia highlighted the importance of strong communication skills, resilience, and the ability to build and maintain trust within the institution. Deans also faced pressures related to accreditation requirements, fundraising, and the integration of research, education, and clinical practice. He concluded with recommendations for developing leadership programs that address these challenges, emphasizing the need for continuous professional development and support networks for deans.

A recurring theme of several authors is the lack of any objective career guidance in medical education. Detsky's (2011) commentary is based on his personal leadership experience and also intends to provide practical advice for individuals newly appointed to leadership roles within academic health science centres. His paper is organized around six key themes: vision, managerial style, knowledge, people skills (emotional intelligence), organizational orientation, and personal development. He offers 21 personal and specific sound bites of advice, one for each year of his own leadership experience.

The Society for Academic Emergency Medicine (SAEM) is a charitable, post-graduate, learned society for specialists in Emergency Medicine, based in the US and with a primarily North American perspective. The SAEM Faculty Development Committee commissioned an expert panel session to discuss this and Cole et al. (2018) published the output from this panel and combined it with a review of the literature between 1990 and 2018. The result is a 5-step conceptual model for personal needs assessment and objective setting American Emergency Medicine specialists might include in their personal development plans if they wished to pursue a career in academic medical education leadership.

Flaer (1998), Nel (2004), Rich et al. (2008) and Lieff and Albert (2010) are some of the most empiric and carefully researched work that focussed on the context of Medical School Deans (Box 6) (below).

Flaer's (1998) EdD dissertation is one of the older publications in my literature review. He used a self-reported survey of 126 US dental and medical school deans to enquire how they perceived their leadership styles and the management perspectives they had used. He employed Bolman and Deal's (1991) four-frame model which includes structural, human resource, political, and symbolic frames. The structural frame focusses on the organisational structure and its importance for success, the human resource frame focuses on valuing and aligning faculty and students with the organizational goals, while the symbolic frame highlights the importance of vision and culture. The political frame addresses power dynamics and stakeholder engagement. His statistical analysis found that both dental and medical school deans used multiple frames simultaneously to approach problems, with the human resource frame being the most frequently used and

the political frame the least. Deans perceived and utilized frames differently based on their individual roles and contexts. The ability to use multiple frames allowed deans to adapt their leadership approach according to the situation, demonstrating the versatility and complexity of their leadership styles.

Lieff and Albert (2010) also used Bolman and Deal's (1991), four-frame model stating that it had “not previously been validated in the context of medical education” (p. 57)[4]. Lieff and Albert explored the cognitive frameworks that medical education leaders in a single Faculty in a Canadian university by means of 16 semi-structured interviews. This study revealed different findings to Flaer (1998); the medical education leaders they interviewed predominantly used the human resource, symbolic, and political frames, with less emphasis on the structural frame. Lieff and Albert (2010) also proposed an additional frame, Interpersonal and work style, which emphasized the assessment of interpersonal and work styles to optimize team dynamics. This study again underscored the importance of a multifaceted approach to leadership in medical education, suggesting that development programs should enhance leaders' awareness and use of these cognitive frames to effectively manage and lead their institutions.

Nel's (2004) PhD thesis addressed the complexities and unique challenges faced by medical schools in the context of South African higher education. He started with a phenomenological approach of an initial literature review, from which he developed several criteria. He then conducted a series of six structured interviews, with participants who were senior leaders in Higher Education in two geographical areas of South Africa, from which he generated a second list of criteria. These two sets of criteria were merged through a Delphi questionnaire survey involving a further six senior leaders in HE from South Africa. It was only in the Delphi process that five of the six participants were recruited because of their expertise and experience in medical education. Nel’s framework also highlights the necessity of objective guidance for the development of future leaders and managers given the dynamic and often volatile environment within South African

[4] Flaer (1998) provided evidence of validation and reliability for the model in education, although not medical education specifically, both in his own study and through the work of others.

medical schools. The resulting framework is complex and multi-layered and potentially non-actionable (Argyris, 2000). Key components of the framework included understanding the unique organizational structure of medical schools, recognizing the impact of external and internal factors, and addressing specific challenges such as goal ambiguity, professionalism, and environmental vulnerability. The framework emphasized the importance of a tailored approach to leadership that considers the unique features of academic institutions and the changing landscape of higher education and healthcare in South Africa. Nel's work underscores the critical role of effective leadership in navigating these complexities to ensure the success and sustainability of medical schools.

Rich et al. (2008) explored the essential characteristics and skills necessary for effective medical school deanship in North America. Based on a comprehensive literature review and input from leaders of executive development programs, their study identified key management skills, leadership skills, knowledge, and attitudes critical for deans. They identified important management skills including institutional assessment, strategic planning, financial stewardship, and team building. Leadership skills focused on visioning, maximizing values, mentoring, and constituency building. The required knowledge base for deans encompassed governance, legal issues, and the process of medical education, and essential attitudes included a commitment to others' success and an appreciation of institutional culture. The paper highlights the evolving complexity of the dean's role, emphasizing the need for a balance between traditional academic responsibilities and contemporary demands such as financial management and external engagement. The authors proposed a framework for the preparation and professional development of deans to ensure they are equipped to navigate the multifaceted challenges of modern academic medical centres.

<table>
<tr><th>Flaer (1998)</th><th>Nel (2004)</th><th>Rich et al. (2008)</th><th>Lieff and Albert (2010)</th></tr>
<tr><td rowspan="6">Medical and Dental school Deans use all four of Bolman and Deal's (1991) frames interchangeably:
structural
human resource
political
symbolic</td><td>Managerial skills and competencies Challenges</td><td rowspan="2">Management Skills
Institutional Assessment
Negotiation and Conflict Management
Communication
Strategic planning
Financial stewardship
Fundraising
Team-building
Recruitment and retention</td><td rowspan="6">Medical and Dental school Deans use all four of Bolman and Deal's (1991) frames interchangeably:
structural
human resource
political
symbolic
They added a fifth frame:
Interpersonal and work style</td></tr>
<tr><td>Infrastructure and Facilities</td></tr>
<tr><td>Performance Areas</td><td rowspan="2">Leadership skills
Visioning
Maximizing values
Knowing self
Mentoring
Building constituency
Making sense of experience
Challenging experience</td></tr>
<tr><td>Leadership and Management Group and structures</td></tr>
<tr><td>Leadership qualities
Managerial skills and competencies
Strategies</td></tr>
<tr><td>Roles that the leadership and management group need to fulfil</td><td>Knowledge
Academic medical centre governance
Legal and regulatory issues
Challenges and expectations of clinicians and scientists
Process of medical education</td></tr>
<tr><td></td><td>Attitudes
Commitment to the success of others
Appreciation of institutional culture
Patience with process</td></tr>
</table>

Box 6: Leadership skills and attributes required of medical school deans (abridged)

Concluding Reflections

I have outlined some of the considerations that should influence the choice of a qualitative or quantitative research methodology to investigate an educational and/or a leadership phenomenon as it occurs in practice. Kerlinger (1957) expressed a strong opinion that university professors should be isolated from the real world, but this leaves researchers open to accusations of divine orthodoxy (Silverman, 2007), an overly paternalistic approach to their research subjects or in an impossible position as practitioner-researchers. The requirements of my programme of study, as well as the phenomenon I wish to study mean that it is simply not feasible to isolate my subjects in an experimental environment, nor to reproduce the opening of a new medical school in a laboratory. When considering my leadership of KMMS, I cannot operate in a vacuum and I must consider the context, organisational behaviour, history and culture within which I work. As a practitioner-researcher I have not found enough theory or evidence to support my practice and I want to use the opportunity of my RBT and my uncommon real-world experience to support the collection of new data for research. The complex and contextual nature of both educational and leadership research means that, while quantitative research is common in both fields, this is not always for the best of reasons. It is not always best to follow a quantitative methodology or operate a statistical analysis that produces useful outputs based on an assumption that this is a superior research paradigm, because these are complex human and social interactions which defy such reductionist analyses and may remain unrecognised as a result. Qualitative research methodologies are not without their own challenges, they can appear inefficient and methodologically inexact. Their value is that they permit researchers to engage with complex behavioural phenomena in context and in ways that may provide new perspectives of accepted practices and orthodoxy, or which offer new avenues of investigation in fields which still have heterogeneity and uncertainty of theory and practice.

Autoethnography is not a common methodology used to research education and leadership. Just as it can produce novel perspectives it can also produce research outputs which are not typical examples of monographs, dissertations or theses. The usual

conventions of autoethnographic research are that the text is written in the first person with an emphasis on thick description (Geertz, 1973) and performance writing (Denzin, 2018). The writing is descriptive and aims to tell a story and enable readers to share in the author's experiences and interpretive enquiry of observed phenomena taken from their own perspective.

Even though there could be no argument that self, team, organisation and system are not important for educational leaders, my own observations of the UK community of medical educators (Chapter 1, Context, opportunity and scope, Box 1, p15) (above), plus the results of my literature review make it very clear that medical doctors find that the requirements to lead in education are different to what is needed in clinical practice. The technical and cultural differences between universities and healthcare, a different ethical or moral code, the different hierarchy and organisational structure, the different centredness (patient or student), the different physical environment, and the different funding models all mean that leaders in Higher Education have a different task and operate in a different culture. This means that, possibly, leaders of medical education must work across multiple cultures or will have a different, hybrid, orientation which would require an understanding of contrasting sociologies of leadership.

Where I did find some literature that was synergistic with what I wanted to research in medical education was in publications about national-level, state-run, secondary education systems as they attempted to respond to some of the challenges of the late-20th and early-21st Century. The challenges which these secondary school educators and leaders described sounded remarkably like those which what I felt that medical education was struggling to meet – the challenges of technology, access to content, learner engagement and of having to increase the pace of change simply to keep up. I scoured, perused and strategically searched for resources but the promising vein seemed to run dry. Developing as a leader usually meant becoming a deputy or headteacher, it meant navigating new bureaucratic processes which were often state or system specific, it meant balancing budgets which were often set by partisan politicians, or it meant following instructions for more technical approaches to sustaining change.

3. Choosing my method

The influence of my own context has prompted me to reflect many times on how a personal biography and construction of a philosophy of leadership are always buffeted by the winds of change. In this chapter I will outline why my context and my goals for my RBT led me to my chosen research methodology. I will conclude by outlining some criteria by which I intend to assess whether I have achieved my ambitions.

As I have described, I am a practitioner-researcher engaged on a programme of study and research that specifies it should be rooted in my professional practice. I enrolled on this programme of study partly because of some observations I made of the lack of any discipline-specific theory, evidence or research of what constitutes good leadership in medical education and the lack of careers advice about becoming a leader in medical education (Chapter 1, Context, opportunity and scope, Box 1, p15) (above). I am engaged in leading an important endeavour which offers an unparalleled opportunity to study this topic. My overall goals for this RBT are therefore to:

1. "Form a distinct contribution to the knowledge of the subject and afford originality by the discovery of new facts and/or the exercise of independent critical power." (School of Education, 2017, p. 16).
2. Investigate some of the characteristics of leadership in medical education and improve the cultural understanding of leadership in medical education.
3. Offer a critical analysis of some specific phenomena concerning my leadership that will be useful for future leaders.

What leadership research emerged from previous new medical schools in the UK?

By the time I embarked on my RBT I knew that the overarching experience I was going to research for this work would be my leadership of KMMS. Many of the approaches to leadership research I examined did not speak to what felt like the right combination of creativity, team building, culture setting and regulatory process represented by my KMMS story. I searched many permutations of, "change", "leadership", "education" and "medic*" in many different databases. The results of this search were described in the preceding chapter.

Since the year 2000, 16 new medical schools have opened in the UK, (Box 7). In the 20 years prior to that, only three new medical schools - King's College London School of Medicine and Dentistry, Imperial College School of Medicine and UCL Medical School were created as the result of mergers of established London medical schools whose histories went back hundreds of years. Despite the opportunity, there seems to have been a paucity of primary analysis and research into the role, challenges faced and contributions of the people who led these new schools. In fact, while Box 7 identifies a named leader involved in each of the new schools, it was quite difficult to determine who was at the helm of several of these schools at their inception. New medical schools come into existence via a range of processes and some of the schools listed do not seem to have had a Dean or Head of School appointed either before or at the point of opening, for example school websites and Wikipedia pages frequently do not record who the Founding Dean was. For some of the new schools listed the closest approximation to the person who led the new medical school project was made.

This paucity of scholarly output from the large number of human-years of work when you consider the number of people involved in setting up each of 20 or so schools represents what Graham et al. (2006, p. 14) called a "knowledge-to-action gap" and is a common occurrence in organisational development (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004).

Name of Medical School	Year of establishment	University	Founding Dean, Head of School or equivalent
Norwich Medical School	2000	East Anglia	S.J. Leinster
Warwick Medical School	2000	Warwick	I. Lauder
Peninsula College of Medicine and Dentistry[3]	2000	Plymouth and Exeter	J.E. Tooke
Brighton and Sussex Medical School	2002	Brighton and Sussex	J. Cohen
Hull York Medical School	2003	Hull and York	W. Gillespie
Keele Medical School	2003	Keele	R. Hayes
Lancaster Medical School	2004	Lancaster	A. Garden
University of Exeter Medical School[5]	2013	Exeter	R. O'Brien
Plymouth University Peninsula Schools of Medicine and Dentistry[3]	2013	Plymouth	J. E. Tooke
Aston Medical School	2015	Aston	A. Ahmed
University of Buckingham Medical School	2015	Buckingham	K. Sikora
University of Central Lancashire (UCLan) School of Medicine	2015	Preston	C. Jackson
Anglia Ruskin School of Medicine	2018	Anglia Ruskin	J. Kinnear
University of Lincoln Medical School	2019	Lincoln	D. McLaughlin
University of Sunderland School of Medicine	2019	Sunderland	S. Wilkes
Kent and Medway Medical School	2020	Kent and Canterbury Christ Church	C. Holland
Edge Hill Medical School	2020	Edge Hill	C. Austin

Box 7: New UK medical schools opened between 2000 and 2020

[5] University of Exeter Medical School and Plymouth University Schools of Medicine and Dentistry were established in 2013 after the original Peninsula College of Medicine and Dentistry (opened 2000) disaggregated to form two new schools. Peninsula College of Medicine and Dentistry's Founding Dean was J.E. Tooke who went on to lead the Plymouth University Schools of Medicine and Dentistry.

My Leadership Story

After the considerations outlined in the previous two chapters it became clear to me that my natural inclination was to conduct some form of qualitative, anthropological and ethnographic field study that would allow me to tell the story of my leadership of KMMS. I had very strong opinions of the sort of culture I wanted to nurture in KMMS, and it was clear to me that the interplay between the established, but different, cultures of the two partner universities and the nascent culture of KMMS was contextualising multiple aspects of my role.

There is a distinct concept of medical leadership in the clinical arena, and medical leaders play a pivotal role in healthcare, driving change, improving patient outcomes, and shaping services. The Faculty of Medical Leadership and Management (FMLM) is the representative body for all medical leaders in the UK. Leadership in medicine goes beyond clinical expertise. In its standards for medical professionals the FMLM makes it clear that it considers that the behaviours of a leader fall into the domains of: self, team, organisation and system (Faculty of Medical Leadership and Management, 2020). Self-awareness and striving to improve are essential, leaders must cultivate a learning mindset, continuously seeking opportunities for professional development and growth. They must be able to communicate clearly and empathetically and be adaptable and resilient. They should be open to change, willing to embrace innovative technologies and treatments, and adept at problem-solving in high-stress situations. Teamwork and collaboration are fundamental in healthcare, and medical leaders should foster a culture of empathy and compassion among the healthcare team and an environment where all members of the healthcare team feel valued and empowered to contribute their expertise. Medical leaders should prioritize patient safety, quality, and the ethical practice of medicine, so ethical decision-making must be at the core of medical leadership. Leaders must navigate difficult ethical dilemmas, ensuring that decisions prioritize the best interests of patients and adhere to the highest standards of professional conduct. The FMLM standards are intended to be applicable to “medical and dental professionals working in … education [and] academia” (p. 4), but in its description of how their standards were developed there is no confirmation of their acceptance by the university sector at large, nor that they have been

specifically tested for their suitability in the university environment. This, I felt, left me without a means to frame my analysis and interpretation of this relationship and legitimise it in the light of my experiences.

The autoethnographic methodology seemed to suit my personal and professional context and to offer a way for my, relatively rare, experience of setting up a new medical school to improve the general understanding of leadership in medical education of the wider academy. While the *auto* part of an autoethnography was now clear to me, the *ethno* and *graphic* parts still needed some clarification. My focus needed to be on the relationship between myself and society, with the intent of gaining a cultural understanding. An autoethnography should result in a work that is "narratively engaging and culturally meaningful" (Chang, 2008, p. 126). To achieve this result, rather than an autobiographical stream of consciousness, requires deliberate selection of fragments of memory or bits of information and then situating them within a broader text which explains their cultural significance in relation to existing theory and evidence. This explanation comes from the researcher and the researcher has complete control over what data they choose to analyse and interpret. The ideas, theory, recommendations or conclusions that an autoethnography generates concerns the interpretation the researcher places on the data and what the events really mean to the actors involved and their environments.

No single method of autoethnography exists, and this is as it should be for an approach which tries to acknowledge the connection between the observer and the community they are attempting to observe. This means that an extended methods section is not a common feature of many autoethnographic texts (Anderson & Glass-Coffin, 2013, p. 65). This challenges positivist and empiricist notions of what constitutes research and makes it hard for students of autoethnography to take their first steps as they feel their way through ambiguous methodologies divined from what they read. One strategy that Ellis and Bochner (2000) recommend is to discover and articulate how personal experience affects the everyday lives of professionals and use the autoethnographic method to aid the development of participants' understanding of the interdependencies of all the agents who work within that environment.

Leading Educational Change

I was in the library of the Franklin Wilkins Building of KCL in London, deep in shelves of books about education. I had a shortlist of three books about leadership in education which I intended to browse, without much hope. I found the first two books, "how to do battle against the evil forces of the Department of Education" (DoE), I thought to myself cynically. The third book, by someone called Fullan (2001) was battered and had lost its dust cover, the library slip on the front page suggested it had rarely been read since being placed on the shelves. I read the introduction, then I tried my universal 'is a book any good?' test and searched the index for something I felt I knew something about. I chose generational theory, something I have researched and lectured on previously (Holland, 2017). Generational theory (Howe & Strauss, 1992) has entered the public discourse as an often adversarial relationship between Boomers and Millennials, however I believe it has utility as a framework which helps educators reconcile themselves to a myriad of change required in educational practices common in the late 20th Century. In this book Fullan (2001) depicted a view of generational theory sympathetic to my perspective and described an overarching approach to leadership in education which felt attainable, reproducible and grounded in pragmatism. He acknowledged that management and leadership, often demonised as the forces of technical change against those arguing for adaptive change (Heifetz & Linsky, 2017)[6], are inextricably linked. Fullan also described a theory of educational leadership which aligned with my own model of leadership better than anything else I found. One of the primary attractions of Fullan's theory for me was its appreciation of the complexity of change and some of the ways it proposed to mitigate for this using moral and cultural approaches which resonated well with some concepts of clinical medical leadership.

Kerlinger (1957) argued over 60 years ago that Professors needed to be protected from time pressured and changing environments and I have discussed how I am not in complete agreement with Kerlinger on the desirability or feasibility of isolating myself from my arena of practice. Not least because my programme of study is meant to be

[6] See Appendix 3 for a short note about technical and adaptive solutions (Heifetz, 1994; Heifetz & Linsky, 2017)

immersed in practice and I do not have the time to isolate myself as I have a medical school to open. Our societal attitude to change especially its inevitability and pace has changed since 1957 as well. Heifetz and Linsky (2017) describe how the increasing pace of change in knowledge societies is generating a whole host of challenges that cannot be solved by simply changing or editing existing processes or policies to suit the new challenge. Importantly for my own context of transitioning into the role of a change leader, Fullan (2001) acknowledges that the phenomenon of change is an elemental theme to which leaders must not only respond but also turn to their advantage. These challenges require novel thinking, innovation and evolution in a new environment on the part of leaders. This potentially protects leaders who embrace change from having to look for iterative, pragmatic and technical solutions that would produce quick results.

Fullan (2020) has updated his book with a second edition and updated his framework for leadership based on how it has performed in the intervening decade[7]. I have chosen Fullan's theories to act as the framework for the method of this RBT because they reflect the context of the challenges I identified as needing to be addressed while setting up KMMS and the journey I took while doing so.

Ethics

Autoethnography presents many scholars with an ethical conundrum. So much so that Deckers (2021, p. 83) describes it as an ethical "quagmire". Many of the lists of criteria proposed for evaluating autoethnographic research do not formally include ethics as a discrete item. Edwards (2021) describes how the ethics of autoethnography are still evolving and remain "messy, fluid and highly contextual" (p. 3). Deckers (2021) agrees, appealing for autoethnographers to address the issues systematically and in greater detail. Concerns about the ethics of autoethnography are often raised in contrast to the perceived ethics of other forms of qualitative research. Lapadat (2017) points out that this argument has a key weakness – in other forms of qualitative research researchers appropriate the voice of others and use a false objectivity to mask the power discrepancy between participants and an invisible controller. In autoethnographic work the researcher is just as vulnerable as other co-participants and has just as much right as anyone else to

[7] Hereafter all references will be to the second edition of Fullan's book (2020)

tell their story. This includes benefitting from any academic recognition, and critique that may arise from their commodification of their own story. Farrell et al. (2015); Tolich (2010) and the British Educational Research Association (2024) all point out, however, that this argument that the story-teller owns the story in autoethnographic work must have some limits, for example when it comes to patients and carers in healthcare contexts, or pupils, learners and their parents and guardians in educational contexts. Deckers (2021); Lapadat (2017); Lee (2019); and Schoepflin (2014) all highlighted how the autoethnographic method actually empowers those who lack power, or who possess lesser status in a power relationship to tell their stories. Ibrahim et al. (2023, p. 1479) took "full ethical responsibility" for their co-created work wherein all named research participants had equal power and took part in the creation of the published work in its final form.

Another ethical consideration is how to identify other players in authoethnographic research. Anonymisation can end up being tokenistic due to the highly personal and identifiable nature of the primary author, and fictionalisation may detract from the conclusions that can be drawn from the research. Researchers must resist the desire to identify individuals because of personal motivations, for example holding up behaviours for public disapproval or to gain the sympathy of their reader. However, there might be appropriate reasons not to anonymise co-participants such as honouring or praising creditworthy behaviours or preventing malign agents from perpetuating their behaviours. In extreme cases it could conceivably even be unethical to anonymise individuals because of their illegal or immoral behaviours. Beattie (2018) took the approach of anonymising names, locations and settings absolutely, whereas Dikomitis (2012) adopted a process of variable pseudonymisation that allowed her to preserve important aspects of culture, location, employment or name when it was relevant to her findings.

There is also a frequent, automatic, assumption that individuals should be given the opportunity to consent prospectively to their behaviours being reported, either in anonymised form or in an identifiable way. This too challenges the conduct of autoethnographic research from the outset, since aspects of the methodology make it hard to obtain prospective consent from other individuals who may or may not be named in the final piece of work. In its latest guidelines the British Educational Research

Association (2024) acknowledges that while consent should “normally” (p. 13) be obtained from all research participants, in the case of auto/biographical and autoethnographic research consent may only need to be obtained from individuals in “some cases” (p. 17). Many reputable, peer-reviewed pieces of autoethnographic research do not make it clear whether or not consent was obtained prospectively or retrospectively (Ellis, 2009; Ellis et al., 2010; Hill, Callier, & Waters, 2019; Wylie, 2020). Lee (2019) argued that on some occasions it was inappropriate to ask for consent. Sims (2019) takes this one step further and argues that consent is actively not required for autoethnographic work. Deckers (2021) considered whether post-hoc consent, after data collection has happened but before publication, is a potential solution. This pits the recollections and justifications of behaviours of one individual against another, and who is to say that the recollections of the researcher(s) are any less or more valid than those of co-participants. His conclusion is that it should not be a definitive requirement to seek the consent of individuals included in autoethnographic research.

Sims (2019) argues that autoethnographic work should not be the concern of institutional ethical review boards at all, especially since these boards may allow their concerns about the reputation of the institution to bias their decisions (Hedgecoe, 2016). However, the absence of any ethical oversight can potentially result in a furore such as that which was created by the publication of a now retracted (Editor, 2022) piece of research by a PhD student, Karl Andersson, that claimed to be autoethnographic but which was very clearly an ill-conceived work from the outset which generated a lot of concern after publication. After reviewing the path from research activity to publication, the journal publishers and Editors concluded that there was a lack of clarity about the institutional oversight of the work and ethical review before it was submitted for publication. This is perhaps the most extreme example of how the autoethnographic researcher has an ethical duty to consider what the impact that publication of their personal story will have on their own life (Ramalho-de-Oliveira, 2020).

Deckers (2021) felt it was probably best for the autoethnographic researcher to seek the approval of an ethical oversight committee, although not necessarily to act on their

advice, and to conduct their research in the expectation that co-participants will read their work and mount a defence, possibly legal, of their actions.

For this RBT ethical advice was sought from the KCL ethics review committee and formal, institutional ethical approval was not deemed necessary, nor was any guidance offered concerning the anonymisation of co-participants. I have carefully considered the inclusion of each of my epiphanies and the impact they might have on identified or potentially identifiable individuals. I did not include some epiphanies because of the potential risk to those I would have described. No epiphanies involving patients were included (there were none relevant to my leadership story) nor were any epiphanies involving students included, except in a peripheral way. I have adopted a form of pseudo-anonymisation using no given names and changing role titles from the specific to a generic description. If it was not pertinent to my personal learning from an epiphany, I have avoided naming or changed the specific institutional affiliation of any individual. Edwards (2021) advises that if autoethnographic work is published more widely than the original purpose for which it was intended, then it would be best practice to obtain further institutional guidance on obtaining retrospective ethical clearance, or on rewriting significant parts of it as a composite case or in a fictionalised style.

Data generation and analysis

Chang (2008) describes how self-narratives can be wide and varied and help authors and readers to develop a deeper understanding of themselves, others and the sociocultural context within which we all exist. Chang suggests that the author should experience a process of self-reflection, self-analysis and self-discovery, while readers can compare their experiences with what they are reading, prompting the reader to examine and learn about themselves. Unless an autoethnographic work is written entirely contemporaneously, the autoethnographer must also base their writing on some form of data. Data is never in short supply when writing an autoethnography. Anderson and Glass-Coffin (2013) describe three main types of data: field notes, personal documents and artefacts, and interviews. Since the autoethnographic researcher must be selective of what data they include they might need to describe the factors that lead them to select certain episodes for analysis and their strategies for analysis. Ellis et al. (2010) describe how

autoethnographers often obtain their data from personal epiphanies which they reflexively analyse using theory and the conclusions of other researchers. I have encountered many novel situations during the time bounded by this RBT which will become some of the most cathartic moments and formative experiences of my professional and personal personas. In my time with KMMS I have:

- led the planning, recruitment and development of a team of over 100 talented people.
- tried to nurture a culture of respect and collaboration including academics, Professional Services colleagues and, later, students.
- authored an innovative curriculum sufficiently aligned with the programme at our contingency school to keep the regulator happy, but sufficiently innovative to generate excitement and a sense of advancement.
- aligned and implemented an extensive range of academic regulations and quality assurance processes to the satisfaction of two universities, a contingency partner school and a regulator.
- developed an extensive network of external partnerships with placement providers, stakeholders and donors.
- led a multi-year, multi-stage accreditation process.
- taken overall responsibility for the planning and delivery of student selection, induction, welcome, orientation and teaching.

From my past experiences of training to be and then becoming a medical Consultant, learning about then becoming an educator, university academic and manager, leading change projects in both environments and trying to hybridise my leadership style to suit both, I have learnt that epiphanies, or sudden realizations or insights, can be valuable in various ways. Epiphanies are disruptive and can act as catalysts for adaptive change by providing the new perspective on a problem or issue or by revealing a previously unseen solution. Chappell (2022, p. 11) describes epiphanies as a universal human experience and uses a series of case studies to describe nine features of epiphanies, present to varying degrees in each instance, that characterise these valuable, overwhelming, externally evoked, existentially significant, sudden and surprising insights that make us re-examine

ourselves and which demand a response. I propose to focus on experiences that I identify as epiphanies throughout this RBT. I personally value creativity and innovation while leading significant change and I have successfully sought out and encouraged epiphanies for myself and my team members. Epiphanies can also be valuable because they can inspire action and motivate individuals to try something new. A sudden realization or insight can provide the energy and excitement necessary to make a significant change or take a bold step forward. I have found that epiphanies have often resulted in significant personal growth and development. When I experience the sudden insight or realization of an epiphany, it often challenges my existing assumptions and beliefs and forces me to reconsider my perspectives and approach to a situation. These are the sorts of episodes which I recognise as catalysing my personal growth and development, as well as increased self-awareness.

Many epiphanies come with a cautionary lesson as well. Dooley (1997) in his proposal of how change can be modelled in complex adaptive systems (W. Buckley, 1968) provides a summary of how any given era's management theories tend to mimic the scientific theories prevalent at the time. The current era of management science is fascinated by complexity and chaos, the task of setting up a new medical school with two universities working in partnership has certainly been complicated and tangled.

Not all leaders place the same value on epiphanies. Others may prioritize data-driven decision-making and rely less on sudden insights, while others may place a greater emphasis on intuition and gut instincts. Ultimately, the value of epiphanies depends on the individual leader and their approach to leadership and decision-making.

If I wanted to use a variety of epiphanies to structure this work, I also needed to consider the approach I would take to selecting the epiphanies I would choose to analyse. I selected Fullan's (2020) theories of leading in a culture of change to help me do this but this would not be enough to winnow all my experiences to fit the scope of this RBT. Chang (2008) suggests a long list of considerations for the autoethnographic researcher when selecting episodes and I shall indicate for each epiphany that follows which of these reasons triggered my choice to include it:

- Recurring topics. Grading events as significant because they recur.
- Cultural themes. Choosing certain events because they are culturally impactful.
- Exceptional occurrences. Grading events as significant because they are exceptional.
- Inclusion and omission. Enhancing the reflexivity of analysis by considering what data has been collected and what has not.
- Present and past. In the absence of objective, empiric data that demonstrates causation, purposeful, ethnographic analysis might help to discern if perceived links are correlation or causation.
- Relationships between self and others. It is fundamental to autoethnographic methods that the researcher considers the connection between themselves and the culture within which they are operating.
- Comparing cases. This allows the researcher to identify similarities and differences between broadly similar events or people and propose reasons why they are so.
- Broad contextualisation. This serves two purposes, the researcher's consideration of context can be used to change their field of view, and therefore the amount or, alternatively, the granularity, of data it is feasible to gather. However, this has an inverse relationship to generalisability, the broader the context the less precise any generalisable application can be.
- Comparing with social science constructs. This is the mirror to Chang's advice about contextualisation. By framing their data analysis using generally accepted social concepts or ideas, the autoethnographer has a conceptual framework to work with. In this RBT my main construct is "leadership".
- Framing with theories. The use of theory is more rigorous than using a construct and enables the researcher to remain grounded and linked to existing work in a way that permits them to propose explanations for what they have observed in their data and subsequent analysis.

The end date for data collection has not stopped these moments from accruing, and each extension to my submission date has provided ample further epiphanies for inclusion. Sparkes (2018) frequently refers to the uncertainty that many autoethnographers have

about deciding when their work is complete. Initially, I planned that this RBT would focus on my transition into the role of Founding Dean over the course of my first year in the post. I imagined that this would produce ample opportunities for analysis and would include the critical starting phases of establishing a project and building a team.

I assiduously gathered data in many of the forms described by Anderson and Glass-Coffin (2013): field-notes, a personal, reflective journal that documented events, places, feelings and analyses and artefacts. I originally intended to end my data collection period in September 2019, and curating these sources helped me adjust to my novel situation and role. As I entered what I hoped would be the final period of writing up my RBT, an unknown person in Wuhan, Hubei, China was about to become unwell with a previously unknown disease caused by a novel coronavirus, now called Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2). While the ramifications of the pandemic reverberated through every aspect of our society and culture, the medical school journey kept on going, kept on producing rich data and my growth as a leader did not stop.

Initially, I resisted expanding the epoch of time that this work would consider, but the exceptional occurrences of the pandemic mean that after three years the extent to which the pandemic affected everything, everywhere all at once is still emerging. In a double blow to my data management, the longer this dilation of the epoch of time I was going to scrutinise persisted, the more epiphanies happened, and the sequelae of seemingly trivial past events meant that some things that seemed unimportant at the time began to assume the status of epiphanies. Consequently, while it feels irrational not to include material that had a cathartic impact on the school and my leadership journey, the dilation of time has meant another round of ruthless data selection. Furthermore, in early drafts of this work, material that I wrote thinking it would be central to my analysis became more peripheral to my autoethnography as a leader of change in medical education. As a result, a collection of appendices has emerged which gives background and context that may be useful for the reader, but which does not form part of the main story of my journey.

My reflective journal became less useful in the second, pandemic phase of my data collection for three reasons:

1. With time, many episodes ceased to be truly novel, and began to be become recurring topics. The sorts of things that began to recur were issues such as medicine requiring special dispensations in the regulations, or the relationship between two universities, or the challenges of setting up new clinical placements becoming repetitious, and the returns on analysing some of these experiences began to diminish. This is a feature of autoethnography that Chang (2008) advises researchers should attend to, the fact that events are repeated may mean that they are more important to analyse.
2. As I became more established in my role my time became less and less my own and more and more of my day was reliably recorded in my electronic calendar. As one of my supervisors put it "you are public property" (Cribb, 2021). This recorded the times, places and venues of my life as well as any others present but, of course, Outlook™ does not record relationships or context, nor does it relate events to social constructs of leadership or generally accepted social science theories. Most importantly it doesn't record the immediate feelings and reflections that events generate. This stimulated me to look also to agendas, policy documents, minutes of meetings etc, all of which recorded some aspect of my leadership behaviours. It is the nature of the modern professional environment that such documentation is universally electronic, and my position meant that not only was I party to the final version of all KMMS related documentation I was almost unique in that I was party to the creation of the vast majority of KMMS documentation either by dint of being the sole author, one of the primary authors, because I saw draft and early versions of most papers and documents or because I ultimately signed most things off as Dean.
3. As the pandemic evolved, working at home became the norm, I needed to devote even more time to the medical school, and I was asked to work more hours in clinical practice as well. All these factors, plus the whirlwind of new experiences that overtook me and most other human beings, meant that I did not have the time or reserves to reflect on many of the experiences that occurred during the pandemic until much later. As the pandemic progressed it also became clear that it

would be an egregious act of academic negligence to arbitrarily choose to ignore the impact of the pandemic on my leadership journey.

One important codicil of my decision to include an analysis of some events taken from this period is, of course, that leadership in a time of crisis, whilst it can have a seminal impact on how a personal leadership style develops, may be tangibly different to leadership styles which are deemed to be effective once the crisis has passed. This was also one of my criticisms of what little has been published about the sociology of medical education leadership. Counterfactual analysis can be useful on occasion, but it has three significant limitations:

1. It relies on speculation and assumption. Since the past cannot be changed, any counterfactual scenario can only be imagined and constructed based on conjecture. This can lead to numerous possibilities, some of which may be more plausible than others, but ultimately, none can be definitively proven. A step too far even for me in my mission to challenge the positivist paradigm.
2. It can be used to justify almost any position or outcome. By constructing different counterfactual scenarios, authors can often find a way to support a particular argument or position. This can make it difficult to determine the accuracy or validity of any given analysis.
3. It overlooks the wider context and complexities of historical or social events. By simplifying events into binary outcomes, it ignores the many factors that contribute to a given outcome, including the actions of multiple actors and the influence of external factors.

So, while counterfactual analysis can be a useful tool in exploring hypothetical scenarios, it must be used with caution and awareness of its limitations. It is important to acknowledge the inherent speculation and oversimplification involved and to consider carefully the potential biases and limitations of any analysis. I will therefore not engage with any counterfactual analysis but do acknowledge that some of the epiphanies that I have chosen to analyse happened during a very unusual period of history.

Anderson and Glass-Coffin (2013) also include interviews as a potential source of data for an autoethnography. Initially I entertained the notion of formally interviewing some key figures in the KMMS project team and some members of the leadership teams at the other new medical schools to compare my experiences and my interpretations of these, but early in the process I decided that formal interviews would be beyond the scope of this RBT. Since I was deliberately taking an approach which privileged my experiences and reflections, I felt that interviews with other people would detract from this. In fact, I met regularly for peer-to-peer, supportive discussions with these colleagues and this allowed me to compare my experiences and determine which were common to most of the other new schools and which seemed to be unique to KMMS.

A different way for an autoethnographer to plan the analytical approach they will take is to consider which features of research output indicate that a valid and rigorous analysis has occurred. Again, there is little agreement on what this should be. Schroeder (2017) graphically described the process of creating a list of criteria and iteratively testing it with a local community of fellow autoethnographers. His original set of six criteria did not undergo any change after this consultation, but he described the rightness of how it felt for him and his collaborators. Several of his colleagues commented on how useful it was to have a list of criteria when judging other autoethnographers' work, especially for PhD examiners and journal editors. Doloriert and Sambrook (2011) and Sparkes (2002) also recall how challenging it can be for autoethnographic pieces to be accepted as formal, finished products of research such as dissertations and theses and Sparkes (2018) points out that the list of lists is continuing to multiply. He is very worried about the impact of these lists of objective criteria – the risk of them becoming checkbox tools to judge the worth of an autoethnographic piece and the limitations that could place on the artistry involved in creating a piece of autoethnography. He does acknowledge, though, that without some criteria to measure the merit of autoethnography, novice and experienced scholars, as well as readers, reviewers and examiners, can be left wondering whether a piece is either complete or rigorous enough. Sparkes (2018, p. 7) also focuses on the rightness he feels after completing an autoethnographic study and disconcertingly says he does not know from where within himself his autoethnographic stories come. Finally,

something that became apparent to me during this RBT is that, since it is based on the experiences of one person, it can be quite challenging to describe transferable recommendations that are useful for others.

Concluding reflections.

I have outlined the process of how I have arrived at seven overarching objectives for this RBT (Box 8) (below). The general purpose is to take advantage of the exceptional event of opening a new medical school which I am leading to record and analyse my story for the benefit of others. My immersion in the work means that I have an unrivalled opportunity to explore some of the social and cultural peculiarities of leadership in medical education. The behaviours of leadership in medical education cannot be automatically deduced from studies of leadership in other contexts and researchers (myself included) may have to question, revisit and adapt theories and models that they have found useful elsewhere.

1. Revealing the self (auto).
2. Reflexive exploration of culture and society (ethno).
3. Aesthetic, coherent story craft about a particular reality (graphy).
4. Investigate some of the characteristics of leadership in medical education and improve the cultural understanding of leadership in medical education.
5. Offer a critical analysis of a selection of epiphanies, grounded in Fullan's theories of leadership for change (2020) and selected based on the considerations described by Chang (2008).
6. "Form a distinct contribution to the knowledge of the subject and afford originality by the discovery of new facts and/or the exercise of independent critical power." (School of Education, 2017, p. 16)
7. Ethical.

Box 8: Overarching objectives for this RBT

An autoethnographic methodology will allow me to use this opportunity to conduct a field-study of educational leadership and obtain a new understanding of leadership in medical education that will be useful for others and may support a proposal that being a

leader in medical education takes place in a distinctive combination of social and institutional spaces.

To achieve this, I have made some resolutions.

1. I will use personal experience to examine and/or critique cultural experience.
2. I will consider past research on leadership in education and seek to build on this research.
3. I will not shy away from the intentional vulnerability of using a methodology unfamiliar to me.
4. I will actively seek a reciprocal relationship with my reader by sharing personal experiences and my journey of growth.

The data used for analysis will be a strategic selection of epiphanies from the first five years of my leadership. Building on my list of overall objectives for this RBT (Box 8) (above), I have devised some criteria for selecting my source material, conducting my analysis and making any recommendations. The epiphanies will not be chronologically ordered but will be aligned with a construct of change leadership in education described by Fullan (2020). I will also select each epiphany according to one of the considerations of what makes an epiphany significant described by Chang (2008). Fullan's theories have grown out of contemporary work and experience which increasingly recognises change as a complex sociocultural process. Throughout this autoethnography I have always tried to be self-aware and appropriately sceptical of any one model of change, so my decision to adopt the model of change leadership advocated by Fullan to structure this work is not an advocacy of the model, but merely its adoption as a tool to improve the quality of my autoethnographic research.

Autoethnography is not a common methodology used to research education and leadership. Just as it can produce novel perspectives it can also produce research outputs which are not typical examples of monographs, dissertations or theses. The usual conventions of autoethnographic research are that the text is written in the first person with an emphasis on thick description (Geertz, 1973) and performance writing (Denzin, 2018). The writing is descriptive and aims to tell a story and enable readers to share in the

author's experiences and interpretive enquiry of observed phenomena taken from their own perspective. This RBT will tell the story of and interpret and contextualise some defining unique and personal experiences to create a self-portrait of myself as a leader. To a lesser extent that story will serve as a historical record of my leadership during the opening years of KMMS. I hope that it will make an original contribution that will be useful for future leaders during the imminent further expansion of medical student places in England.

These criteria feel right for me, should fit within the scope of this work as an RBT, align with my desire to use an uncommonly used methodology in this field to catalyse my own growth as a researcher and leader and analyse what I believe is the important phenomenon of leading a new medical school. By doing so I hope to generate different perspectives of leadership in medical education to what more conventional analyses might produce.

Part 2: Building a Medical School

4. The start

In this chapter I shall introduce my methodology and method by means of four separate epiphanies which I have selected to provide a broad contextualisation (Chang, 2008) of some of the significant individuals and institutional attitudes which shaped my introduction and first steps in leading KMMS. These epiphanies provide the opportunity to reflect on the established culture in these two universities specifically, and possibly other universities more generally, for which the advent of KMMS represented a new approach, a new culture and the need for adaptive change.

Epiphany 1: My introduction to Kent and Medway Medical School

I was a little nervous, as is often the case when entering a new environment to meet with important people and have important conversations. My mentor, Professor Val Wass, introduced me to a Head of Faculty at a University in Canterbury. At the time I was working at GKT SoME and the large curriculum renewal project I had worked on for the past few years had largely ended, and I was keen to find another project to work on. I had been at GKT for 8 years and had been part of the team which had developed and deployed a thorough review of the programme, its first in 18 years. The remainder of the team had either already moved to new institutions, retired or were planning a move and I too was feeling the urge to utilise what I had learnt about university medical education. My frustrations were becoming significant and affecting some key working relationships. Val thought there might be an interesting project for me in Canterbury.

It was a hot day in August, the university was largely empty, and I was not familiar with where I was going. The campus felt like several quintessentially 1960s buildings were slightly too close together, necessitating some peculiar thoroughfares, and diminishing the attempt to convey a campus-like feeling to the estate. The dated architecture felt dilapidated, despite being in good repair, and the whole development was dominated by an ecclesiastical spire, in a typical 1960s architectural style. I found the building and office my meeting was in and was welcomed by an enthusiastic, energetic and passionate person with whom I had a stimulating conversation for over an hour about how to address many perceived social injustices in education generally and medical education more specifically.

My 1st introduction to my future colleagues in Canterbury, Kent happened years before my appointment as Founding Dean, but it eventually set the course of my career. During this conversation I felt I developed a rapport and a feeling that we could work together. Just over a year later I left KCL, but not for Canterbury. I moved to the University of Surrey (Surrey) to develop a bid for a new medical school there. Less than nine months after that, Surrey's bid for a medical school failed but Kent and CCCU's was successful. After the failure of Surrey's bid my immediate line manager departed quite quickly, and my own fixed-term contract was due to end in a matter of months. I had not been in this position before and it caused stress and friction at home, I needed some certainty, or I was going to have to return to full-time clinical practice for at least a short period. This was not something I particularly relished. I applied for several jobs until the winnowing effect of the timelines of asynchronous appointment processes meant that the KMMS role was my preferred and only option. As part of the recruitment process I was provided with a redacted copy of the KMMS bid document which had been jointly authored by the two universities.

Epiphany 2: What did we get wrong?

"What did we get wrong?" asked my old line manager at Surrey when I told them I had a copy of the KMMS bid. I agonised about what to say, it was a privileged document and still had a very limited circulation. My former colleague is an inspirational person who had invested a huge amount in the bid at Surrey, personally and professionally, and the failure of that bid was a huge blow. They had recruited me from KCL and we worked together, met each other's families, stayed in each other's homes and become more than just colleagues. They had been selflessly supportive of my application for the post at KMMS and expressed genuine pleasure that my career benefitted from the outcome at Surrey. They appeared to be suffering from extreme self-doubt and undergoing an adaptation to change process which was full of sadness and grief.

I chose my words carefully. We knew the contents of our own bid and I tried to keep to aspects of the KMMS proposal that were either in the public domain, or which could be inferred from publicly known facts.

"They only asked for 100 places", I said. We'd bid for nearly 200 places, nearly 20% of the total number of places available overall, and there had been a lot of agonising over whether this was an egregious number, albeit one which kept our financial model viable.

My friend expressed incredulity about how they were going to make that work financially. I dissembled slightly because I was not actually convinced that the KMMS proposal was financially sound. I explained how they had received immense support from local NHS and local-government sources with the promise of significant financial support.

In the run up to submitting Surrey's bid, we had been increasingly anxious that the University had not fully accepted everything that we felt needed to be considered in setting up a medical school. We developed an entirely new programme, not predicated on any other school's programme, and advanced our arguments that the school should be at Surrey. Prior to submitting our bid, it started to feel as if our proposals were being overruled and certain aspects of the bid for places were being heavily influenced by university orthodoxy. We were not able to convince the university to bid for what we felt was a reasonable number of places nor to garner promises of significant financial support from any external source. We voiced to each other a feeling that there was an air of entitlement around the Surrey proposal that was not going to be helpful in the context of a national proposal partly intended to disrupt some aspects of the medical education establishment.

Broad Contextualisation

The document we were discussing was the successful joint bid from Kent and CCCU for 100 funded places for undergraduate students to study medicine. In 2016, the then Secretary of State for Health, Jeremy Hunt announced an expansion of 2500 places for medicine at the Autumn Conservative Party Conference (Torjesen, 2016). The official invitation to apply for places by means of a competitive process was announced by HEFCE shortly after I started at Surrey (HEFCE, 2017) The process was very competitive and the rumour was that HEFCE received anything from 2 bids for every place available to 9 bids. Submissions had to describe how their proposal would meet five government priorities for the additional places (Box 9).

- Widening participation and improving access, so that the medical workforce is more representative of the population it serves.
- Aligning expansion to local NHS workforce needs, with an emphasis on priority geographical areas, including rural and coastal areas.
- Supporting general practice and other shortage specialties, so that the NHS can deliver services required to meet patient need.
- Ensuring sufficient provision of high-quality training and clinical placements (with funding provided to HEFCE for the additional teaching costs and to HEE to support additional high-quality placements).
- Encouraging innovation and market liberalisation.

Box 9: The Government's priorities for allocating the additional 1000 places (Abridged from: HEFCE, 2017, p. 4)

In the briefing for what it would consider in the process of ranking submissions HEFCE (2017, p. 5) stated that it would assess how well applicants described how they would meet the UK Government's priorities based on the following criteria:

- The approach being taken to ensure access and successful participation for students from under-represented backgrounds, with evidence from existing initiatives.
- The location of new provision in relation to the geographic areas prioritised by the Government.
- Availability of high-quality training placements to support provision or plans to develop it (including confirmation from relevant NHS trusts and other providers).
- A focus on the prioritised specialties of general practice, psychiatry and any other shortage specialties.
- Relevant curricula innovations.
- The financial sustainability of all proposals.

The KMMS bid met the criteria with sufficient merit to be awarded 100 places, one of the biggest allocations. KMMS would open in September 2020! A unique aspect of the bid was that it was a collaborative bid between two universities, Kent and CCCU, where Val had

directed me two years previously. It described explicit aspirations that KMMS would be different, that it would draw on the best from across both universities and that part of the KMMS innovation would be to challenge the status quo in medical education. The team of people who wrote the bid were jointly led by Professor Debra Towse, from CCCU and Professor Peter Nicholls, from Kent. Most of the collaborators were not medical school graduates, some were. My interpretation was that the difference that the bid described was mostly based on the historical perceptions of these non-medical contributors of medical schools as privileged, elitist bodies with huge amounts of social and financial capital. That's not to say they were wrong – in many cases their perspective was refreshing and insightful. The best of both universities was an aspiration to showcase aspects of both universities, but it was also a reasonable and prudent desire to utilise efficiently what already existed wherever possible. The stated intention to be different was mostly an intent to have a different demographic of student from the typical medical school. It later became clear that the way KMMS was to be governed was also part of the quest for difference, this was based on a belief that an undergraduate medical education programme would be better managed if it conformed more to the university norm.

These two epiphanies represent the start of my leadership journey and illustrate that sometimes these journeys do not start where we might think and often involve goodbyes as much as hellos. At the start of my journey these epiphanies speak to me as an opportunity to provide the broad contextualisation that a credible autoethnography requires (Chang, 2008). I have already offered some key information about myself; these epiphanies are more about the culture of universities that seek to set up new medical schools and how these projects are influenced as much by people without a medical degree as by qualified medical practitioners.

The collaborating universities

For universities in the Higher Education (HE) context as it was in 2016-2018, to undertake the challenge of opening a medical school with no start-up funding formally available from central sources was a breath-taking challenge. The bravery of the two collaborating universities should not be underestimated. At a time when student numbers were already

static or falling and student fee income was falling in real terms, an undertaking of this size and cost had significant risks for both organisations.

Kent was granted its Royal Charter in 1965. It is one of the most recognisable of what Beloff (1970) termed the 'plate glass' universities, in 2003 it expanded to a satellite campus in Medway, Kent and took its current name. At the time, Kent called itself the UK's European University and had campuses in Brussels, Paris, Athens and Rome. It had a gold rating in the Teaching Excellence Framework (TEF) and was ranked 40th out of 128 participating institutions by the Times Higher Education (2018) (THE) in the 2014 Research Excellence Framework (REF) cycle, rising to 38th place in 2021. Kent has experience of working in partnership with other Higher Education Institutions (HEIs) to co-produce and co-deliver programmes and is one of two equal partners in the Medway School of Pharmacy (MSOP) which opened in 2004. The MSOP is a partnership between Kent and the University of Greenwich (Greenwich) and is based on the campus in Medway which is jointly used by Kent, CCCU and Greenwich and is called 'Universities at Medway'.

CCCU also opened in the 1960s, first in 1962 as a Church of England college for teacher training. It established its first Bachelor of Education degree programme in 1968. Through the '70s and '80s it expanded into religious education and health education. It was granted its degree awarding powers in 1995, for programmes which were accredited by Kent. In 2005 it was awarded full university status. CCCU also has a presence on the Universities at Medway campus and delivers programmes in health, social care and early years care there. CCCU had a silver rating in the Teaching Excellence Framework and was ranked 72nd by the Times Higher Education (THE) after the 2014 REF. It fell to 92nd place in the 2021 REF cycle. Kent and CCCU previously worked in partnership to set-up and deliver a Physicians Associate programme at the Medway campus which is now solely delivered by CCCU.

Medical Schools

Medical schools are different. Medicine as an undergraduate degree leading to registration for practice as a practitioner registered with the General Medical Council (GMC) has only been part of the British university system for just over a century, as long as the GMC itself has existed. Medicine and HE have not always been comfortable bedfellows

and medical schools are often accused of elitism and exceptionalism in the university community. The apocryphal saying is that every vice-chancellor who does not have a medical school would like one, and every vice-chancellor who has one would like to get rid of theirs. The source of many of the tensions between medical schools and their parent, or hosting, universities are lost in time, but the advent of a new medical school within an established university, never mind two, is disruptive, and managing this disruption became one of the unifying themes of my role.

There were many reasons for this disruption, and it will be the focus of many of my epiphanies to come, but the collaborating universities often seemed to be surprised by the novel challenges presented by setting up KMMS and the ways in which medicine simply did things differently to other programmes and could not abide by university orthodoxy. During my role, the main facets of the disruption I observed or experienced were:

1. Regulation. Every aspect of UK professional practice, education and training in Medicine is regulated by the GMC. Universities are familiar with regulators but if they have never taught an undergraduate medicine programme before they will not have dealt with the GMC. The GMC is powerful because its primary mission is to protect patients. This introduces tensions into the ways in which a university might normally operate, for example, student support is not just a matter of fulfilling a duty of care to students, medical schools are also greatly concerned with ensuring that patients, now and in the future, will be safe in any encounters they may have with a vulnerable student who requires support. The GMC is an interventional regulator which mandates the process of accreditation for a new school, and which can force the novation of students on a new school's programme to that of their contingency school or withhold accreditation of the university's medical degree as a Primary Medical Qualification (PMQ).
2. The programme. Medicine is a vocational programme teaching and training individuals a unique subject in ways which are both broad and deep in preparation for a specific job, that is to enter the UK Foundation Programme as safe and competent practitioners. It is more than 70% delivered off the university's

premises as placements that are often likened to apprenticeships and the tariff paid to these placement providers by central government is more than the income the university itself receives for delivering the programme. Most medical programmes specify immense amounts of contact-time, the teaching involves subjects and content that require specialised teaching facilities and materials, for example, anatomy centres, human cadavers, clinical skills labs and simulation suites.

3. The faculty. Medicine is mostly taught by medical practitioners. Not all medical schools are led by qualified medical practitioners, but the vast majority are. Many medical school academic staff are not full-time professional academics in the conventional sense of the word, and it is difficult to benchmark the CV or career trajectory of a clinician medical educator with a portfolio which includes clinical practice against the quintessential academic career envisioned by most university Human Resource (HR) departments.
4. Context. KMMS is a partnership medical school hosted by two universities, Kent and CCCU. In the UK there are only two other such medical schools, Hull York Medical School (HYMS) and Brighton and Sussex Medical School (BSMS). BSMS is the contingency school for KMMS. There has been one other partnership medical school in the UK, the Peninsula College of Medicine and Dentistry (PCMD), which was a partnership between the universities of Exeter and Plymouth. PCMD opened in 2000 and in 2012 the two universities decided to disaggregate their school and expand independently. The inter-institutional relationship and management and cultivation of the relationship between CCCU and Kent jointly, and KMMS as it became more and more tangible and discrete an entity, was always an important contextualising factor that another new school would not have dealt with.

Early in my appointment I realised that one of my main tasks is to bring two universities along their own learning curves of what it means to have a medical school. That meant that I would be influencing change in the culture of those organisations, while trying to create a medical school with a distinctive culture of its own. Given this context of two institutions and my past experiences of how university orthodoxy can fail to accept how

different medical schools are, my third epiphany illustrates my growing concerns about the way in which I experienced not just a cautious approach to letting me start but an actively disempowering approach to managing me and the school.

Epiphany 3: Don't make any decisions

I was on the phone to one of my two line managers. When I was offered the post at KMMS I negotiated an early release from my contract at Surrey. This meant I could start less than a fortnight after the interview. This took many people by surprise, as they expected that I would require a 3-month notice period at least. Now I was sweating slightly because I had resigned, but my new employers seemed reticent to let me start. Eventually I was permitted to start but I was told to keep a low profile and not to make any decisions. I wondered if anyone really appreciated how much work there was to be done and how little time there was to do it.

This reticence to accept that KMMS would, and had to, be different was the commonest of all the recurring experiences I have had. Clearly a significant phenomenon and one which Chang (2008) recommends I attend to because of that significance. During my first month, while I was meeting people, introducing myself and exploring the dynamic between the two parent-partner universities, it quickly became apparent that there was insufficient recognition that change would need to be a two-way street and that both universities would need to change in response to the new entity that was growing within them. There are various categorisations of how individuals, teams or organisations can respond to change, for example, Heifetz and Linsky (2017) contrast 'technical' with 'adaptive' changes, while Christensen (1997) described 'sustaining' with 'innovating' changes. Both make the same distinction between change that experts can achieve by applying what they already know and change that needs study and understanding of a novel challenge before adaptation or innovation in response. In both models, disaster strikes if a novel challenge is unrecognised as such or if, despite successfully recognising new challenges, old solutions are used to try to surmount new challenges.

The primary authors of the KMMS document had never worked in a medical school before, but they had worked in universities for many years. While it is was laudable to want to achieve a paradigm shift in how medicine would be taught at KMMS there was often not

sufficient recognition that if a certain approach was the norm in UK medical education, then it was most likely because it was the most satisfactory way of achieving a desired outcome.

An early decision

Despite the advice not to take any decisions, one of the first things I did was to pause the decision about a cadaveric anatomy facility while I took some time to evaluate the relative merits of using human cadavers to teach anatomy as opposed to a technologically advanced and possibly less costly option. One of the two partner universities was poised to build a human cadaveric anatomy facility and assumed that the medical school would automatically want one, but this was not self-evident to me. The decision to use, or not use, full-body dissection, prosections, plastinated specimens or other human tissues in a newly starting PMQ programme is an important one which has implications for pedagogy, cost, and reputation. Of equal significance is the role of an educational leader in horizon scanning how teaching methods will change in the 21st Century.

How to teach anatomy to medical students studying for their PMQ has been the topic of discussion for quite some time now. As well as the need to teach anatomy as a subject, decision makers need to consider the utility of the time required for full body dissection in a highly specified programme and the cost, ethical and religious context and regulatory environment of maintaining a supply of cadaveric material. More recently, the advent of new technologies has meant that the visual and kinaesthetic nature of anatomy dissection and/or prosections is more easily reproducible in the classroom without the use of human tissue. During the UK lockdown of 2020/21, many medical schools were unable to teach cadaveric anatomy using dissection due to the dual constraints of social distancing and a lack of embalmed cadavers.

A significant decision?

I was holding up part of the planning process for a multimillion-pound building while I considered how best to teach anatomy in KMMS. Unsurprisingly, I framed this as a pedagogic decision and Appendix 4 summarises my perspective of the contemporary context, evidence and theory concerning anatomy learning and teaching. The decision not to use human tissue to teach anatomy to undergraduate medical students is less

contentious than it was historically, but would have inevitably been challenged by some stakeholders, especially those from a surgical background, and would have greatly surprised some significant individuals at both universities.

I felt that my active decision to concur, rather than comply, with the CCCU plans to build an expensive facility as part of the medical school development has been significant for the medical school. Ultimately this decision was as much about growing my own self-confidence as anyone else's. The significant cost of the facility was included in the overall budget for KMMS and, since this was the expected, planned and budgeted-for decision that both universities already anticipated, no one saw it as contentious. As a result, I reassured several people that I did not make unexpected choices for idiosyncratic reasons. I would not be able to do my job without making decisions that went against what either university might be inclined to do. I would have to advise and advocate for alternative choices on occasion as well. My next epiphany is selected to illustrate the contrast between agreement and disagreement and the relationship between myself and others (Chang, 2008).

Epiphany 4: Two ends of the same bridge.

I think my university colleague bought the coffee that afternoon, my field notes do not record who did, but the social ritual of coffee in a public place was probably necessary to prevent things escalating still further. I was meeting the Director of Student Support at the University which was going to lead on this service for KMMS. We had not met before, and my colleague had been in post even less time than me, but we were both trying to manage a tense situation between the two parent-partners and the medical school which seemed to be worsening every time I heard about the latest development and which stemmed from a proposed decision that initially seemed inconsequential but which had turned out to be deeply challenging to both universities. My colleague, an extremely experienced practitioner in the field of student support, described how the two universities were both at one side of a bridge and KMMS was at the other, both seeing different parts of the same thing. I later wondered if they used this metaphor in other conflict resolution situations. Expert teams with years of experience of delivering specialist student support to over 10,000 students at either institution were disagreeing with a KMMS proposal that we needed the medical school

to be the gateway and provider of student support services. My colleague described how their university was the lead institution for KMMS student support and their team had systems and processes in place to deliver these for tens of thousands of other students. Months of dialogue, meetings, emails and group workshops leading up to this meeting established that the university student support team reluctantly accepted that, since KMMS students were going to spend about half their campus time at the other university, which had more expertise in supporting students on health and similar vocational programmes, there was probably a legitimate argument for the equivalent team to be involved as well. So, the argument went, permitting the two teams to each deliver aspects of their service which they particularly excelled at. The high costs of student support could then be shared between the two collaborating universities as well.

My coffee companion rehearsed this establishment-centric perspective, which I had heard innumerable times before. I held on to my coffee mug and tried hard not to sigh, I knew my face often did not hide my frustrations however and their body language suggested they already knew my feelings on this.

I tried to explain that the GMC would require KMMS to take responsibility for ensuring not only that students were supported but also to ensure that patients would be safe with our students, while on the programme and after they graduated. This meant we couldn't let students fall between the inevitable cracks if the two universities provided a fragmented service. I felt that this arrangement would mean that qualified medical practitioner-educators had to be enabled to monitor students and determine if they were putting patients at risk. So, KMMS needed to know about the student with bipolar disorder so that they could not harm patients by neglect if they were depressed or if they had a manic episode, we needed to know about the drug abusing student because they would be placed in situations where they might be able to access controlled drugs.

My colleague's eyes widened. Just the information sharing required for this sophisticated system of student support was beyond anything either university's systems were prepared for, never mind the resource and power that would need to be placed within KMMS.

This was not the first, nor the last time when it felt that the collaborating universities rejected an adaptive change that I was advocating because they wanted to do things a

certain way and they preferred a technical or sustaining approach (Heifetz & Linsky, 2017). After experiences like this, I often felt that there was a prejudicial view of KMMS as always asking for a bespoke solution which incurred additional and unnecessary expense of opportunity costs, and which ignored the efficiency of utilising existing processes.

Concluding Reflections

My active decision to proceed with the anatomy facility passed with barely a ripple, seemingly because it was an expected acquisition as part of building a medical school despite the huge cost. My proposals for a seamless, compassionate and safe Fitness to Practice process encountered a minefield of objections leaving me to decide whether to fight for an adaptive change to both institutions' approach to student support. It seemed that both institutions would usually prefer a technical change on the grounds that that this was the way to harness the best of each university. The leadership skills I could already bring to my new role included expertise in medical education (which garnered respect from certain quarters while it induced concerns about privilege and elitism in others), the construction of arguments that others would accept and a high degree of comfort in the uncertain, start-up environment requiring problem solving as we went. I was learning where my skills would allow me to argue successfully for adaptive change when required and when I would be better off accepting technical solutions and forming these to the needs of the medical school. It was becoming clear that this was going to be a lot more complicated than I originally anticipated.

My two universities and new colleagues outlined an exciting and innovative vision of a new medical school which had been judged against many other competing bids and objective criteria and had come out on top. There was clearly value in that bid and any change I proposed to the vision would not be automatically accepted. I could not just lead the creation of a brand-new medical school and contemplate the inevitable catalysis of change in the two collaborating universities from afar. For example, the universities had already decided which institution would have responsibility for various functions of programme and school administration. In dividing these functions between the two institutions, some barriers inevitably emerged between different cultures, expectations, and bureaucratic processes which it was also my job to overcome. What was less obvious

to me at the outset, but rapidly became one of the most stimulating aspects of my job, was that not everyone shared my perspective or enjoyment of managing uncertainty. I would have to get involved in the wider activities of both institutions to lead the medical school to provide that reassurance and influence.

To do so I would have to grow from my own current understanding of leading change to something more sophisticated.

5. Moral Purpose

In the previous chapter I discussed my realisation that KMMS was a cathartic change for some individuals and challenged certain orthodoxies in both universities. I realised that part of my job was to turn that vision, originally written by others and now one I had to champion, into reality. While I could more easily make decisions that aligned with the vision and which amounted to technical changes, I encountered quite significant resistance to decisions which entailed adaptive change, or which were perceived to threaten the original vision. To address these concerns, I needed to engage with the huge range of stakeholders, considerations, levels within the organisations and more and integrate and balance these to make any progress. In this chapter I shall describe how I started to approach this task. I will frame this using the first component that Fullan (2020) advised leaders of change in educational cultures to embrace: Moral Purpose. I have chosen these epiphanies because this episode became one of the most culturally impactful actions I took in the early days of my appointment (Chang, 2008). The contrast between each epiphany highlights issues in how I built the KMMS culture and team and how that culture was not always reflected in some of the processes and behaviours required of the school by external parts of either university. This gives rise to questions about whether the moral purpose of a medical school transcends that of its hosting university, whether a strong moral purpose is an inevitable feature of a medical school and what happens if the actions of either the medical school or the university traduce that moral purpose. I will return to these themes often during the rest of this RBT.

Epiphany 5: Writing the KMMS vision, values and mission statement

By email:

> Dear Chris,
>
> I am the Marketing Manager for the Faculty and am part of the Marketing and Student Recruitment Group for Kent and Medway Medical School.
>
> As part of the action plan, we need to start working on the KMMS prospectus and I wanted to arrange an initial meeting with yourself and a few colleagues to discuss ideas and content.
>
> Would you mind letting me know when you have any availability in the next two weeks? We would only need an hour and I'll arrange it at Christ Church.
>
> Many thanks
>
> Elsie
>
> Elsie Craven
> Marketing Manager
> Marketing and Communications

Box 10: Personal communication

One morning in late November 2018 I arrived at Governor's House, the building that KMMS was being housed in, to meet Elsie and six other colleagues from across both universities who made up most of Workstream 2: Marketing, recruitment and Stakeholder Engagement, one of 12 workstreams initially supporting the KMMS project.

Over the course of the next 2 hours, we discussed various aspects of the marketing and student recruitment strategy and the pragmatic aspects of items such as the prospectus. The prospectus was needed urgently so that we could have literature and material available for student recruitment. With a September 2020 start we would be interviewing candidates in Winter and Spring of the 19/20 academic year; they would need to have applied through the Universities College and Admissions Service (UCAS) in the preceding Autumn of 2019, so we needed to host our open days and deliver our recruitment events in the 18/19 academic year. The universities have different formats, different colour schemes and different layouts for their prospectuses and other printed and digital materials and it seemed like a brief and not controversial decision to agree that the KMMS information within each parent-partner university's prospectus would not conform to either institution's individual house style but

would follow the KMMS style and be the same in each publication. It was only later that I realised that that brief and innocuous moment in the meeting represented a significant decision that was only possible because of the seniority and number of people who were present from each collaborating university.

Shortly after this meeting I found myself staring at a blank screen trying to write the KMMS mission and vision statements. These were needed quickly. I was the only KMMS substantive employee and the Founding Dean but by now I realised that the governance of the KMMS project was not the fast and dynamically responsive system that it needed to be to achieve the pace of work required. The decision about format, layout and colour scheme for the prospectus was unusual in the speed with which it was taken and the absence of a need to consult widely with various other stakeholders.

I needed to write something that properly reflected what I wanted for KMMS, but it also needed to align with the hopes and aspirations of multiple stakeholders. The resulting mission statement and vision would need to be true to the bid and criteria set by HEFCE. However, these needed further development to incorporate references to specific factors that would be recognised by clinicians and peer medical educators otherwise it would not be credible in the UCAS marketplace. The challenge was doing this in a way that remained accessible to the archetypal, naïve but eager 17-year-old applicant, their parents, more mature applicants and many interested observers and lay-people who would read our copy.

Michael Fullan and Moral Purpose

Fullan proposes that moral purpose in education leaders "falls far short" (2020, p. 24) of what is manifest in the business world. He is not saying that education leaders lack moral purpose, but that it needs to manifest as actions which lead to accomplishments which are aligned with that purpose in order to be useful and effective. Reiser (2000) argues that the impact of what he calls the "moral order" of a medical school is "profound"(p. 3), and that staff role-model this moral code for students in everything that students witness about the school. He also agrees with Fullan that educators do not always recognise how powerful their actions can be when they neglect to attend to this aspect of the school. Our Mission and Vision statements were ways in which I felt KMMS could begin to articulate

our moral purpose in ways that would tangibly influence our culture and our behaviours. Fullan cautions that arguments for morally purposeful change grounded in evidence simply demonstrate that something *can* be done. I had demonstrated the utility of this in my discussions pertaining to the pedagogy of anatomy. Stating and restating the morality of a proposed change merely tells people that something *should* be done. In my private reflections I have wondered if this was why I was initially unsuccessful in convincing colleagues of the merits of my proposal for a more adaptive change for student support. Finally, telling people *how* to change in a moral vacuum does not *make* change happen. So, while having an moral purpose is a good starting point, people need time to understand, collaborate, learn and make sense of things as well. Educators, Fullan observes, have their moral purpose "handed to them on a plate" (p. 30), in medicine this is probably even more the case.

Fullan (2020) goes on to say that there are too many barriers between moral purpose and its manifestation as educator behaviours. Educational leaders need to ensure that their team workers can see a direct linkage between what they do and what they contribute to the moral goals of the organisation. In this way the linkage becomes the golden thread that joins an organisation's people to its True North (Toyota, 2020). After articulating an moral purpose, it is the leader's responsibility to build and enable a team to visualise and achieve the moral purpose in their daily work. Fullan proposes that the moral purpose of education is self-evident, surely the moral purpose of medical education is equally obvious?

The moral purpose of Kent and Medway Medical School

Some of the assumptions I was making about the relationship between medical schools and their host universities were predicated on my experience of inter-relationships as they were for established schools, sometimes developed over hundreds of years (Appendix 5). When medical schools became part of the established university structure in England in the late 1800s, some compromises were required to adequately recognise practicing clinicians in university structures and accord them appropriate academic rank. The result is a wide range of heterogenous arrangements for the structure and organisation of medical schools in the UK. It was clear that I needed to rapidly take both

universities on a journey to understanding this set of circumstances and reach a mutually satisfactory arrangement for KMMS and Kent. My work to develop the mission, vision and values of KMMS naturally led to our articulation of the moral purpose of KMMS. My hope was that the KMMS moral purpose would help make change happen.

The mission, vision, values and goals of KMMS

The mission for KMMS was naturally informed by the priorities of the UK Government and the HEFCE bidding process as described above. The application form required substantial information under the following headings:

- Widen participation in medicine.
- Address significant health inequalities in Kent and Medway.
- Provide high-quality placements.
- Ensure that all our students have significant exposure to primary care, mental health and acute medicine.
- Have an innovative curriculum.

The two people who led the writing of the bid and who became key to my role, Debra Towse, Pro Vice Chancellor (Medical Education Development) at CCCU and Peter Nicholls, Dean of Kent Health at Kent articulated the universities' vision for KMMS by 2030 (Box 11).

> KMMS will be a beacon for first class medical education (measured according to the Teaching Excellence Framework (TEF) and National Student Survey (NSS)) and research (according to its Research Excellence Framework (REF) rating), and the first choice for all those aspiring to achieve excellence in person-centred medical care in the UK.
>
> By providing a distinctive, socially diverse and insightful graduate supply chain, KMMS will enable, influence and drive changes within the clinical workforce to deliver high quality healthcare and outcomes across Kent and Medway.

Box 11: Vision for KMMS by 2030 as stated in HEFCE bid

I developed this vision further after the meeting described in Epiphany 5 (above) for use on publicity material, websites etc (Box 12).

KMMS will:

- Be a beacon for first-class medical education and research, and the first choice for all those aspiring to achieve excellence in person-centred medical care in the UK.
- Innovate in teaching, research and leadership.
- Offer early clinical placements that showcase GP, Community and Mental Health on a par with all other medical specialties.

We will produce a new cohort of medical graduates who:

- Will be representative and inclusive of the communities our graduates will serve.
- Will understand the critical importance of integrated, multi-professional care.
- Will find global solutions to local challenges and lead, manage and innovate in 21st Century healthcare.
- Will be confident, entrepreneurial advocates for patients, their families and their communities.

Box 12: KMMS vision as stated in publicity material in 18/19 academic year

About a year later in late summer 2019 I organised a team away day with a facilitated session to develop collectively a set of KMMS values and complete the triad (Box 13). By the time we started to have open days for our 2020 applicants we had a mission statement written by the original authors of the bid to HEFCE, a vision written by that same group but then amended solely by me and a set of values which emerged from a KMMS team away day.

Even though articulating the moral purpose of KMMS in its mission, its vision and its values started out as preparation for our first recruitment cycle for our pioneer cohort of students, it ultimately turned out to be much more useful in getting many different stakeholders enthused about the inevitable adaptive change that opening the school would entail. However, I was not always successful in achieving this.

- Be brave
- Be kind
- Be respectful
- Be passionate
- Be collaborative
- Be innovative
- Be curious

Box 13: KMMS Values

(Kent and Medway Medical School, 2023b)

If mission statements, vision and values are tangible ways in which an organisation publicly commits itself to some form of shared ethos and culture, then there should be some linkage between these declarations and an moral purpose. Warter (2019) proposes that universities are complex and idiosyncratic organisations which attach value to individual characteristics such as critical thinking and autonomy while needing to respond to changes in their business environment which require unity of purpose and collegiate action to navigate successfully. Beytekin, Yalcinkaya, Dogan, and Karakoc (2010) describe how the tensions and balances between these competing values can be used to assess dominant and subordinate values in an organisation (see Chapter 7). However, Gurley, Peters, Collins, and Fifolt (2015) demonstrated that clearly articulated, frequently referenced mission statements and visions at a single university in the United States can fail to gain any real traction. Lewkonia (2001) reviewed the mission statements of medical schools in the US, Canada, the UK and Australia. Stylistic differences aside, most of the mission statements Lewkonia analysed highlighted the importance of education, advancement of knowledge and service to society, but rarely described "objective outcomes data and measures of medical school performance referenced to the institution's stated missions" (p. 1).

When it comes to individuals who assume roles in clinical medical leadership, Moen and Prescott (2016) describe how the NHS attached increasing importance to values-based, shared leadership approaches in the 2010s. This has been reflected in the evolution of

documents such as the Faculty of Medical Leadership and Management professional standards (2020). The implication is that inculcating a shared sense of responsibility amongst all participants in the organisation's endeavours would improve quality and service. To achieve this, a shared, values-based culture with a clear sense of purpose is essential. Bligh and Brice (2007) proposed that a medical educator should have a tripartite skillset encompassing teaching, research and management within which they describe a nested set of core values: professional identity and integrity, commitment to scholarship and reflection, respect for others and the promotion of quality and safety of care. These have been adopted by the Academy of Medical Educators (2021) as being central to their professional standards. When the roles of clinician, leader, academic and educator are merged in the role of a medical school dean, tensions start to proliferate. Daugherty (1998); Evans (1998); Rich et al. (2008) are all American authors writing about the role of US medical school Deans whose publications my literature review identified (Part 1, Chapter 3, Research methodology used in previous studies, Box 4, p41) (above). All describe domains of management, diplomatic and interpersonal, knowledge and attitudinal skills and all describe the importance of a medical school Dean in articulating and embodying values aligned with their school's culture.

One of the reasons I was so excited to be offered the chance to turn the KMMS bid into reality was because I thought I was aligned with the moral purpose implied in the bid authored by the two universities. I was instrumental in refining the mission statement and authoring the vision and an equal participant in the exercise to construct our KMMS values and I found them to be equally inspiring. The especially enticing aspects of these statements were the promise of welcoming innovations in medical education, the emphasis on person-centredness and the absolute prioritisation of equity in selection for places at our school. Many of these clearly resonate with the picture of me painted by my Hogan Personality Inventory™ (Appendix 1) Since we described these three important public statements, they have become touchstones for us. They were frequently referred to in our team meetings during the pandemic lockdowns and are still mentioned now when we challenge each other to be "brave" or "kind". We discuss them in staff training events, open days, welcome days, fundraising events and much of our publicity materials

reference one or all of them. I detect that they resonate with our stakeholders across both universities and further afield.

Epiphany 6: Human Resources

This resonance was not universal. One example was in how Kent intended to meet the HR requirements for the medical school. KMMS' needs were clearly opaque to many outside the medical school. Some colleagues saw our requests as examples of medical elitism rather than indicative of our aspirations to catalyse adaptive change. My next epiphany demonstrates that when the moral purpose of the school was not self-evident to other parts of the university (the *can*, the *should* and the *how*), and we were unable to *make* change happen, this had a negative impact on those of us who did believe in the moral purpose of KMMS.

"Chris, I'm worried I won't be able to get a mortgage", said Simon during one of our fortnightly, 1:1 meetings which had been virtual since the first UK lockdown several months earlier. I didn't know what to say, was this hyperbole, anxiety due to a personal financial situation or yet another legacy of some decisions taken about how KMMS HR matters would be managed, and which all seemed to be bearing fruit in unexpected ways. I was deeply affected by my colleague's situation, he had brought his young family from overseas to join.

The two universities decided that the best way to employ KMMS faculty was as employees of one university only. The University and the Director of HR was not convinced that KMMS HR matters needed to do anything other than follow standard university processes, and we were coming up against many of the accommodations required of universities since the late 1800's to merge the professional structure of medicine with the academic structure of a typical UK university. The consequences of this were now manifesting as distressing situations for my colleagues and me. My reality was that the medical school job descriptions and contracts were non-standard for the university because they needed to include clinical time and NHS pay scales. Some needed to be issued as joint appointments with NHS providers, while others were substantive appointments to the university, for example GPs are not NHS employees and some Doctors work for local government or for charitable organisations. Academic ranks appeared inflated because the academic career map for either university did not adequately recognise and reward

experience and expertise gained in professional clinical practice. I felt a huge responsibility to every member of KMMS who joined us at start-up and aspects of our employee relations were causing me significant moral injury (Litz et al., 2009) .

The obstructions felt never-ending and many of our HR processes developed iteratively and painfully and continue to do so. Clinicians were appointed to contracts and remuneration packages that were adjusted in later years. A decision about how remuneration packages would be structured and a reluctance to appoint our faculty to clinical academic contracts resulted in Simon's concern about obtaining a mortgage. We quickly realised that KMMS needed to attract new people into the region due to the size of our recruitment drive and the talent profile available locally. This meant that we needed to look like a competent and desirable employer. An erratic HR service was not conducive to giving this impression. The obvious conclusion was that we were being provided with insufficient HR resource for a start-up on the scale of KMMS. More intangibly it felt as if our moral purpose as articulated in our mission, vision and values was not sufficiently motivating to change HR approaches at Kent.

Concluding Reflections

Medical schools have not always been part of the university community and structure. Each medical school has a different culture, as does each university that hosts a medical school. Often the inter-relationship between medical school and host institution is unique and not as it is between other parts of the organisation. Sometimes there is a wide organisational gap between the two, in other cases they are much more enmeshed. The advent of new medical schools in universities that have not had medical schools before continues to catalyse change, both in approaches to medical education and the way in which medical schools are organised.

Fullan (2020) recommends that educational leaders should prioritise the articulation of a shared moral purpose for the organisation they are leading. I have described how I went about doing this at KMMS. The KMMS values have become touchstones within KMMS for many colleagues and widely respected across both universities. Certain individuals in both universities, especially those who were co-authors in the successful bid, were enthusiastic about what the medical school offered for each institution, increased status,

increased research income, or a more intangible effect on the university culture and ethos. There was also apprehension about the change that KMMS would inflict and the social and financial capital that the school would acquire, and other colleagues were more reticent in welcoming the work, the adaptive change or the impact of the school on their existing environment. In some circumstances I experienced what I felt as moral injury when I felt that the moral purpose of KMMS was being compromised by university orthodoxies, for example in some of our HR practices.

6. Understanding change

In the preceding two chapters I discussed my growing understanding of the impact that KMMS was having on the culture of the universities and outlined my work to articulate the moral purpose of KMMS. Fullan (2020) recommends that leaders advocate for the moral purpose behind the major change they are leading. This happened during my first year and was useful in obtaining engagement across a wide range of stakeholders. It was starting to emerge, though, that a strong moral purpose is not a panacea, and there are risks if an especially strong moral purpose is compromised.

The epiphany I have chosen for this chapter was significant because of the emotional tensions that emerged when I came up hard against this clash of cultures. KMMS' enthusiasm for change being doused by the cold water of university orthodoxy was not what Chang (2008) would call exceptional, especially in the pre-opening planning and development stages of KMMS, but it was cathartic. What this epiphany also provides, compared to any other example of this cultural clash, is the opportunity to frame what happened using some theories of management and leadership, another of Chang's recommendations. These theories helped me to reflect on where I might have gone wrong here and adopt the open mindset for learning recommended by Keating et al. (2017). Some of my reflections led me to wonder if medical schools are sufficiently unique as to deserve their own sociology of leadership.

Epiphany 7: Rescuing the design sprint

"Chris, Alice has asked me if there is any way in which you can come and rescue this sprint?" asked Susan on the phone. This sprint was focusing on the specification and design of the KMMS Virtual Learning Environment (VLE) . It was in its third day, and I was in another meeting which we ensured that I could leave, but why did Susan sound quite so rattled? This was the sprint we were most apprehensive about, and we'd known that things were getting tricky, but the preceding days had gone well enough, and we'd hoped that I wouldn't be needed. What Susan described sounded as if some senior colleagues from one of the universities reached the end of their tether in the final day of the sprint.

"OK, where are you again this morning?", I asked, because this sprint had been a bit itinerant due to room availability. Susan directed me to the University of Kent Enterprise Hub. So, I set off across the open spaces of the campus. When I got my bearings slightly wrong, I ended up in a hamlet of student accommodation blocks and needed to take a shortcut across what turned out to be more muddy terrain than my shoes were intended for, and then found that the building was crescent shaped with a glass façade and no discernible entrance. I arrived at the hot and overly cramped seminar room feeling like I needed to regain my composure while Alice briefed me on what was going on. Alice, Susan and Leanne were beside themselves with anxiety, because they thought that the sprint was about to cause more harm than good.

The three of them had told me at the end of each of the previous two days about a lot of behaviours which raised their concerns. Openly scathing and sarcastic remarks about other colleagues' contributions, an undercurrent of scepticism about the time that was being devoted to this activity while people could have been getting on with the day job and different and conflicting cultures and approaches to creating and using a VLE were brought into the open. It felt quite awkward at times. It was clear that the Information Technology (IT) teams from the two universities were not yet comfortable with the amount of disclosure that working together on the KMMS project was going to require, and secondly, we invited current, non-medical, students to the design sprint, and it was becoming apparent that they didn't hold the current VLE run by either university in high regard. A 3rd year student from another programme described how they used one university's VLE during their time on their programme. They described finding most of the front-page text and instructions useless, they explored the VLE in an organic and self-directed way, they wanted simple pages with less text and more obvious clickable paths to the information they required, preferably signposted by graphical means. Finally, they stated bluntly that during the three years of their programme they had not regularly used large sections of the VLE for their programme, because faculty personally provided the information when asked and they had often found most of the information redundant and out of date. This was met by stunned silence by the IT team from the associated university and some schadenfreude by the IT team from the other university. Further discussion revealed that the IT teams regularly met with faculty to

plan the VLE for this student's programme but rarely, if ever, met with student users. It seemed that faculty either didn't convey or account for students' requirements in those meetings or hadn't appreciated the student perspective. While we were planning this sprint, Alice and I sensed that this exclusion of the student perspective might be an issue and so the presence of students was a deliberate attempt to pre-empt this situation for KMMS. It seemed that the strategy had misfired, and we were at risk of alienating some key colleagues who we needed to achieve our vision.

Alice and I hoped that bringing IT professionals and current students together in the design sprint forum would catalyse new thinking about evolutionary change. The behaviours, the scepticism about the event and the discomfort caused by the public disclosures meant that neither IT team was able to work collaboratively and creatively towards a solution for the KMMS VLE and the presence of students was adding to the discomfort, rather than facilitating collaboration. Alice, Susan and Leanne had discussed their concerns with me at the end of each day but hoped to draw a line each time. We agreed that if it continued during the third day, they would call me in to try to restore things. While the attendees at the sprint ate their buffet lunch, we put our heads together in the corridor outside and we decided to try to separate out the IT colleagues who were clearly experiencing most dissonance as a result of the activities of the sprint and Alice would take them to a break-out room to try to address their concerns directly while I tried to re-engage the other participants by a combination of participation, role-modelling and advocating for our vision of what was required.

Digital First

I always believed that if KMMS was to deliver a 21st Century medical school experience, then we needed to prepare a digital environment for our students which would support their learning and their engagement with KMMS and both parent-partner universities. I called this "digital first". This was meant to mean that our preference for pedagogic approaches, learning materials and administration would be digital and that we would enable students and staff to work in a digital environment.

The imminence of radical change in the HEI sector due to the development of learning technologies has been predicted for quite some time. Noam (1995) predicted a "dim

future" (p. 247) for universities as a result. There are many other reasons why medical schools, at least, require a physical seat of learning, but the de-escalation of the importance of didactic content in a medical programme is a very real phenomenon. KMMS offered an opportunity to take a tangible step towards this new model. In a previous role I worked with a passionate but frustrated Learning Technologist, who felt constrained by an institutional approach to VLEs that viewed them simply as a repository of knowledge, a school and academic faculty which was deeply sceptical of the opportunities offered by new functionalities, and a student body that largely ignored the VLE unless they were specifically directed to a particular part of it and who mostly held it in low esteem.

As in all other walks of life, digital technology is advancing in healthcare too. The UK Government has made it clear that there needs to be a deliberate, strategic and mass movement towards adoption of digital technologies in health and care that needs to move faster than is currently happening (UK Government, 2018). In my own clinical practice I work in largely paper-free environments and those places where the Electronic Patient Record (EPR) (Gordon, Geiger, Lowe, & Jickling, 1998) is not a ubiquitous reality are planning for it in the near future.

I imagined that IT colleagues in universities would be keen to advance this digital first agenda and that students would be of assistance in changing culture. I equally thought it was perfectly reasonable to use this opportunity offered by KMMS and two institutions which both said they wanted us to be a catalyst of innovation, because the cultural barriers to doing so would be minimal and my rationale for doing so would be seen as self-evident.

I thought that the key arguments that justified this were:

- The digitalisation of the education environment and the adoption of digital technology in healthcare meant it would benefit our students to learn and practice in mostly digital environments.
- The challenges of delivering materials to learners and their teachers across a distributed geographical area that incorporated two university campuses and multiple NHS venues.

- The capacity to use the VLE to make the KMMS brand seem modern and forward-looking.

The challenge was not just getting the digital systems of two universities to work together so that we could use them seamlessly. Like any other VLE for any other programme, we needed students to be able to access high-quality learning materials remotely and we needed their teachers to be able to do so as well. The added issues were that not all our teachers would have university logins, our students would be studying on NHS premises and living in NHS accommodation where Wi-Fi access can be unreliable, and clinical systems need to be kept secure, so firewalls are common. Students would need to access content and features for assessment as well, so systems needed to provide the security, resilience and governance required, even in a remote and distributed way. By year three of our programme, we were planning for our students to spend an entire year at a time in hospital placements. Placements designed in this way are called Longitudinal Integrated Placements (LIPs) (Norris, Schaad, DeWitt, Ogur, & Hunt, 2009), and adopting this approach meant we needed to facilitate remote working for our students to the point that they would have a level of digital access to programme materials equal to what they would have on campus. This terminology of digital first, and the need for remote learning that would present more challenges than our IT colleagues were used to, predated the advent of the pandemic and periods of lockdown and virtual working that started in March of 2020. In late-2019 getting engagement to produce learning and teaching materials, from timetabling to supporting the academic content creator, from VLE to learner who needed to be able to access content from anywhere in the world was raising significant challenges for everyone. After many conversations with IT colleagues, we concluded that the requirements for the medical school VLE were still underappreciated. The design of the KMMS VLE was fundamental because we recognised that the amount of work required to create it meant that it was vital that these two teams worked together if we were to achieve what we wanted and needed. We needed to agree key principles about the KMMS VLE: what university would host it, would we use an existing platform from one of the universities, or some chimera of both or a bespoke purchase? What new functionalities did the IT teams need to consider that the medicine programme would

require which they had not needed to provide before? All these decisions needed to be made before we could begin creating user-facing content. Time was pressing and we expected the GMC to request examples of VLE content when they next visited.

A wicked problem

As I highlighted in the introduction to this chapter, this was just one example of a recurring issue of determining how to navigate the competing priorities of two collaborating universities, who sometimes seemed to have mixed feelings about their problem child. It was beginning to be one of the main issues that consumed my time and energy and the resources of KMMS. The most recursive and procrastinating discussions that we were having in KMMS project board meetings seemed to focus on the most wicked of our problems.

Wicked problems were described in the late 1960s by Rittel (n.d.) and Churchman (1967) and have a number of characteristics. All authors begin by explaining that 'wicked' is not a moral description, instead the term means resistant to resolution because the proposed solutions may turn out to be worse than the symptoms. The criteria for wicked problems are shown in Box 14, unsurprisingly they are common in complex adaptive systems, and many of the especially challenging aspects of the medical school project seemed to be wicked. It was a recurring experience that a wicked problem resisted technical change and required an adaptive change.

- Ill formulated social system problems.
- Confusing information available.
- Many clients and decision makers with conflicting values.
- Ramifications for the whole system are thoroughly confusing.

Box 14: Criteria for Wicked Problems

(Churchman, 1967)

The first KMMS Project Manager came from Klynveld Peat Marwick Goerdeler (KPMG) International Limited, the Anglo-Dutch multinational. They had recommended a project structure involving 12 workstreams, each with executive leads from both universities to lead the project. Half were based in each university in an apportionment described in a

legal memorandum and which presented me with 24 executive leads to work with. The workload required of these workstreams to start-up KMMS, especially work that was to be undertaken by non-academic, professional services staff, was bundled into existing employees' portfolios by adding notional and fractional amounts of full-time equivalent (FTE) time into individual roles and departmental budgets and very few additional members of staff were recruited. Additionally, Kent was undergoing a significant reorganisation at the time. This was intended to involve shedding a large fraction of workforce for the good of the wider institution and meant that many roles were being re-evaluated, making it relatively easy for managers and directors to notionally include the work associated with the start-up of KMMS into portfolios that were in flux already. The disadvantage was that, since the institutional direction was to reduce headcount, everyone was feeling that the same amount of work was being done by fewer people and now KMMS represented yet more work, and we were asking for significant adaptive change that would take people away from work unrelated to the school that was still regarded as the priority activities of these roles. At the same time the executive sponsors for each workstream felt that KMMS was helping to preserve posts that would otherwise have been lost. Line managers maintained that in this state of flux it was not yet clear that the resource provided for the work required to support KMMS was sufficient, hypothecated or identified as resting with the correct individual.

This meant that we were working within a set of nested but conflicting attitudes to KMMS:

1. Our collaborating universities were both committed to KMMS at the highest level.
2. The colleagues from the wider workforce of each university were each based within a single, autonomous institution.
3. It was KMMS colleagues that felt the strongest imperative to work seamlessly across both institutions.

The recurring issue seemed to be that the degree of collaboration we were seeking was greater than what our colleagues were already doing, and this seemed to be a blind spot for many of our co-workers. We were often told that they already collaborated with their counterparts in the other university, or that the universities already had partnerships which worked well. Our experience was that KMMS was aspiring to more seamless and

more integrated working than was previously the case, and some of our requirements were essential for the success of the project and aligned with our moral purpose. In our work with the GMC, it was already clear that they had an expectation of how a medical school should look and function and it was clear that we needed to create a medical school that looked like it met this expectation with a discrete function and presence. This set KMMS slightly apart from the two universities and this was a constant tension for all parties as two autonomous institutions tried to accommodate the arrival of a third entity which was meant to be drawing on the best of both universities, but also needed to function as a discrete unit and provide students and staff with a seamless user experience. Additionally, our explicit mission to innovate and be a catalyst for change meant that we were intended to do things differently from the outset.

So, KMMS was being set-up across two universities, both of which were undergoing some organisational change, which for one was very significant. This meant that the way in which KMMS was meant to integrate into the societal structure of the two universities was ill-defined and difficult to conceptualise. The project was fast-paced, and KMMS needed to develop in an iterative way to accommodate the competing requirements of its various stakeholders, since these were also evolving. Many people were operating with a lot of uncertainty and the information available changed often. The KMMS team, the teams from either university, our regulator, students (current and future), our contingency medical school, the NHS in Kent and Medway etc., all these stakeholders, and more, had different and conflicting values and different interpretations of what would constitute success for KMMS. The ramifications for the two universities were already starting to confuse people and the consequences were being conflated with other university factors, such as financial and human resource pressures.

All these factors meant that the established culture and moral purpose of two universities and the nascent KMMS culture often felt like they were at odds, even though the ultimate goal was the same, and we had frequent, circular discussions about key decisions that failed to achieve reconciliation. Fullan (2020) advises that successfully leading change cannot be reliant on people following innovation for its own sake and must involve people and organisations becoming open-minded and receptive to innovation. moral purpose

goes some way towards encouraging people to coalesce around a touchstone but is not guaranteed to achieve this for everyone. The contexts of organisational change associated with fears for job security and the financial stability of the universities were inhibiting people's capacity to adopt an innovative mindset and KMMS was beginning to throw up wicked problems which were slowing the project down dangerously. Fullan suggests that a powerful way to encourage colleagues to have a greater willingness to accept innovation is to present it as an opportunity for everyone to learn together, and the design sprint was an attempt to do this.

Design Sprints

Alice was a godsend when she arrived. The original project manager supplied by KPMG reached the end of their contract and the subsequent project manager was out of their depth from the moment they arrived and had a very short tenure. Alice, our third project manager in two years, rapidly restored purpose and direction to the management of the project. She was a whirlwind of energy, ideas and enthusiasm. The first thing Alice addressed was our cumbersome, confining and complicated project structure. We needed to transition the workstreams to a new, smaller structure in a way that did not mean that we lost any ground during the transition, and we were aware that there was a risk that colleagues would react badly to the change and possibly disengage from the medical school project. I had organised the 12 workstreams into 6 'high-touch' and 6 'low-touch' workstreams to try to make the demands on my time more manageable. This was partially successful but was now starting to show signs of strain too and the situation was becoming untenable for everyone. Alice and I worked to slim that team down and got approval for a more agile and functional reporting, governance and oversight structure and quickly moved on to the next thing. Proposing a further round of streamlining our project structure, this time focusing on governance, this was agreed by the Universities Joint Management Board (UJMB) – the overall decision-making Board chaired by the two Vice Chancellors. I did not realise the significance of what we achieved at the time.

Alice is a passionate exponent of design sprints, and she thought that this methodology would help to manage the transition to the new way of working and help us unpick some of our wicked problems. I had heard of design sprints before but not used them, I felt that

they could present this process as a learning opportunity. Originating in Scientific Management (Taylor, 1911), a design sprint primarily involves bringing together designers, engineers, managers, marketeers, users, customers (if the focus is a commercial product) and any other key stakeholders, at the start of the process of designing a product. The intention is to avoid what scientific managers regard as inefficient and recursive aspects of a typical consultative and creative process. This means that one of the key characteristics of a sprint that differentiates it from other consultative processes is its time-limited nature, five days to three weeks is typical, depending on the scope and complexity of the product being designed. The activities undertaken during a sprint are often quite heterogenous, but the common intention is to have mixed sub-groups of the team work on aspects of product design in tasks that will offer opportunities for team members to take advantage of new perspectives and to have conversations with people involved with the product from the whole production chain, from design to purchase and use in the real world. One vital initial stage of any sprint is to explain the methodology, address any scepticism about it and try to ensure that everyone is engaged in the sprint with an open mind-set. The methodology appealed to me as it seemed likely to foster collaboration and discourse. The universities were less enthusiastic. When Alice and I initially proposed design sprints we wanted to conduct 12 different sprints, each focusing on a different aspect of the project and each bringing together stakeholders from as wide a reach as we could achieve from the previous workstreams so that we could articulate and plan to address their concerns. We were challenged on the amount of time we were scheduling for them and the number of people we were inviting. The executive sponsors for the workstreams received many representations from line managers that KMMS did not warrant 12, five-day workshops, each involving large groups of people from across two universities. After some negotiation we reduced the number of sprints we felt acceptable to 6, we reduced the time to a maximum of 3 days, and we reduced the number of people involved in each sprint. Alice and I thought that this compromised what we could achieve, but something was better than nothing. So, despite the restrictions on topics, time and people, we decided that a design sprint methodology was still the best approach.

The executive sponsors for the IT workstream were some of the most vocal in objecting to the design sprint methodology because of the resource it required. We later found out that the IT director from one university had previous experience of a sprint and was unimpressed by the experience. They also happened to be one of a small group of colleagues I encountered during the KMMS journey who had previously worked in other universities with a medical school and who felt that they had specific knowledge and experience of a medical school's requirements as a result. Often this expertise was welcome and useful, sometimes it fostered blind spots because running and maintaining an established system did not always mean that colleagues understood what was required to set up a novel system in a partnership between two universities. This particularly applied to the VLE and my digital first strategy.

Alice and I sensed from the outset that this was likely to be a sensitive sprint and the conduct of the first two days seemed to have confirmed that. We hoped that the methodology would create a flat-hierarchy environment, with multiple stakeholders who would engage with the challenge of a real-world opportunity in an open-minded and constructive fashion. Instead, what seemed to have happened was that two groups of IT professionals, primed to be sceptical of the activity and who were still uneasy about working together came to the sprint, demonstrated unhelpful behaviours and had felt either humiliated by the feedback from students, or enjoyed the spectacle.

How had it gone so badly wrong?

A management proverb, often misattributed to Peter Drucker, says "culture eats strategy for breakfast" (B. Moore & Rose, 2000, p. 28; O'Toole, 2017), and is often used when leaders reflect on why their strategy for change did not achieve all that they wanted to achieve. Fullan (2020) suggests that by aligning the moral purpose of an educational endeavour with a culture of learning, strategy stands a much better chance of success. Hence Fullan's advice that instead of culture being "the way we do things around here" (Deal & Kennedy, 1982) which change must push against, an educational leader frames what needs to be done as an opportunity to learn.

There is a plethora of descriptions on how to catalyse innovative change or transformation from the top, from the bottom or by leading change. Much of this advice is

so generic as to be another example of Argyris' (2000) useless, non-actionable advice which leaves people feeling that the change cannot be managed. Fullan (2020), who I have chosen to guide me, recommends Mintzberg, Ahlstrand and Lampel's advice to be "pulled by the concerns, not led by the concepts" (1998, p. 373). Our concern was that the medical school was having to spend so much time negotiating the prevailing culture of the two universities that this was becoming a risk, both for the school developing its own culture or, more worryingly, for getting the decisions it needed to open in time. This design sprint demonstrated that we had not sufficiently recognised that our concerns were not always shared.

The prestige, power, social and civic missions and strong moral purpose meant KMMS attracted many committed and proactive colleagues who were energised by the prospect of what seemed possible. Alice, Susan and Leanne were amongst the most energetic members of the nascent KMMS team. Start-ups tend to attract what E. M. Rogers (1983) referred to as early adopters; the project needs attention and resource and appeals to people who like the excitement of being involved with something that is special, unique or innovative. These attributes are often part of what helps the team stay the course, deliver the project and manage any gaps between expectation and outcome that emerge. These are exactly the sort of people who will enthusiastically adopt a strong moral purpose. Using Rogers' taxonomy of different types of consumers and their affinity for innovation, one estimate is that 16% of people are keen adopters of innovative technology, but only 2.5% of those people will be the most enthusiastic of these early adopters, who he termed innovators (E. M. Rogers, 1983, p. 247). Rogers depicts how adoption of innovations by a population is an ongoing process and G. A. Moore (2014) characterised a chasm between early and keen adopters and other members of a population with lesser degrees of willingness to adopt a particular innovation. This chasm often represents the point at which promising technologies fail to become mainstream, but it can also become a social chasm between the members of a start-up project team and the rest of the sponsoring organisation. As this sprint evolved, Alice and I began to worry that our design sprint strategy was deepening the chasm.

Change Savvy

At this stage my change leadership guru provides a precis of his 40 years' work, which he calls "the skinny on becoming change savvy" (Fullan, 2020, p. 44) (Box 15). Fullan unpacks the nine strategies with short examples, supporting research and some anecdotes to bring the examples alive. These nine strategies helped to structure my reflections afterwards about what went wrong.

1. Be right at the end of the meeting.
2. Relationships first (too fast, too slow).
3. Acknowledge the implementation dip.
4. Behaviours before beliefs.
5. Excitement prior to implementation is fragile.
6. Accelerate as you go.
7. Beware of fat plans.
8. Communication during implementation is paramount.
9. Become a lead learner.

Box 15: Becoming change savvy

(Abridged from: Fullan, 2020, p. 46)

The first five strategies are particularly relevant to an analysis of the design sprint itself; the remaining strategies help to situate the sprint in the bigger and longer task of enacting the KMMS digital first strategy. Reflecting on these strategies helped me appreciate why this became an epiphany for me.

Was the Design Sprint Change Savvy?

1. Be right at the end of the meeting

As this sprint started to wobble, Alice and I agreed that I would be in reserve to be called on the last day. The sprint was not where the decision to have a digital first strategy was being taken, but it was a significant activity required to implement the strategy. This was an opportunity for KMMS to be remembered for making the right decisions about the strategy and for seeking advice as to what those were.

Our plan for the sprint was to ensure that our participants felt included, that we would gather all the facts and opinions we could and would collate them in describing a jointly determined plan. My pre-conditioning from my experiences with the VLE in my previous role meant I'd underappreciated just how little consensus there would be. In failing to achieve consensus we were not sure that what we heard from participants was what they honestly thought and felt about the VLE. Is it possible to be right if there is no consensus? I felt that we didn't get to where we wanted to be, but we learnt that this was a more wicked problem than we thought.

2. Relationships first (too fast too slow)

All new leaders must reconcile the pressure to be agents of change with the right amount of respect for existing culture and Fullan offers the advice from Herold and Fedor (2008) (Box 16) for leaders entering a new environment with the intention of engendering change. Fullan advises that it takes six months for an effective leader to obtain sufficient contextual literacy to engage with jointly determined change.

- Careful entry into the new setting.
- Listening and learning from those who are there already.
- Engaging in fact finding and joint problem solving.
- Careful diagnosis of the situation.
- Forthrightly addressing concerns.
- Be enthusiastic, genuine and sincere.
- Obtain buy-in.
- Develop a credible plan.

Box 16: Change-savvy leadership

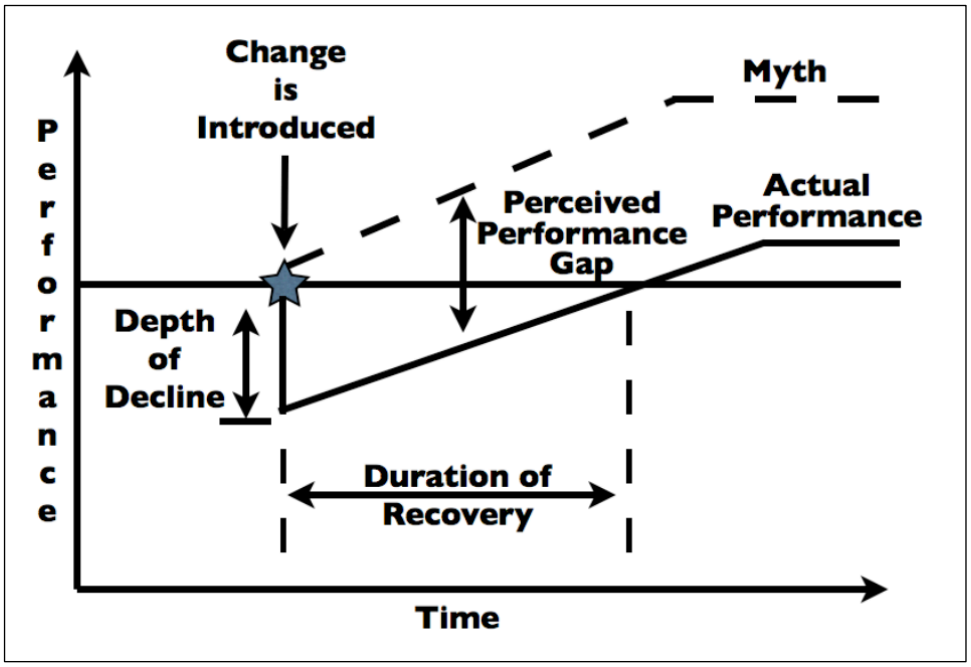
(Herold and Fedor, 2008)

I tried to demonstrate these behaviours from the outset of my appointment, for example my non-decision about the anatomy centre in Epiphany 3, and I doubled down on reinforcing these in the design sprints. Six months was 25% of the time we had before KMMS was due to open and there was a lot to do. Alice, Susan and Leanne fielded some comments about why I wasn't at the first two days of the sprint because I needed to

attend to something else. When they reported that they just couldn't get the participants at this sprint to engage with it the way we had hoped, I began to feel that I was "contextually [il]literate" (Fullan, 2020, p. 49) in not attending. Perhaps I was unaware of some pre-existing cultures in the two universities, or that there were occult or overt derailers, either in the sprint or elsewhere, who were acting to adversely affect the sprint's outcome.

3. Acknowledge the implementation dip

There is a myth about change that infuses many case studies and business texts that change immediately results in improvement. In fact, this is rarely the case and it is important to recognize something which has been called the implementation dip (Herold and Fedor 2008) (Box 17). Even with the best pre-implementation preparation and a culture of risk appetite and management there is always a decrease in performance when change is introduced. The objective is for this depth of decline to not cause performance to fall below critical thresholds. This is true of any project and the thresholds of what we are prepared to tolerate are what determine how much preparation and risk management is needed in advance. For example, the project to launch a new passenger airplane will have extremely low tolerances of decrease in performance and risk management will be extremely conservative. Whereas the launch of a new product into an environment which evolves quickly and with an entrepreneurial culture will probably tolerate much greater decrements in performance. New brands such as Uber and Lyft provide ride-hailing services in metropolitan areas around the world but are yet to make any profit, yet they have startlingly high market valuations (Avedian, 2022). This is an example of how poor outcomes in one metric of performance (profit), can be tolerated in more entrepreneurial environments to an extent that would not be accepted for other for-profit companies in established and more risk-adverse markets.



Box 17: The myth and reality of post change performance

(Abridged from: Herold & Fedor, 2008, p. 89 Figure 7.2)

I think I underappreciated this, although Fullan (2020) suggests this may have been understandable because change leaders don't always fully appreciate the implementation dip. They are focused on ensuring that the early stages of rapid improvement will result in shared accomplishment and pride for all members of the team. I was focused on the introduction of the new VLE in time for KMMS to open, and thought the sprints were required to minimize the depth of decline in KMMS performance and the duration of recovery from that point. I hadn't understood just how much change my colleagues were already experiencing on multiple fronts. KMMS did not have dedicated and ringfenced IT staff for the project and my IT colleagues were on a different journey with multiple changes, with a resulting impact on their performance. The reorganisation of university structures and roles, uncertainty and concern about other major IT projects as well as our own, all the self-inflicted change to the KMMS project structure, all of these compromised the sprint because they engendered an implementation dip in the delivery of my Digital First strategy.

4. Behaviours before beliefs

The thrust of this insight on how to be change savvy is that offering new experiences and the opportunity to try new behaviours to team members can achieve more than any in-house workshop or mandate from the leader. I thought a lot about this when I was reflecting on the design sprints. We started with a proposal for all the sprints that would have allowed us to spend some time witnessing the new way, but the time for our sprints was eroded. For this sprint, we supposed that IT colleagues would have insight into the implications and potential for what we were proposing, we thought they would be enthusiastic about the opportunity, and we anticipated that they would be advocates for the proposal. I didn't think there was an exemplar medical school to visit to provide an experience but that hearing from students about their experiences of the two VLEs would be sufficient. I still think all these things are correct, but we did not notice that there was still no shared concept of the team we needed to create to implement the required VLE coming from across both universities. The people who would implement our vision came from both universities and my attempts to become culturally literate had not had sufficient time to reap the reward of building the confidence of our IT team and agreeing a common vision before we started discussing how to enact that vision. My lesson here was that I should have tried harder to improve the chance of them arriving at the sprint with a much more open mindset.

5. Excitement prior to implementation is fragile

This cautionary advice is important to the overall strategy of implementing a change process. It is meant to remind leaders that, in the long hard slog of change, the team needs tangible successes to celebrate along the way. It also means that leaders build credibility by attending to this activity, both by celebrating the successes, but also by acknowledging problems and admitting mistakes. This is a reality check for the leader who wears overly rose-tinted glasses, prompting them to remember that implementation comes with challenges and it's not all plain sailing. This design sprint certainly became a challenge, and I worried about the legacy it generated for quite some time. It predated the SARS-COV-2 pandemic which tested the resilience of many HEI digital learning resources. When KMMS opened in September 2020 we delivered over 80% of the first year of learning

and teaching digitally, which was testament to the work that everyone achieved. It would involve a lot of counterfactual analysis to consider how the KMMS digital first strategy would have fared without what Haass (2020) called the acceleration of history by the pandemic. The changes across the wider HEI sector due to the pandemic meant that a lot of the implementation dip I was expecting, and which could have been worsened by the legacy of this sprint, happened just as KMMS opened and began delivering its programme. This meant that any dip could be excused by the pandemic, and we benefitted from the massive shift to online learning that became a universal priority for the entire sector.

Change Savvy-ness in the Overall KMMS Digital First Strategy Implementation

6. Accelerate as you go

Too much apprehension about the implementation dip can lead to the effect of the dip being magnified and Fullan recommends "purposeful action" (2020, p. 52) to push on through. While the sprint itself may not have occurred entirely as we wanted, ultimately, it did help us get to a point where it was recognised that the KMMS VLE had tangibly different requirements that were going to need quite some work to deliver. This helped accelerate our collective work in the longer-term.

7. Beware of fat plans

In Fullan's experience, the documentation of plans for change tends to be large, carefully and artistically presented and full of lots of smaller initiatives – what he terms "fat plans" (2020, p. 55). When I started at KMMS the brief was to open a medical school in keeping with the 27-page submission for HEFCE and a vision of a medical school built on a partnership between two universities which would take advantage of the best of both partners and would be a catalyst for innovation in medical education. There was not much detail beyond this, so it was not a particularly fat plan. When I started, I had three months to write a comprehensive submission for the third stage of the GMC accreditation (General Medical Council, 2020) process that would describe how the school would be delivered. I was the main author of this submission, and it was over 800 pages long to provide all the information the GMC requested. This was an opportunity to really exert my personal influence over the school and the programme and it felt important to take that

opportunity. This was one of the first places where I articulated my digital first strategy. At the time it seemed like a logical and reasonable conclusion about how the school would need to do things if it were to be successful, and I assumed that after receiving approval from the top of the project team that it would be universally accepted. On reflection, I started to wonder why I even supposed that everyone would be in full agreement with the entirety of an 800-page plan. Perhaps the way this sprint went was a consequence of my failure to test the individual components of a plan in a way that would make the proposal real and meaningful for those who would have to implement it.

8. Communication during implementation is paramount

This insight paraphrases the important role that communication has in following the preceding guidelines in Fullan's list (Box 15) (above). He divides the actions required into three steps:

1. Collectively plan for what could happen during implementation.
2. Don't spend too long worrying about it before enacting it.
3. Have a communication plan for the implementation phase.

Alice and I intended that the design sprints would be part of this important role for communication in the KMMS project, and we expected the sprint to facilitate our collective planning. The sprints were intended to bring together diverse constituencies, they would bring the plan into a common and shared vision for the school and invite contributions as we planned for implementation. Within the timeline we were working to we certainly didn't have time to worry about it before enacting it. The sprints would facilitate some planning for testing and adjusting but not facilitate rumination to the point of paralysis. Communication for the implementation phase was not part of the design sprint remit, although it would help us identify the stakeholders with whom we would need to communicate.

9. Become a lead learner

Here Fullan (2020) is exhorting the change leader to exhibit behaviours that are also advised by many other paradigms of leadership – those of the learner-leader. It also

unifies the overall goal of this part of change leadership. We tried to run this sprint with an opportunity for the KMMS team to role-model how we were listening and learning. We intended for the process to give colleagues the opportunity to feel part of the KMMS project and we thought of the sprint as being part of a bigger process of achieving my digital first vision for KMMS. We anticipated that our moral purpose would make this something enjoyable that colleagues would be motivated to do.

Keating et al. (2017) describe one of the cardinal features of learner-leaders as being how they adopt a growth mindset and, when things do not go as expected, they do not see it as a sign that they have an intractable deficiency. Instead, these episodes are signposts for areas where they, as leaders, can develop. I will return to my attitudinal response to setbacks in Chapter 10.

Concluding Reflections

The design sprint became an epiphany which catalysed my growth as a leader of educational change. It helped me to realise that in large organisations with mixtures of centralised and decentralised functions, in projects that involve stakeholder-facing and non-stakeholder-facing colleagues and in teams where there are core and non-core team-members, it is potentially fatal to assume that everyone has the same priorities, motivations or desire for change or success that the leader will have. This is particularly important when the core project team have a sense of a strong moral purpose, as this can be alienating rather than engaging for more peripheral collaborators. At times it has even felt like I have led KMMS out on a limb, that we have no allies, and that the sole aim of the universities has been to resist the adaptive changes that KMMS asks for. The original governance structure, with 12 workstreams and 24 executive sponsors might have been intended to be helpful in one way, but it was also very effective at limiting the speed and autonomy with which we could move the KMMS project along. We had grudging permission to run our undergraduate medical programme since the regulator required it, but the ways in which the process of medical education differed to other programmes and the ways in which KMMS has wished to do certain things differently to established politics, policies and processes were not welcome. When I did not have autonomy to make

decisions it felt as though I was in a straitjacket which was loosened just enough to permit me to run the undergraduate programme and nothing more.

My analysis of this epiphany helped me to realise that the most important investment that a leader can make in a new environment is to spend the time it takes to become culturally literate and try to understand the different perspectives that people will have of the proposed, likely changes that the new leader has in mind.

7. Relationships, relationships, relationships

How does a leader acquire cultural literacy? I had an iterative journey to understanding that the KMMS culture I sought to create was far away from the hierarchical, stable and rules-based order of things in my universities. I noticed that the nature of several key professional relationships were characterised by the cultural orthodoxy of the universities, rather than the start-up, adaptive change culture of KMMS. Cameron and Quinn (2006) have described how there are a plethora of frameworks that have been created to better understand the culture of organisations and which have been used to research the impact of culture in universities. One reason for the proliferation of so many frameworks is the "complex, interrelated, comprehensive and ambiguous" (p. 31) nature of organisational culture. Fullan (2020) attaches a fundamental importance to the relationships that change leaders establish and attends to this next.

In this chapter I will reflect on six epiphanies, all of which I selected because they illustrate a different facet of the relationship-building tasks I faced at KMMS. Chang (2008) also confirms that it is fundamental to autoethnographic research to consider relationships.

1. I will start with an ending, that of my professional relationship with the colleague who I introduced in Chapter 4, Epiphany 1: My introduction to KMMS, p55 (above).
2. My next epiphany is about an aspect of the relationships I needed to cultivate as Dean that I underappreciated to begin with, and which was one of my major ambassadorial duties.
3. The third is about the team I wanted to build for KMMS and my challenges in convincing others in the wider universities of the necessity of some of the senior posts I felt were required. This was an early sign of potential conflict between cultures.
4. Then I will discuss how I realised I could use our advocates within the two universities, and one of our strongest advocates in particular.
5. Epiphany five is about a step I took to actively cultivate the two universities' grasp of how our concerns were broader than the university requirements for a new programme and the potential power of the regulator.

6. My sixth epiphany is about how I led the KMMS team in working with established parts of the two universities to build their confidence and trust in us as we sought to make some innovative and brave choices about how KMMS would be different, ultimately producing a joyful result of which everyone is proud.

All six of these epiphanies reflect different aspects of how my role as Dean required me to build a team, nurture a culture, develop the curriculum and regulations, build a network of trusting stakeholders and partners, lead KMMS through an accreditation process and more. The network of relationships I needed to achieve this was immense and needed to be collaborative, trusting, focused and to hold itself to high standards.

Epiphany 8: Departure

We had quite a hot early-summer heatwave in 2021. I was in my garden office, where it felt I'd spent most of the preceding 18 months. Such was the derangement of the pandemic that on several occasions I even thought of setting up a camp-bed since I was spending so much time there! I knew I was privileged to have this space, so many of my colleagues and students had much less satisfactory working environments during the pandemic. The one flaw is that a combination of insulation, three computer monitors and everything else I use to work remotely, and a full-sun position in the afternoon, means that it regularly gets to over 27 degrees inside on hot days. It was one of those overheated afternoons, during a UJMB meeting, while I was worrying that my laptop was going to overheat and wondering if I should go and get some ice blocks for it to sit on, that one of my line managers announced their departure. We got to the end of the agenda and Professor Rama Thirunamachandran, the VC for CCCU, pointedly asked if there was any other business. My colleague told us that they would be "stepping away" from their role before the end of the year. This person had been my first contact with KMMS in 2016, had been one of the main authors of the successful bid and rightly felt a strong sense of ownership for the school. They had been a strong and consistent source of support for me throughout my time leading KMMS, especially in challenging me to think outside the medical hegemonic box. Their announcement was not a discrete epiphany and after two and a half years of leading KMMS I didn't think I would feel bereft without them. This moment became an epiphany when I realised that their personal impact on the overall KMMS journey was so significant and ubiquitous that a newcomer

would bring with them a different dynamic and necessary readjustment which would ripple across the whole KMMS system in myriad and unpredictable ways. The constancy of our professional relationship throughout the journey made me consider my role as a stable presence in the opening of the medical school while other members of the university leadership teams came and went.

One of the jobs of a leader is to help their organisation navigate change. In the context of a medical school which is a partnership between two universities, I was reporting to 2 Vice-Chancellors (VCs). I was also working with a contingency school which was also a partnership, bringing another medical school Dean and another two VCs to the KMMS network of relationships. As I have already described, the initial network of 24 senior decision makers I was presented with was unmanageable and I got agreement for three successive changes to reduce and improve this.

When Kent reorganised, several senior colleagues moved on and new colleagues arrived. Initially, I thought this was the inevitable churn of people in a large team, but they also brought about changes in relationships that were not within my control, and the removal of some support which I had begun to take for granted felt very different. The reorganisation at Kent came just as KMMS entered the final 12 months before opening and was just bedding in as the pandemic began. During that turbulent time, another co-author on the original bid chose to leave discretely and quietly with minimal fuss. As this coincided with the start of the pandemic and the rising tensions surrounding our preparations for opening, their departure felt anti-climactic, probably because any emotions I felt about their leaving were drowned out by all the other emotions of what was going on at the same time. Meanwhile, I continued to have one constant and vital figure in the creation of KMMS. They were incredibly influential as they steadfastly sought to protect the interests of their institution. We did not always agree on decisions or strategy for KMMS and the one thing that I could rely on them to do was inform me when they thought I was wrong about something. Their departure coincided with what started to feel like the re-emergence of stability. This began to feel like a period when KMMS could re-trim its sails and when both universities were starting to see clear blue skies beyond the storms of finance and student experience that the pandemic stirred up. I recognised that

this was an epiphany when I recognised that I felt very differently about one individual's departure than another's, and I will return to this later in the chapter.

More to relationships than relationships

Fullan (2020) states that making and maintaining good relationships is the second most important job of a leader, "as you can't get anywhere without them" (p. 63). I was coming to understand that my network of relationships extended more widely than I anticipated and that some aspects of the composition of that network would be within my control, but many would not. I knew that one way in which I could engage people was to help them feel the passion I felt for what KMMS was trying to do through our moral purpose. Fullan emphasises that the core priority for every leader in education should be cultivating a culture that sees collaboration and a focus on learning as morally imperative work that the school is there to do. He also highlights a dichotomy between businesses and schools which he describes as the need for businesses to have souls and for schools to have minds. In his opinion there is a difference between having a soul and having an moral purpose. Businesses, he argues, need to support people in feeling an authentic connection with their organisation. They need to respond to the fact that their employees want to feel like they are making a difference and to understand their place in a greater whole. Conversely, schools tend to attend to relationships quite well but need to remain focused on their main function, namely learning, with a business-like relentlessness. Without keeping this objective in mind, relationships become unfocussed, and work becomes either about maintaining relationships to the neglect of the education of students, or on the actions and process of learning, such as lectures, seminars and workshops. Whereas what is needed is attention to how teachers and learners experience the educational process and enabling colleagues to use that experience to continuously get better and better. Moral purpose is what binds these two aspects of the soul of a school together – the relationships it has and the actions it performs. As I built my network of relationships, I took every opportunity I could to articulate the moral purpose of KMMS, keeping it strong and clear for everyone as I worked to recruit a team to help us stay focused on all the tasks we needed to complete.

This was challenging enough with a rapidly growing KMMS team, but the challenge of also maintaining upwards, downwards and sideways relationships across the changing landscape of the two university partners meant it felt impossible at times. I spent several sessions with my career coach discussing the challenges that arose out of the changes in the wider organisations that were beyond my control and my responses to them. Professor Malcolm Reed, Dean of BSMS, counselled me that I needed to get used to a constant amount of churn, and that in the fullness of time I would end up being the person involved with the project for longest, with the only memory of why certain things were the way they were.

Bringing the mind and the soul together

When Fullan (2020) emphasises the importance of leaders' relationships in binding mind and soul together, he is very much in the mainstream. He is aligned with some theories and methodologies of quality improvement and of service design which equally prioritise relationships (Appendix 6). All these approaches advocate that leaders need to provide support, especially when the organisation is finding the going tough, and that they need to inculcate a constantly getting better mindset, seeking innovation and being humble as to where those innovative ideas can come from.

The medical school's relationships within two organisations

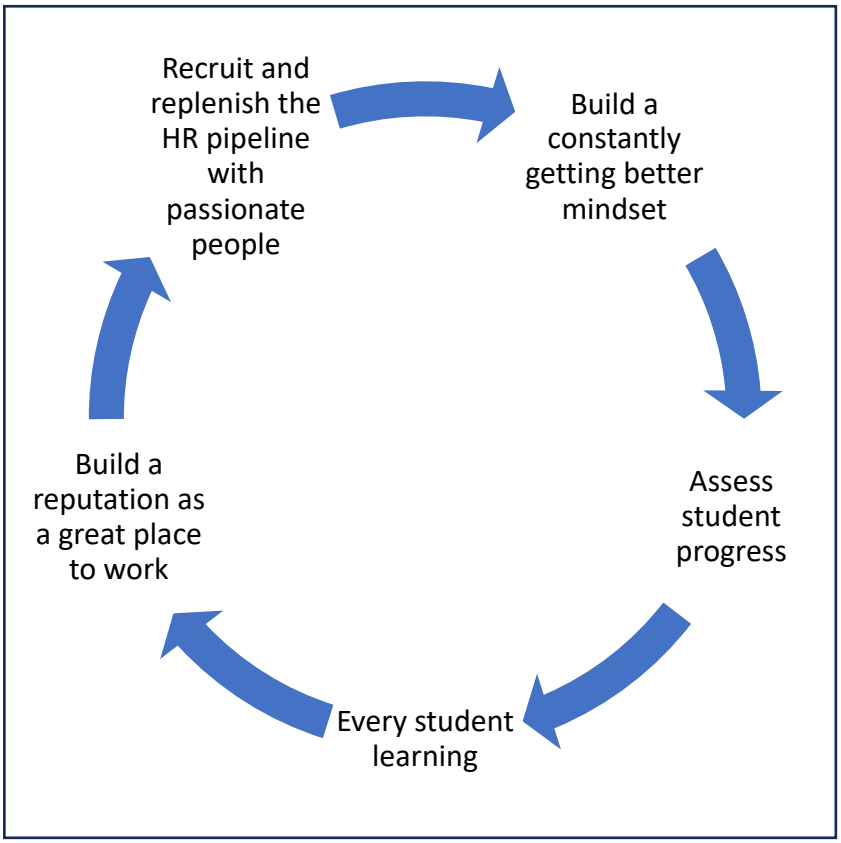
KMMS is 'affiliated' with a Faculty (or equivalent) at each university, whereas BSMS sits outside of the internal structure of both universities. This means that BSMS is easier to manage jointly, but it also means that BSMS has no direct access to pooled services such as HR or research support at either institution. This requires BSMS to have these functions duplicated within the school. When CCCU and Kent were planning for KMMS they felt that this was not efficient, so KMMS avails of pooled services from one or other university according to a schedule agreed in a Memorandum of Agreement. When Malcolm and I discussed the relationships I had to cultivate across our two universities, we frequently compared the advantages and disadvantages of these different arrangements. I wished for the autonomy that Malcolm seemed to have, Malcolm cautioned me that greater autonomy comes with less of a safety net when things go wrong. It was a case of be careful what you wish for, as each of us learnt more about the other's successes and frustrations.

The overarching KMMS experience is one of speed. When I wished for Malcolm's greater autonomy, it was often triggered by a sense that the inertia of orthodox institutional process was making me feel like a hamster running in an uncoupled wheel. As I led the plethora of activities and tasks required of us all, I wanted my energy to go into spinning up the KMMS flywheel (Collins, 2019) (Box 18). The utility of Collins' concept of a flywheel (2001, 2019) is that it helps to convey the importance of establishing a limited number of reproducible quality improvement steps. The idea of a flywheel also resonates for me because of the impression of speed and finely balanced control that it evokes. After September 2020 the list of tasks already required of KMMS, and me, increased still further to include the delivery of learning and teaching activities for students, monitoring student experience, satisfaction and progression and providing student support.

My KMMS flywheel is based on one used as an example by both Collins (2019, pp. 20-24) and Fullan (2020, pp. 86-87). It was created by Deb Gustafson, the principal of an American public high school on an army base in Kansas which was put on improvement measures by the Kansas Commissioner of Education. While working with a challenged, demoralised and changing workforce, Gustafson spoke of trying to promote a True North for the team which generated energy from the success of every learner. It suited the context of KMMS well as a school that needed to fashion a new identity and culture and aligned well with my feelings about celebrating the success of all our diverse student body.

Everyone at KMMS built relationships between and within the universities in a short space of time, thus enabling the flywheel. Throughout the KMMS journey, it has often felt very much as if the KMMS project and team brought new ideas, different perspectives and a different pace of work to both partner universities. This challenged both universities' cultures at times and needed me, and all other KMMS colleagues, to be adaptable and sensitive to these cultural frictions and to develop antennae which could detect these abrasive moments and challenging cultural interfaces. The way in which I failed to challenge university orthodoxy around HR for KMMS is one of my biggest regrets. If I am ever invited to open another medical school and accept, one of the things I would do very differently is the cultivation of a stronger relationship with the Director of HR. Over 5 years, the pace of recruitment we needed to maintain has never kept up with our need for

more people. I have tried to work more closely with HR colleagues than almost any other professional service, as recruitment and the resulting employee relations has continued to be one of the most significant aspects of my role.



Box 18: The KMMS flywheel

(Abridged from: Collins, 2019, p. 22; in Fullan, 2020, p. 87)

I have already referred to the resourcing needs that the speed of our recruitment plan required in Chapter 5, Epiphany 6: Human Resources, p97 (above) and the sense of moral injury that arose because of not feeling that KMMS was adequately resourced. I still feel that if I'd adhered to our intended pace of recruitment then, once I established the process of building the team of able and passionate colleagues KMMS required, my role should have been to ensure that we were collectively focussed on constant improvement and keeping the flywheel spinning.

The other reason why Gustafson's flywheel suited the KMMS context was because, in all the relationships I nurtured within the two universities, there was a repetitious nature to some of the reasons why abrasive moments arose. Again and again I sensed alignment

between the components of her flywheel and these phenomena. Chang (2008) is clear that repeating phenomena should attract the attention of the autoethnographer. I will illustrate some of the components of my flywheel with epiphanies taken from the period between September 2018 and September 2020, before we had any students, and which map to the flywheel's separate stages. I have chosen to do this because this was the period when the flywheel was still gathering speed and many interactions with the wider universities were at least as much about building trust as they were about any more tangible outcome.

1. Build a reputation as a great place to work.

I will start with an epiphany that does not relate to substantively employed KMMS or university colleagues, but which concerns a different group of colleagues I hadn't expected to work with. One of my early experiences was the novel experience of joining the KMMS Fundraising Board. It took me by surprise when I realised how our reputation and my zeal for KMMS was a key ingredient for our fundraising success.

Epiphany 9: KMMS Fundraising

We gathered one evening in late Autumn 2018 in the Boardroom of the University of Kent. This was wood panelled, thickly carpeted and one of those rooms that deadens all sound. Karen, Rama and Hils all clearly knew the people who were gathering socially and there were conversations about garden parties and summer holidays all around. The meeting was convened and I was introduced to the group, but not the group to everyone else. As things proceeded, I gleaned that there were several Deputy Lieutenants of Kent, several people who were something called Kent Ambassadors, some Knights and Dames, and a couple of Lords in the room. I was glad I had worn my suit! People referred to other fundraising campaigns they had been involved in, these ranged from large public buildings, to charities, to corporate fundraising events. I was beginning to wonder what I could contribute and was feeling as if I had gate-crashed a party. Then I was asked to give a short description of the medical school to help formulate a script that we could use to make our case. I decided to give a short declamation that I was very familiar with by now, and which I have given many times since. This covers the medical workforce pressures in Kent and Medway, the widening gap of healthcare inequalities, the abject failure of widening participation endeavours in

medical education and how the medical school would address all of these. I finished with a vision of 21st Century healthcare that includes robotics, personalised medicine and artificial intelligence and linked this to our innovative curriculum. There was stunned silence and I thought I had misjudged the room and what had been asked for, but the questions and comments, feedback and compliments that followed demonstrated how engaged and excited people had suddenly become.

When I was preparing for the recruitment process for this post, I read extensively about the role of a medical school Dean. It was clear that the role of Dean of a US medical school was different to what was common in the UK (Bassaw, 2010; P. F. Buckley, 2014; Christner, Smith, & Appelbaum, 2020; Daugherty, 1998; Martin, 2011; Petersdorf, 1997; Schieffler, 2016; Yedidia, 1998). Nowhere was this more apparent than in relation to fundraising. This difference was also apparent in the more rigorous literature review I conducted (above). In the US, Deans are key to fundraising and are expected to cultivate a network of generous donors and philanthropists. Here in the UK, this aspect of the role of Dean is much less significant. However, for this round of expansion of medical school places, there was no funding from central government (HEFCE, 2017) and the winning institutions were each going to need to raise funds of tens of millions of pounds.

I never expected to spend so much time supporting the raising of funds for the KMMS project, and I have given variations of this talk many more times since then. I can now wax lyrical about KMMS for quite some time without any notes and I have become friendly with quite a few of the people who seemed so far removed from me socially at that first meeting. The fundraising team raised over £30 million in the first two years of operation. This was the biggest fundraising endeavour ever by either university and our success has merited celebrations, but has also generated some envy as we obtained funding from sources that weren't reachable before. The two main factors that we felt drove the success of our fundraising were the passion and conviction of the KMMS team for what we were doing and the enthusiasm with which we were able to talk about our civic mission of widening participation in medicine which attracted the major part of our individual and foundation donations by far. There was a clear linkage in our fundraising endeavours between philanthropic funding and scholarships and the impression we have conveyed of

a unique team working on an important project who are all passionate, collegial and enjoying their work.

2. Recruit and replenish the HR pipeline with passionate people

Every stage of every appointment to KMMS has felt like it has been challenged by the rules, bureaucracy and precedent of both universities (Chapter 5, Epiphany 6: Human Resources, p97) (above). The job descriptions, the advert, the necessary pay premium for medical clinicians was startling to the universities and every digression from the usual university practice required a paper outlining why we were breaking the mould.

Epiphany 10: KMMS Senior Leadership Roles

I had some leave booked in the September that I started at KMMS, and I attended my second UJMB virtually from the South of France. This was pre-pandemic so I was worried about the signal that this would send to my new employers about my dedication to the role. I was keen to build my team and presented a paper requesting the recruitment of 5 Key Roles. These were to be:

- *Undergraduate Programme Director (UGPD)*
- *Lead for Quality and Governance*
- *Lead for Assessment*
- *Lead for Admissions*
- *Lead for Student Choice*

The internet connection was not great and so I had to turn my camera off and the microphone I was listening to the room with was mounted on a wall which had a lavatory cistern on the other side. Every so often all I could hear was a bizarre noise which sounded like a cross between my grandmother's old vacuum cleaner and a food blender. I presented my paper with every expectation of it being uncontroversial and the posts being approved. The Programme Director and the Leads for Admissions and Assessment were obvious pre-requisites in my mind, the Academic Leads for Quality and Governance and Student Choice were part of ensuring that we were prepared for the GMC accreditation process and were able to take full advantage of the opportunities for collaboration with both universities. Instead, it was rapidly shot down and I will never forget the words of one Vice-Chancellor

coming through my computer speakers, "I just don't understand what these people will do". I was so stunned by the gap in understanding that I could not collect my thoughts sufficiently to turn the board to my way of thinking from 800 miles away and the meeting concluded without the posts being approved.

On my return I persevered and worked constantly to improve understanding and get the posts approved. Over the course of the next six to nine months we recruited to three of the five posts. Disappointingly I failed to persuade colleagues of the importance of the remaining two posts in the form I originally envisioned. The Lead for Student Choice was refashioned as an allocated responsibility for someone in the established KMMS academic team to undertake. The portfolio of activity has now exceeded the capacity for one individual to undertake this as an addition to their main academic role and we are revisiting this in a different way. The functions and responsibilities for the Lead for Quality and Governance I originally envisioned were largely taken over by the professional services team, but some critical academic duties have become too onerous for myself and the existing UGPD. The time has now come for the school to appoint a Deputy Dean and the job description for this includes many of the executive responsibilities anticipated for the original Lead for Quality and Governance.

I was tremendously pleased with the appointments we did make. Three varied and diverse colleagues, all with significant medical school experience and expert in their domains of work, who continue to lead, inspire and innovate to this day. In particular, the talent and competence of the UGPD, Dr Anna Romito, was what enabled us to manage with a reformatted Lead for Quality and Governance as a professional services role until now. In turn this allowed us to postpone the appointment of a Deputy Dean role to much later in the start-up process. This has allowed time for greater trust in our HR requests to develop and we have demonstrated the need for this post much more tangibly and been able to describe the role in the context of a much more established school and programme, helping the universities to understand that it is an ongoing requirement rather than something needed solely for start-up. All five posts felt equally time-critical for the medical school when I requested them, and the refusal of all five at first and then two seemed like a disaster, finding ways to manage the delay allowed me to better evaluate

the talent of the team I did build. I have been able to create better job descriptions and roles that were much more complementary to each other because of the delay. That extra time has given me the opportunity, as Gustafson found in her endeavours in rural Kansas, to focus on recruiting people with passion and potential rather than experience. Recruiting people with passion and a cultural fit with the KMMS moral purpose has helped us to collectively manage the gaps in our human resource in the face of huge amounts of work to do, and to think and learn about how we can best articulate that in our recruitment campaigns and selection processes.

3. Build a constantly getting better mindset.

The KMMS vision (Chapter 5, The mission, values and goals of KMMS, Boxes 12 and 13, p94-95) (above) talks of becoming a beacon of excellence but I was mindful of the likelihood of an implementation dip (Herold & Fedor, 2008) (Chapter 6, Was the Design Sprint Change Savvy, Box 15, p112) (above) and the unlikelihood that we would be excellent right from the get-go. Merely opening KMMS required a huge human resource, technical resource and incurred immense fixed costs which the universities needed to fund. The money was not just spent on people, facilities and estates, and subject and programme specific learning resources, but also on more intangible things like developing joint policies, procedures, IT systems and administrative processes. For those of us who'd worked in medical schools before, many of these were simply fixed costs, for example an adequately resourced Fitness to Practice process. Yet the universities often seemed taken aback by these requirements, as if they were unanticipated or much more complex and nuanced than they anticipated.

Epiphany 11: Qwickly

By phone:

Leanne: I've emailed you the proposal paper, the business plans and some slides.

Me: Didn't we discuss this at the last UJMB?

Leanne: Yes, but procurement have asked for more detail and further authorisations. They don't understand why the existing [VLE] attendance widget isn't enough.

Me: (sigh), I'll talk to them…

If I was going to make KMMS a great place to work for colleagues who were attracted by the innovation and enterprise environment of a start-up and who were excited by our moral purpose, one of the things I had to do was persuade the universities to give me the tools to do this. The process of committing to a £15 million building or a multi-million-pound cadaveric anatomy facility (see: Chapter 4 and Appendix 4) was beginning to seem disconcertingly easy compared to the tribulations involved in procuring a £15,000 digital system for monitoring student attendance across two universities and multiple placement providers (Qwickly Inc., 2023). This was much more challenging, requiring many more papers, business proposals, pre-meeting socialisation and approval. Both universities felt they already had systems which could provide this functionality and needed to be convinced that the split university campus sites, the different IT systems, the distributed campus for clinical placements and the attendance regulations of our programme as well as the UK Home Office's requirements for students with a student visa all meant that none of these options could provide what we needed. It took a prolonged period and for KMMS colleagues to follow the hierarchical and managerialist processes of two universities for us to obtain permission to proceed with such procurements. I became very used to intervening in such processes when they stopped progressing and learnt that escalating concerns to one person in particular could produce results. Their responses were firm, instructional and effective. People listened to them and they always protected their university's interests when it looked like the other university was getting everything its own way. They were a vital conduit between KMMS and the Senior Leadership Team. If I could persuade them of the necessity and urgency of the request, that I and KMMS were not being profligate and understood the need for financial governance and an audit trail, then one university would respond quickly and positively to our requirements, and often the other would follow. Such a small thing as a digital student attendance widget that could work where our students were going to be, felt like an important and tangible artefact of what we meant by excellence. It wasn't just excellent teaching, or excellent estate, it also meant excellence in professional services and in data management. This was all intended to project a professional competence that was focussed on enabling our students' endeavours.

4. Assess student progress

Medical schools have lots of exams and universities use targets, data and key performance indicators to measure performance. Medical school assessments are specialised, not just in the content they assess but also in the way they are standardised, standard set and how students' results are analysed using psychometric techniques. In a new school, the pressure to evidence how well our students are doing is immense which provides an incentive to over assess and accumulate ever more assessment data.

Just as our first cohort is due to graduate, the GMC will be introducing the first ever UK national licencing exam, the Medical Licencing Assessment (MLA) . This exam will be a requirement for every final year medical student from the 24/25 academic year onwards. This happens to coincide with our first cohort reaching their final year and it is impossible not to imagine that the results will be used in some shape or form to compare all medical schools by means of a league table, even though it the GMC has reassured all schools that this is not the intention.

Epiphany 12: The GMC Medical Licencing Assessment Roadshow

It was Spring 2019, and a huge number of people were crammed into a hot and noisy classroom. The windows were open, but the sounds of major construction were almost deafening as part of the medical school was literally being built just outside. All these people, very senior leaders from across two universities, came to hear the GMC talk about the MLA as part of a national timetable of roadshows visiting every UK medical school. I was sweating slightly, but not from the heat, I knew from contacts in other medical schools that these roadshows were often quite startling for attendees, due to the firmness and authority with which the GMC team spoke about the implications of their proposal for the MLA. I invited the GMC roadshow to KMMS and invited nearly 30 people from across both universities - most attended. For nearly all these colleagues it was their first interaction with the GMC, and I was grateful that so many people gave up their time for the meeting.

I began to realise that it was a common theme of discussion between myself and my peers at the other new medical schools that our universities were needing to reconcile many long-held attitudes to regulators and Professional, Statutory and Regulatory Bodies (PSRBs) as irritants and impediments to academic autonomy and independence, and

accept the power, influence and potential impact of the GMC accreditation process on the opening of 'their' new medical schools. Conversations with my peers frequently described brinkmanship and sabre-rattling behaviours on the part of universities unwilling to bend to the GMC's will, with the GMC always getting its way by using the ultimate threat of novation. Early in my time as KMMS Dean I began to emphasise the power the GMC had to disrupt our project plan. I became well used to saying, "we need to do this, or the GMC will…".

I and my KMMS team were confident that our assessment system would more than adequately support our students in preparation for the MLA. We understood the arcane language of standard setting and psychometrics which medical school faculty are fluent in, and we understood where we needed to conform our final assessments to the requirements of the MLA. I set up the meeting with such a large group of attendees partly because I needed all these colleagues to understand the reach and impact of the MLA in medical education, but also because I needed to demonstrate that the KMMS team was competent, could work with a powerful regulator professionally and act as a trustworthy link between the two universities on a highly specialised aspect of medical education and assessment that they were not widely familiar with. I hoped that by demonstrating our competence and building trust it would encourage the universities to give us leeway to be agile and fast and to entrust us with a high degree of autonomy in selecting the evidence that would demonstrate our students' progress on the programme.

5. Every student learning

To begin with we did not have students, but we needed to select students who we thought would be excellent learners. Medical schools select high tariff students via the UCAS system and the oversubscription for our places is immense. Our applicants are impressive people and know that they need to stand out amongst many other impressive people. We have a vision and a mission to Widen Participation in medicine and so we needed to select the best learners we could identify in a fair and equitable way. In order to do so, we think we have come up with something really innovative (Chan, Anthony, Quinlan, Smith, & Holland, 2024) and it is the fruits of our labours by which we judge ourselves.

Epiphany 13: Admissions

I'd just finished giving a second-year lecture about how the NHS is structured and managed. It is a dry topic and my lecture was on a Friday afternoon. All our lectures which cover core topics and which are given in person are mandatory to attend, so the lecture theatre was full. A tall, black, male student came down to the lectern, I assumed he wanted to ask a question about one of the more prosaic aspects of NHS management I'd just been talking about.

Student (hesitantly): Are you – ummmm- like, the Dean?

Me: Yes, I am.

Student (still uncertain): Oh, OK, I wasn't sure if you were, like, in charge, yeah? Is that what the Dean does?

Me: Well, yes, I'm the person who takes responsibility for the medical school.

Student: So, I – ummmm – wanted to say something if you're, like, in charge?

Me: Sure, anything at all. I really appreciate feedback about anything to do with the school.

Student: (rushed) I just wanted to say thank-you for my place here. It means so much to me and my parents. I never thought I would get to be a doctor and KMMS was the only medical school I applied to, and I couldn't believe it when you offered me a place… yeah, so….

Early in my appointment, before the delayed Lead for Admissions post was filled, I met with university admissions and student recruitment leads from both universities. All were professional services colleagues, some had experience of working in universities which had medical schools, none had direct experience of selecting for medicine programmes. I estimated that we would have application ratios of about 10:1 for our 100 places. My prediction was met with frank disbelief. Neither university had programmes with this sort of application ratio and the emphasis of every other recruitment event was to generate an application from as many attendees as possible. I tried to draw a distinction between recruitment and selection, meaning that receiving applications would not be the issue, instead it would be selecting the right applicants from the huge number of applications we would receive. The key would be how we met our ambitions to widen participation in medicine in the face of significant oversubscription.

I recommended that we should adopt some conventional approaches to this, things that I knew were widely practised in many other medical schools around the world. Like most other medical schools, we would use additional stages in our selection processes such as the University Clinical Aptitude Test (UCAT) and Multiple Mini Interviews (MMIs). We would ask for background personal data and contextualise our offer to individual candidates with a different offer for applicants who came from a WP background compared to those who did not. We would not use things like personal statements, work experience or predicted grades which are commonly recognised as introducing bias into medical school selection that favours applicants from better socio-economic backgrounds. We would make different offers of required A-level tariff points to selected applicants based on their WP background.

After the KMMS Lead for Admissions was appointed, they proceeded to disrupt everyone's thinking about how to do this, including my own. Our selection process required new IT resource, expertise and administrative steps. We call the most important part of our process "contextualise everyone" (Chan et al., 2024) and elements have been adopted by some other medical schools and HEIs. It entails using a measure of secondary school performance called Attainment 8 . and indexing each applicant's achieved GCSE grades against their school's Attainment 8. This produces an equitable adjustment to every candidate's achieved grades that we then use for part of our ranking. Since our contextualisation is applied universally for all home students this allows us to make a single offer for A-level grades required to obtain a place, rather than making a different, lower offer for WP applicants, which is what most medical schools do currently.

In our first four years of student recruitment and selection we have had application ratios of up to 20:1. Medical schools which overrecruit are sanctioned by the Office for Students and we have managed to fill all our places every year without overrecruiting or going into clearing and despite both rampant grade inflation from 2020-2022 and grade deflation in 2023. In every year we have had one of the highest WP selection rates of all medical schools and in the 22/23 academic year we achieved parity with the general UK population for the proportion of our students who came from a widening participation background. Something we do not believe any other medical school has ever achieved.

From those initial meetings to the present day still, colleagues from the wider university exhibited high degrees of anxiety about filling all our places. My KMMS colleagues and I remain more anxious about possible over recruitment and the fines from Office for Students (OfS). My epiphany is repeated almost every time I meet our students. I have met KMMS students who have come from immensely well-off backgrounds, as well as some whose background is severely deprived. Our medical school is diverse, and this is reflected in the clubs and societies that have opened under the auspices of the student MedSoc. Every time I think about our diversity, I am joyful and proud, more importantly I think it allows us to be crystal clear to all our students that they are here because we actively chose them and because we think they will make excellent KMMS students and KMMS graduates, and for no other reason.

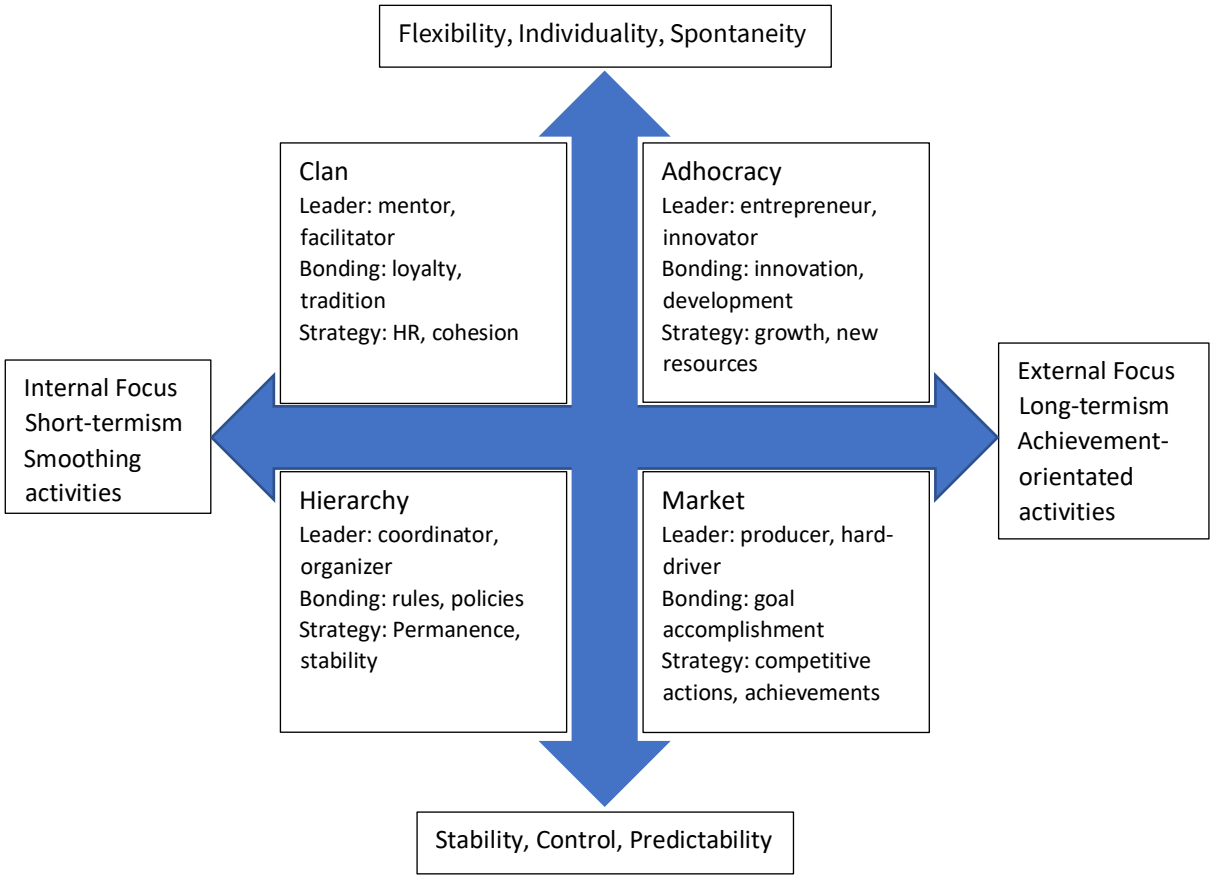
Competing Values, Competing Cultures

I have mapped these epiphanies to the items on my KMMS flywheel and described how they illustrate some aspects of my attempts to create a self-perpetuating culture of striving for excellence in KMMS:

- The impact of my ambassadorship on others
- The attractiveness of the school to others
- How I needed to use our advocates in the wider universities
- How I tried to help our universities understand some of our concerns
- How our joint endeavours have achieved results of which we all feel proud

It took some time for me to understand that the KMMS flywheel was dependent on a KMMS culture that was different to the hierarchical, stable and rules-based order of things in my universities and that there was a risk of conflict between our different cultures. The Competing Values Framework (Cameron & Quinn, 2006) (Box 19) orientates organisational culture along two dimensions. The first tries to account for contexts which mean that effectiveness requires the organisation to be “changing, adaptable and organic”, or “stable, predicable and mechanistic” (p. 34). Cameron and Quinn (2006) think that most universities fall into the latter culture typology. I maintain that my leadership of KMMS as a start-up placed us in the former. The second of these dimensions attempts to describe whether an organisation’s effectiveness benefits from an internally orientated, integrated

and unified approach, or from an externally orientated approach which values differentiation and rivalry and which focuses on interacting and competing with others beyond their traditional boundaries. Again, universities seem to naturally fall into the former camp, and I feel KMMS is required to have an external orientation and to interact and compete with the stakeholders, participants and observers of our endeavours, as I have described using this series of epiphanies. The utility of these two dimensions is that they permit researchers to depict cultures as falling into one of four quadrants and as possessing the archetypal characteristics of the typology to a greater or lesser extent. The framework also highlights some of the challenges that I and KMMS face whilst building and maintaining our culture both within and external to two collaborating universities.



Box 19: The Competing Values Framework

(Abridged from: Cameron & Quinn, 2006, p. 35; and Smart & St. John, 1996, p. 221)

The framework seems to be particularly good at finding common ground in the various typologies of organisational culture that have been used in the literature about higher

education organisational culture (Smart & St. John, 1996) and applies well to these in generic and recognisable ways. The duration and constancy of one of my professional relationships at KMMS throughout several years was vital to the strength of that relationship and to allowing us to find the common ground that existed between us personally and our organisations.

Maclean (2016) wrote very descriptively of the maddening effect of the collision of the ongoing neoliberalisation of the UK university sector with a historically elitist culture of academics operating within established hierarchies. She identifies that minority and low-power, low-status groups in the academy particularly feel the strain of the multiple and contradictory forces this culture change is engendering, and that this frequently has a negative effect on their mental health. Her assertion that "universities are exceptionally hierarchical" (p. 182) is borne out by the work of other authors using the Competing Values Framework as well as other tools (Beytekin et al., 2010; Schulz, 2013; Smart & St. John, 1996; Warter, 2019). A hierarchical culture is the result of a prioritisation of stability and inward-facing activities whereas flexibility and an external focus seem to result in a culture that can be typified as what the framework calls an Adhocracy. An added complexity to the KMMS context is that, as Maclean (2016); Schulz (2013) and Smart and St. John (1996) describe, all members of the academy have experienced a neoliberal and managerialist change in the wider culture of universities and responded to it. Historically, the department, school or college, run by academics in a collegial way with little control or interruption from the university hierarchy, tends to adopt a clan culture as described by the framework and, even in the most marketized of universities, academics find greatest job satisfaction and lower levels of role stress if they can maximise exposure and participation to this culture in their professional roles.

When other university colleagues and I disagreed about significant issues it seemed to me it was almost universally because my colleagues were exhibiting hierarchical traits in their attitude and approaches to KMMS and were reluctant to accept my recommendation for adaptive change, preferring instead to adopt a technical change using established policies and procedures. I would typify both universities' cultures at that point in time as being predominantly hierarchical with a desire to become more market driven in response to

wider changes in the UK HE sector but perceived as necessary for survival rather than philosophically attractive. Clan behaviours and culture were not particularly visible in our interactions. Naturally, our predominant interactions with CCCU were with the Faculty of Medicine, Health and Social Care, and this included several long-established health programmes the largest of which were the nursing programmes. Interestingly, health professions, especially hospitals, are also noted in the literature as being predominantly hierarchical in their nature, along with two other elitist professions - religion and law. I often detected tensions relating to the arriviste nature of the medical school in this Faculty community and suspicion that the medical school would naturally assume that it was at the top of this university and health hierarchy, and I continuously and actively worked to address these tacit and explicit concerns. This was most starkly highlighted when leaders in the hierarchical culture of CCCU proposed changing the name of the faculty to which KMMS is affiliated at CCCU from the Faculty of Health and Wellbeing to the Faculty of Medicine, Health and Social Care. Colleagues at KMMS formally and informally advised against this change but it was still enacted. The inclusion of medicine in the faculty's title as well as placing it at the front of the faculty's name before we even began teaching our programme resulted in several difficult interactions with CCCU colleagues, who assumed that I was one of the chief instigators of this change.

Our challenging interactions with Kent and Kent colleagues were often because of similar frictions but were compounded because Kent also underwent a radical re-organisation called Organising for Success (Davies, 2020) during the development phase of the KMMS project. This entailed sweeping changes to a Faculty and College structure which had its origins in an original vision of an interdisciplinary and collegiate university heavily predicated on a less elitist version of Oxbridge Colleges. The reorganisation was also justified on the basis of a need to respond to the neoliberalisation of the HE sector, caused significant disruption, was associated with a 10% reduction in headcount across the university and devolved greater budgetary and administrative responsibilities to six new Divisions which replaced the previous Faculty structure. This meant that while KMMS was building its network and establishing cultural norms, the culture at Kent underwent significant change which attempted to move the major cultural paradigm from one which

had historically been very common at many UK universities (academics preferring to operate in a clan culture and interacting with a hierarchical university leadership with a degree of distance between the two (Smart & St. John, 1996)) to one where academics mostly operated in a hierarchical university with an increasing importance attached to a market culture. As might be expected, this cultural shift did not happen instantly or wholesale and individual academics often adapted to the new cultures even more slowly. Nor was the change wholly successful with further adjustments required even years later. While the changes were underway, Kent's ability to impose its hierarchical culture on KMMS was significantly reduced. This later resurged once the changes at Kent stabilised, and it was remarkable how quickly the typical, hierarchical university culture reasserted itself.

Concluding Reflections

This complex analysis of my professional relationships has been in two stages. First was my realisation that one individual's impact on the overall KMMS journey was so significant. I learnt to work with new colleagues and began to take for granted the stability of the ways in which they could aid the KMMS journey and the support they provided for KMMS. When that was threatened, I realised that whoever replaced departing colleagues would bring with them a different dynamic and require a necessary readjustment. These changes would ripple across the whole KMMS system in myriad and unpredictable ways. This made me consider my role as a stable presence in the opening of KMMS while other members of the university leadership teams came and went. As that stable presence I developed another set of relationships that were about motivation, ambassadorship and generating pride and enthusiasm that would be self-sustaining. These two networks of relationships were at odds with each other at times and I and other KMMS colleagues shuttled between the two environments and cultures, offering each a glimpse of the other.

Effectiveness is a subjective and contested metric which is often used in the evaluation and analysis of organisational culture. An effective relationship is a more contextual matter. All leaders are advised to build effective relationships, but in the context of a start-up operating within an established culture I experienced frictions that were probably

unavoidable. I led KMMS to be exciting, outward looking and innovative, but nested within two universities with much more stable, hierarchical and at times conservative norms. This tension has affected many aspects of the KMMS journey. I found the Competing Values Framework to be useful in this analysis because it frames these typologies well and provides a common language that helped me understand what was going on around me.

Until their departure, the duration of my professional relationship with certain individuals as avatars and advocates for one or other university matched the timeline of my involvement with the KMMS project. Colleagues often manifested a cultural typology that the Competing Values Framework would identify as hierarchical, and this was nearly universally replicated by other leaders, peers and colleagues. While the culture at Kent underwent a period of flux, this provided the opportunity to offer a brief comparison of the relative differences in my experiences of working with less avowedly hierarchical partners. Kent started with a more conventional university culture which combined academics with a clan culture with leaders and managers with a hierarchical culture and which was reorganised in a way that disrupted the clan culture of the academics and imposed a more hierarchical and market orientated structure on the university community. Over time the typical hierarchical, clan culture of academics reasserted itself once again.

Throughout all of this I felt that KMMS needed to have a culture that the framework would typify as an Adhocracy (Box 19) (above). This cultural paradigm was not common nor deliberately fostered by either university, but it was extremely effective at powering my KMMS flywheel (Box 18) (above). This meant that my KMMS orientated cultural paradigm was diametrically opposed to hierarchy and clannism and this caused personal and professional tensions. The situation at Kent was very different because of their own reorganisation, this meant that my colleagues there were immersed in cultural change already and it was very difficult to identify which cultural paradigm held sway for quite some time. During a period of institutional change at Kent, the introduction of the medical school was simply experienced as part of that wider process.

8. Knowledge Building and Deep Learning

I have now discussed the moral imperative which leaders can call everyone to answer and some aspects of preparing colleagues to embrace change. In the preceding chapter I reflected on the networks of people I needed to engage with to achieve change. Now, Fullan (2020) recommends considering two more phenomena. He starts with advice about building interconnected teams, which build knowledge collaboratively and which share and manage that knowledge collectively. Next, he moves to consider how those interconnected teams of collaborative educators engage students in learning and develop sense-making and knowledge creation activities for students which are engaging and galvanising. The connection between the two constituencies of educators and students is knowledge management and learning behaviours.

The event that ultimately triggered my epiphany that I will discuss here is a planning meeting for another building. This time the Pears Building at Kent. This building was not planned with highly specialised teaching facilities in mind. This was to be the KMMS administrative hub and to include some generic teaching spaces, for example seminar rooms, a lecture theatre and two computer labs. I am making an intentional association between the construction of physical spaces and pedagogical constructivism because I want to draw attention to how the physical space in which we work, teach and learn can help and hinder leaders in achieving their objectives. I will conclude this chapter by drawing these different concepts of the construction of the physical and the moral or cultural aspects of the medical school together under the idea of a salutogenic and compassionate workplace. Considering another building project permits a comparison between some of the similarities and differences between the work required to design this building and some of the issues I noticed when planning the Anatomy Learning Centre in Chapter 4. Comparison between cases is one of the criteria Chang (2008) recommends autoethographers consider when choosing events of significance to analyse.

Epiphany 14: The unused Pears Building

Another meeting, this time in the Estates and Facilities building at the University of Kent, a collection of semi-permanent modular buildings backing onto an area of ancient woodland.

Another moment when I reduced a room to silence, and all faces turned to me with looks ranging from delight to incredulity. This time I said that I wanted to completely rethink the top floor of an entire building. The reactions were not because my request came at an inopportune point in the project plan, in fact I was welcomed at the start of the meeting and encouraged to voice any suggested changes to the draft plans because this was meant to be a concept meeting with the architects and builders and the proposed plan was still merely a guide for the overall footprint and scale of the building. When we got to the top floor, having made changes throughout all the teaching spaces of the building based on pedagogy and technology, the group assumed that the conventional one and two person offices with full length windows at the level of the surrounding tree canopy, arranged around the edge of the building and with utility, common and service areas in the centre of the floor receiving natural light from rooflights would be uncontroversial and would not need that many changes. The most important question was how big the Dean's office was to be and whether I wanted a Dean's parking space. Instead, I said that I wanted to sweep all of that away and have an almost entirely open plan area, no specific office for the Dean and desks arranged in hubs for mixed academic and professional services teams predicated on different functions and operations for the school, such as curriculum, assessment, General Practice and research. I wasn't sure which of these was the most radical of the requests I'd just made. It was certainly the first proposal for a shared and collaborative space for both academics and professional services colleagues made by a School at Kent.

In a later meeting one of my colleagues from Estates and Facilities told me it was a request they waited for years to receive, and to finally be asked to design such a space for KMMS was exciting but also truly demonstrated that KMMS was determined to be different. This was much more like the sort of reaction we had expected from our IT colleagues during the design sprint. The architects were pleased because it was a different brief to the one they usually received, especially from university clients, and the financial planners for the KMMS project were pleased because it made the space significantly cheaper to build per square metre – something that allowed us to incorporate other features into the building such as gender neutral lavatories and a kitchenette in the students' common space.

The construction of the building started and continued through 2019. Our plans were stress-tested, and contingencies were made for Brexit. I learnt that the UK no longer manufactures nails and other fixings, inconvenient when building a largely timber-framed building. We received a gift of £2 million from the Pears Foundation (2020), for which they gained the opportunity to name the building. The construction company, Wilmott Dixon, managed the various limitations and contingencies of the pandemic lockdowns of 2020 and the building was handed over only a few weeks later than the original schedule in October 2020, a truly impressive feat (Wilmott Dixon, 2020). By the time we received the keys to the building we had welcomed our first year of pioneer students to a welcome week which was delivered in a socially distanced format and were into the second national lockdown with a work at home order and all non-clinical teaching delivered virtually. We were unable to have a formal opening ceremony for the building, so we had no celebration of our school opening, something that was not rectified until 2023 (Kent and Medway Medical School, 2023a, 2023c). Nor could we celebrate the arrival and commencement of our pioneer students. We did not schedule a meeting in the new building in that entire academic year. I visited occasionally to find where my collection of cacti had been left by the removalists, to rescue them and to periodically water them. By the time we had permission to use the building again at near normal capacities and without stringent social distancing, the KMMS team had not met face to face as a large group for 18 months, while the building was still being built, and we had all grown used to working at home in the interim. We delivered almost all the first year's teaching virtually and recruited so many teaching, academic and professional services staff to KMMS that the team nearly doubled in size. Some of my new team-members were recruited, onboarded and started work through an entirely virtual and distanced process.

I worried about the impact of all of this on the nascent KMMS team and the culture I planned to champion.

Work cells or open plan frontiers?

When I completely changed the direction of travel for the plans for an entire floor of a building, I was convinced that it was a change I wanted to enact. Unlike the Anatomy Learning Centre at CCCU, this time I was deciding something that the universities did not

expect. We visited the new medical school building at Anglia Ruskin University (ARU), built only a few years earlier for one of our new medical school peers. It was arranged on similar egalitarian, shared and collaborative principles and based on facilitating the development of an adhocracy culture rather than enforcing hierarchical or clannish barriers predicated on professional discipline or background (Chapter 7, Competing Values, Competing Cultures, Box 19, p139) (above). I also personally visited the Hull York Medical School (HYMS) building at York University and discovered that they were just preparing to move out of their 20-year-old building, built to a more conventional cellular office design, so that it could be remodelled to an open plan design intended to promote collaboration. Their need for a radical overhaul was also being driven by how narrow corridors and a series of security doors were countering the welcoming and student-centred ethos of the school the team aspired to. The Googleplex in California and the concept of a WELL Building Standard created by the International WELL Building Institute (IWBI) (2023) have stimulated some new ideas about workspaces and communities of work, and I felt that some of this modernity and innovation would reflect well on KMMS.

In his ethnography of a London medical school in the 1990s, Sinclair (1997) felt that medical schools were the fourth typology of total institutions as described by Goffman, "… institutions purportedly established the better to pursue some workmanlike task, and justifying themselves only on these instrumental grounds" (1961, p. 5). This is an attitudinal perspective that some universities may have of their medical schools, and which continues to perpetuate some aspects of the historical relationship between institutions. Medical schools certainly have a profound effect on the ethical development and professionalism of those who work and study within them and Reiser, in his depiction of the moral order of a medical school describes how every co-worker, academic and professional services colleague, is "bound together in a common educative mission" (2000, p. 6). He goes on to outline his opinion that every member of staff has multiple opportunities to role-model how to treat people with respect and dignity and, while academic staff have the opportunity to do this in the places where education happens, professional services colleagues have a significant opportunity to role-model this in all the other ways in which the medical school intrudes on a student's life, these being immense

and wide-ranging in a total institution. He also reflects on how artefacts, policies and traditions that are chosen for display and historical events that are chosen for recording, publicity and for celebration all influence its institutional identity – its culture. In my own professional experience, in every medical school I have encountered, as a learner, a practitioner, an educator, a manager and a leader, this has rung true. This is also highly problematic because it means that the very walls of a medical school can inform its hidden curriculum in ways which counteract the mission to socialise medical students into contemporary models of person and patient centredness.

Even though a lot of healthcare happens behind doors which are closed to laypeople, a huge amount of healthcare is provided by a team of people who are often simultaneously present, sharing knowledge, problem-solving and managing uncertainty. A 1:1 consultation with a healthcare professional may be the only part of any patient's healthcare journey which is provided in a solitary cubicle, even if the walls to that cubicle are merely curtains. I wanted KMMS spaces to foster teamwork and collaboration, to enhance collaboration and flatten hierarchies. As well as the real-world examples of HYMS and ARU, I also wanted KMMS to emulate many of the open, shared and collaborative work environments of the NHS. I agree with Sinclair (1997) and Reiser (2000) that every aspect of how a medical school operates is an opportunity to role-model professional behaviours for students and help them better understand the working environment they are preparing for.

In the planning stages for the Pears Building, my vision of a mixed and open-plan space was met with scepticism and even some derision from academic and professional services colleagues. Noise, privacy, confidentiality, the effect on the team if senior staff had offices and more junior colleagues did not. I considered reverting to a cellular floorplan and mandating an open-door policy instead. Then I saw how this was being tried by individuals in both universities' leadership teams. It generally lasted no more than a few months and then the doors started to stay closed. I thought the challenge of elitism was legitimate and dispensed with the Dean's office entirely, turning it over to a common pool of flexible individual and small meeting rooms. I brought all my books home, but left my cacti spread out across the desks. KMMS was already using a large open plan space in

CCCU and at one of our pre-pandemic team days we'd discussed and agreed some ground rules for working in such spaces. Colleagues could request headphones and do not disturb signs and already knew that foods with strong odours should not be eaten at desks, so I was hopeful that we were already developing a culture that would ameliorate some of the most common disadvantages of the open plan workspace.

In the post-lockdown world, many employers are engaging with their workforces about hybrid working. Previously, academics had a lot of autonomy about where they worked, and I was explicitly supportive of this and took advantage of it myself, but professional services colleagues did not have the same autonomy. They did not have an automatic right to request a hybrid working pattern and I observed a high degree of resistance to agreeing to this when it was requested. Now, both universities give all employees the automatic right to request hybrid working, up to two days a week working at home if they are full time employees. Additionally, with the ongoing growth of the KMMS team and changes to our office space at CCCU, we are now in imminent danger of not having enough room for the whole KMMS team to be in our combined office space simultaneously, so we are actively encouraging all members of the team to adopt hybrid work patterns.

Open plan offices have their origins in scientific management and were first described by Leffingwell (1917). He was unambiguous that the benefit of open plan offices was primarily financial, with reduced construction costs, pooled labour and more efficient layout of physical spaces to improve workflow being some of the prime benefits he mentions. Baldry and Barnes (2012) described how this became the most common format of corporate office space by the 1960s and Richardson et al. (2017) carry on the story, telling how the public sector also increasingly adopted this format of workspace from the 1970s.

In the corporate workplace an extensive literature base shows that there are advantages and disadvantages to open plan workspaces (Box 20). Kim and De Dear (2013) describe how the most contested aspect of open plan workspaces is the trade-off between reduced privacy and increased communication. The counterargument to objections about privacy and personal autonomy over individual workspaces tends to be that the nature of work

has changed with the advent of the knowledge-based economy and the rise of the knowledge-worker.

Advantages	Disadvantages
Greater opportunities to meet and network	Loss of personal, visual and aural privacy
More informal meetings	Noise
More efficient workflows	Loss of control of ambient environment
Increased communication between supervisors and team-members	Inability to personalise space
Greater group sociability	Increased perception of crowding
Reduced construction and maintenance costs	Fewer friendship opportunities
Enhanced business performance	Concerns about security
Employees prioritise collaborative working when in open plan spaces	Less space for focussed work requiring individual concentration

Box 20: Summary of the advantages and disadvantages of open plan workspaces

Dul, Ceylan, and Jaspers (2011) and Waber, Magnolfi, and Lindsay (2014) describe how companies are now harvesting data about where their employees spend time in their workspace and what they spend their time doing. This is then used to commission buildings which include hard architectural features which catalyse meetings between employees who would not otherwise meet and softer digital functionalities which facilitate communication and the sharing of ideas and knowledge.[8]

De Croon, Sluiter, Kuijer, and Frings-Dresen (2005) and James, Delfabbro, and King (2021) have demonstrated that universities remain one of the last bastions of the cellular office-space but, even here, the move to open plan workspaces seems to be inexorable. Many researchers have presented this as a clash between two competing paradigms: the

[8] Digital monitoring of employees' activity has increased in line with the huge adoption of hybrid working post-pandemic, and Allyn (2020) describes how this data is not always used with employee benefit in mind.

neoliberal, hierarchical and managerialist cadre of a university with the clannish, professional identity of the academy. They acknowledge that the financial imperative of a university to cover the actual costs of its activities has become more important and more challenging and that universities have needed to reduce their overheads and increase and diversify their sources of income to do this. However, there is a clash between the need to reduce costs and increase income, the increased importance of partnerships, collaboration and joint enterprise with industry, and the continued need for university employees to have space for private and confidential tasks which require sustained periods of uninterrupted concentration. On this occasion the clash I thought I was provoking was between the hierarchical university and the adhocracy medical school.

Scientific management, managerialism, neoliberalism, marketisation all seem to point towards open-plan spaces as being cost-effective to construct and maintain and that they foster collaboration and teamwork. A significant part of the literature suggests a degraded subjective experience of working in these environments with reduced privacy, confidentiality and ability to concentrate and loss of control over one's immediate physical environment being highlighted as common disadvantages. These were all certainly considerations, but I and the leaders at other medical schools, new and established, who had the opportunity to build or extensively refurbish our facilities all felt that the fostering of teamwork and collaboration, the enhanced collaboration and the reduced hierarchies were priorities that tipped the scales in favour of open-plan facilities.

Centeredness

Contemporary Deans and Heads of School were at medical school at around the time, or perhaps the decade before, when Sinclair (1997) was conducting his ethnography and Reiser (2000) was formulating his ideas about the moral order of a medical school. At the same time, the concept of centredness in healthcare was emerging as a strong force for change. The imperative to attend to the health and care service user's lived and emotional experience became increasingly common in the late 1990s and early 2000s and the concept of patient centredness (also called person-centredness by some healthcare professions and disciplines) has become an increasingly important driver of many service reforms and improvements (Darzi, 2008; Francis, 2010, 2013). Person-centeredness

featured in the HEFCE bid and the KMMS mission and vision (Chapter 5, The mission, vision, values and goals of KMMS, Boxes 11-13, pp93-95) (above), so it is very important to our culture and something which we feel makes KMMS stand out from other schools. In the university sector, student-centredness has become a common phrase, which, like person-centredness in healthcare, is often used imprecisely and with aspirational intent.

The idea of centredness is derived from a model of therapy developed by Carl Rogers (1967) and which C. R. Rogers and Freiberg (1994) later developed as student-centred learning. In 1985 the Chief Education Officer for Birmingham described student centred learning as "… a development which is at the cutting edge of change in education." (Crawford, J. in: Brandes & Ginnis, 1996, p. ix). In education, student-centredness has often been taken to mean a pedagogic approach focussing on the actions and behaviours which occur in and around the classroom (Box 21) but, as Ramsden (2003, p. 74) makes clear, "The emotional aspect of the teacher-student relationship is much more important than the traditional advice on methods and techniques of lecturing would suggest.". He goes on to say that "… truly awful university teaching is most often revealed by a sheer lack of interest in and compassion for students and student learning." (p. 95).

1. The learner has full responsibility for their own learning.
2. The subject matter has relevance and meaning for the learner.
3. Involvement and participation are necessary for learning.
4. There is a high-quality relationship between learners.
5. The teacher is a facilitator and resource.
6. The learners see themselves differently because of the learning experience.
7. The learner experiences confluence in their education.

Box 21: Some of the main principles of student-centred learning
(Abridged from: Brandes & Ginnis, 1996)

There is no agreed definition of what person or patient centredness is in healthcare. Blackie, Case, and Jawitz (2010), and Eklund et al. (2019) found that there is even some divergence emerging between the behaviours associated with person-centred care and

patient-centred care. Eklund et al. (2019) found that both models do share nine key themes (Box 22).

1. Empathy
2. Respect
3. Engagement
4. Relationship
5. Communication
6. Shared decision-making
7. Holistic focus
8. Individualised focus
9. Co-ordinated care

Box 22: Nine themes common to both person-centred and patient-centred care (Eklund et al., 2019)

The internal and external mandate to socialise medical students as professional and patient-centred practitioners helps to mitigate, but does not completely eradicate, the risk that we might fail to appreciate the fact that it is the totality of the experience that the medical school offers that will inform the professional development of its students, a theme that both Sinclair (1997) and Reiser (2000) emphasise. If I had not attended to the nature of a medical school as a total institution, then a dissonance would have emerged between the school's formal curriculum, which attempts to be student-centred and to inculcate patient-centredness as a professional behaviour, and the hidden curriculum, which imputes that helping people and respect and consideration of others are secondary to the technical acts of providing an education and evaluating how well students have acquired the necessary learning. Waddington (2016) also noticed this dissonance between what we try to teach and our organisational cultures and what educators do and how school cultures operate in other healthcare programmes. I wished to pre-empt and mitigate for this phenomenon at KMMS. I observed a huge focus on the technical behaviours of centredness: lecturers thought about how they could make the transactions of learning student-centred and healthcare professionals thought about how they could do the same for the transactions of care. I felt that this was a thoughtful evolution of all

aspects of how individuals and organisations provided education and care but that it was not applied holistically to all the functions of the individuals and organisations I was working with, for example the way in which we administered the programme, the way in which we performed bureaucratic interactions with each other and with students, the way in which we supported students in distress and celebrated students' successes. I felt that, given the strength and power of the relationship that members have with total institutions, the impact of this dissonance could be so significant as to cause moral injury to students because they were being trained to be person or patient centred practitioners by individuals who worked within either or both of university or healthcare environments where this language of centredness was becoming increasingly common and powerful and yet the hidden curriculum all too often might not live up to these standards. I wanted students to be able to expect that they would be provided with good role-models for centeredness in all these interactions so that they could both have the best learning experience possible, but also so that they could learn how to adopt centredness into their own professional practices, but I was concerned that this was not happening.

It is well known that medical students have fluctuations in their reported and observed capacities for empathy and compassion that they feel for themselves, their peers and their patients during their studies. These fluctuations have been well documented and studied over the past three decades (Hojat et al., 2009; Neumann et al., 2011). In their systematic review of the phenomenon Andersen, Johansen, Søndergaard, Andersen, and Assing Hvidt (2020) suggest several changes that programme leaders could make to preserve empathy, such as home visits with experts-by-experience or the introduction of medical humanities to a programme, and how these might help to cultivate students' empathy. It's noticeable that these are many of the same changes that are proposed to help make students more patient centred as well.

It is hard to find a single term that adequately crosses the boundaries of the medical school as a workplace for staff, a total institution for students and as an educational environment which fosters centredness and professionalism. In my own mind as I articulated my rationale for the open plan workplace one word kept coming up in my thoughts and in interactions I had with colleagues: compassion. When I started to search

for other research which used this term, I discovered a rich seam of literature about the compassionate university.

Compassionate workplaces

In her consideration of how space can humanise care in hospital van der Meide (2018) suggests several features that resonate with my own experience of working in health and care environments for over 30 years. Person-centred hospitals need to meet the requirements and expectations of patients, their families, and healthcare professionals. A pleasant hospital environment will be clean, free of clutter, and well-maintained. This can help prevent the spread of infections and promote a sense of well-being and is a particular focus of inspections by the Care Quality Commission (CQC). Hospitals should be designed with the comfort and well-being of patients and staff in mind. This should include adequate amenities, comfortable furniture, soothing colours, and natural lighting. The design should also be welcoming and easy to navigate and promote a sense of safety and security by including visible security measures, clear signage, and easy access to emergency services.

Most definitions of compassion agree with Atkins and Parker (2012) when they propose that compassion involves both feelings and a response. For example, many researchers base their work on a standard definition of compassion as a "… sensitivity to suffering in self and others with a commitment to try and alleviate and prevent it." (Gilbert et al., 2017, p. 1). By caring and nurturing weaker and more vulnerable members of our communities, we aid the overall chances of the survival of our species. This effect is most obvious when we care and nurture our own offspring.

Emotions can be clustered into three different emotion-regulation systems: threat and self-protection, drive-seeking and soothing-affiliative. Goetz, Keltner, and Simon-Thomas (2010) consider three theoretical perspectives of compassion (Box 23) and argue that compassion is distinct from other soothing-affiliative emotions, such as sadness, love or empathy, because these other emotions do not result in the specific set of behaviours with an evolutionary benefit that arise from feelings of compassion.

- A form of empathy applied to the vicarious experience of another person's distress.
- A blended variant of the emotions of sadness and love.
- An affective state distinct from distress, sadness and love which motivates specific behaviours towards others.

Box 23: The three main theoretical accounts of the emotional basis of compassion (Goetz et al., 2010)

Compassion is not a new concept, but over the past 20 or 30 years it has been studied and adopted as a therapeutic intervention in healthcare (Irons, 2013). The therapeutic benefit of compassion has resulted in it being increasingly included in the taught component of healthcare programmes, often as an aspect of the required professional development of practitioners, for example, the UK-based Collaboration for Compassion in Healthcare Education (C4CHEd) (University of Plymouth, 2021) aims to improve the delivery of education in compassionate practice in healthcare education.

Individuals display compassion and compassionate behaviours, but organisations are not intrinsically compassionate and must foster that behaviour in their members. Dutton, Workman, and Hardin (2014) conducted a review of the literature from a heterogenous range of workplaces and synthesised three features of a compassionate workplace (Box 24).

- Members of the organisation perceive themselves as similar.
- Members of the organisation have a close personal relationship.
- Leaders are mindful of their hierarchical social power and the power structures in their organisations.

Box 24: Three features of a compassionate workplace (Dutton et al., 2014)

They highlighted that researching compassion in the workplace "…is in its infancy in terms of depth and breadth of empirical research." (p. 278). One of the few centres that researches compassion in the workplace is The Centre for Compassion and Altruism

Research and Education at Stanford University School of Medicine (2020a). Whilst compassion as a professional and therapeutic behaviour in healthcare is accepted and has been the subject of a lot of research, and the role that compassion plays in the corporate workplace has become a more recent topic of interest for scholarly consideration, the modern, neoliberal, managerialist and financially driven university is not widely regarded as being an environment which cultivates compassionate behaviours (Boyd & Grant, 2019; Caddell & Wilder, 2018; Maclean, 2016; Petersen, 2011; Waddington, 2016, 2021). Individuals within universities can feel compassion, and frequently do, but the other institutional priorities to which they must attend often mean that they must frequently subjugate their desire to exhibit compassionate behaviours and prioritise other activities. Waddington (2016) describes how a relentless drive to achieve excellent objective metrics and standards erodes morale. What is concerning is that she also highlights that the impact of this vigilance on task-orientated behaviours is magnified in the context of a pressure of work that leaves "little time for reflection, thinking and the development of sustainable relationships between different parts of the organisation."(p. 5). The evidence suggests that this dissonance results in moral injury for members of the academy or, what Smyth (2018) terms more evocatively, the zombification of university practices, leadership and staff. Some authors and institutions are seeking to make cultural and behavioural interventions and recommendations for how universities can become more compassionate (Boyd & Grant, 2019; Trail & Cunningham, 2018; University of Worcester., nd; Waddington, 2021). These resources that help to enhance compassion are welcome but do not extend to considering what a workplace physically designed to enhance compassion might look like.

Forooraghi (2020) identified three approaches to office design that may promote health:

1. Health-focused approaches which aim to promote worker health, well-being, or safety, for example air filtration, sound proofing, natural light and office amenities.
2. User-focused approaches which include participatory and co-design methods in the early stages.
3. Office-concept approaches which promotes an activity-based flexible office layout.

She found very limited evidence of the impact of these approaches, especially those related to health promotion and a general lack of measurable outcomes and methods. Roskams and Haynes (2019) noted that while regulations exist to optimise physical health in buildings such as minimising airborne pollutants or sources of environmental discomfort, no such regulations exist to mandate that buildings actively promote health. In fact, there is no real consensus on a unifying definition of what constitutes a healthy workplace (Jensen & Van Der Voordt, 2019). The IWBI offers an accreditation against its voluntary standard (2023), which it claims is evidence based and which includes requirements for promoting mental and physical health and wellbeing as well as the physical characteristics described by Forooraghi. Several universities around the world have achieved the IWBI WELL Building accreditation. Chrysikou, Tziraki and Buhalis described how healthcare architectural design has also become "…one of the first areas of architecture to explore and subsequently introduce evidence." (2018, p. 5). The scholarly output on how architecture or design of the workplace might enhance compassion focuses on constructing clinical facilities such as care homes, hospitals and clinics. Famously this includes work by Nightingale (1860) in her description of her eponymous wards and by Ulrich (1984) in his description of how a view from a hospital ward window might positively influence recovery after surgery. Sailer, Budgen, Lonsdale, Turner, and Penn (2008) report that the principle is more generously applied to healthcare projects than to office design. Interestingly, they question whether the rigour of what evidence-based design does occur approximates to the rigour of evidence-based medicine.

A widely chosen neologism for designing a built environment which focuses on the active promotion of health seems to be 'salutogenic architecture'. This is based on the theory of salutogenesis proposed by Antonovsky (1979) as an antonym to pathogenesis and intended to focus on factors that support human health and well-being because these are often different to the factors which cause illness and disease. It is beyond the financial means of most universities to contemplate razing their entire campuses to the ground and rebuilding a salutogenic utopia to replace it and there is no irrefutable evidence as to the benefit of taking such a step. The Anatomy Learning Centre at CCCU had to be fitted

into the under-croft of an already designed building. The Pears Building offered the opportunity to design a new health and care education building from the ground up and to think about what a building that would foster a culture of compassion might look like as part of that process.

A space to foster compassion.

In the post-lockdown world, the office space is being re-examined through the lens of the COVID-19 pandemic and long periods of working at home. Proliferating blogs, opinion pieces and editorials are discussing the compassionate office, the human-centred office, the humanized office, the biophilic and salutogenic office and more. There is no consistent language nor taxonomy and one of the commonest results in Microsoft Academic (Microsoft Corporation, 2021) for a search on “humanized AND office AND design” concerns specialised connectors for networked IT equipment in an open plan office. Todres, Galvin, and Holloway (2009) propose eight dimensions of humanization: insiderness, agency, uniqueness, togetherness, sense-making, personal journey, sense of place and embodiment. Apart from a sense of place, none of these directly relate to the physical place that humans occupy, but they certainly do relate to culture, moral purpose or moral order. Furthermore, some of these dimensions might be facilitated or hindered by physical limitations, for example agency, uniqueness and togetherness. As discussed above, open plan offices may reduce peoples’ feeling of agency or increase their feeling of togetherness.

Thinking more about mental health, a common consideration of salutogenic architects is creating a built environment for people suffering from dementia, either in the creation of bespoke facilities (Chrysikou et al., 2018) or adjusting existing, public environments so that they are more welcoming to people with dementia (McLaughlan, Annear, & Pert, 2018). Forooraghi (2020) found that psychological health considerations reported in the literature were mostly related to meeting basic psychological needs of safety and security or promoting generic well-being. After his initial idea of salutogenesis, Antonovsky (1987) went on to propose that some people manage external stressors better than others because they have a better Sense Of Coherence (SOC). This is a trivalent concept which depends on an individual’s sense of whether the events they are experiencing are

comprehensible, manageable and meaningful. Evidence suggests that a stronger SOC is associated with better health outcomes (Braun-Lewensohn, Idan, Lindström, & Margalit, 2017; Idan, Braun-Lewensohn, Lindström, & Margalit, 2017; Koelen, Eriksson, & Cattan, 2017) and with a lower all-cause mortality (Super, Verschuren, Zantinge, Wagemakers, & Picavet, 2014). Roskams and Haynes (2019) therefore propose that a salutogenic workplace will attend to an architectural design which ensures that people have an ordered and consistent (comprehensible), rich and resourceful (manageable) and personally and professionally purposeful (meaningful) environment within which they can work, and which will therefore nurture their SOC.

The concept of a workplace that promotes health, rather than one which is not deleterious to health, is relatively new and lacks a substantial evidence base. The IWBI has conducted a financial analysis of the benefits to organisations of investing in healthy buildings (International WELL Building Institute, 2022). There is clearly a gap in the available literature to help support people planning new offices in making sure that those spaces promote psychological health and behaviours which will support the psychological health of others. The value of compassion in the workplace is hardly considered at all in any of the published literature on the merits and demerits of open-plan workplaces. My motivation for asking for the open-plan and team-organised architectural design in the administrative hub in the Pears Building was about creating a space which would allow the medical school to grow a culture that was compassionate. I felt that this was vitally important because we would be teaching our students that compassion and collaboration were vital professional behaviours that they must acquire to be safe and competent medical practitioners. I witnessed elsewhere a powerful dissonance around this phenomenon which Reiser (2000) also feels is important and which Sinclair (1997) describes as highly probable in a total institution. I believed that it could cause moral injury to colleagues who worked in medical schools to not think of this aspect of our hidden curriculum and attempt to ensure that it did not manifest in KMMS.

When I started this RBT I anticipated that I would focus on the period from September 2018 until September 2019 and that it would not be possible for me to be sure if I made the right decision about the Pears Building. I certainly had doubts about my request for an

open plan space with pooled private spaces. I believe that the pandemic has helped to justify my decision and, with time, we have addressed many of the major disadvantages of open plan workspaces (Box 20) (above). I have learnt that active researchers do have some justifications for private spaces that I have not been able to provide by any other means than a private office. For our education faculty and our professional services colleagues our space does seem to enhance peoples' SOC (comprehensibility, manageability and meaningfulness). I tried to take a holistic approach to the design of our administrative space and accounted for the limitations in open-plan workspaces by providing an activity-based flexible layout with shared spaces, task-orientated spaces and spaces for individual and group work. No-one has a dedicated single office, which is intended to promote a flat-hierarchy and collaborative culture. Workspaces are arranged in organic clusters of up to 8 people who are all broadly focused on the same jobs that the medical school needs done with no distinguishment made between academic or professional services job roles. Everyone now has a laptop to aid working at home, which aids people in moving from one space to another, and there are several standing desks, and accessibility desks with special IT equipment. The whole floor is flooded with natural light and looks out into the treetops of ancient woodland on three sides. The building is climate controlled using a passive system which is meant to reduce the energy use of the building for heating and lighting and current pandemic precautions are encouraging us to open windows as much as possible so there is a shared understanding that temperature might not be to everyone's preferences anyway. We have instituted rules for talking and eating at desk spaces, created spaces for socialisation and purchased lots of pot plants, large and small. Everyone is expected to clean their workspace with anti-infective wipes at the end of each day. Some colleagues have taken permanent ownership of some workstations and have begun to personalise their workspaces, but we are not yet fully staffed, and this may not be possible in the longer term. We have notice boards and celebratory spaces for people to place artefacts which bring happiness and joy to their working day, and which help us to celebrate collectively the progress that the school is making and to forge our group identity more. I have tried to enculturate a trust-based working culture for KMMS from the outset. This has not been how most academics are used to operating, although healthcare professionals who are new to the university

environment are more used to this in a tacit way. Colleagues from professional services are less used to this than anyone, or are used to a more supervisory relationship, but the past 18 months of working from home and the advent of hybrid working for professional services colleagues has brought that aspect of working more into normal practice. We still have many less than full time (LTFT) colleagues whose schedules might not normally overlap with others', but virtual working, a virtual chatroom and other digital platforms that we are now well-used to are ameliorating that aspect of meaningfulness in peoples' work lives.

Concluding Reflections

Before starting this consideration of my epiphany surrounding the Pears Building, I would never have imagined that I needed to know the first thing about architecture to open a medical school. In both of my universities I was fortunate to be invited to participate in the design of estate, facilities and whole buildings intended for KMMS. Initially, I thought that I had other things which were more important draws on my time but over time I came to realise that I truly believed that there was a reflexive relationship between the design of our spaces and the culture of the school. My conceptualisation of the apex behaviour and cultural belief that I wanted to nurture was compassion. Compassion is felt to be a therapeutic intervention and a professional behaviour in medicine, it is felt to be sorely lacking in many parts of the modern Higher Education system.

I had periods of self-doubt about making the KMMS administrative hub in the Pears Building predominantly an open plan space. During the periods when the team worked from home I especially worried that the space was not being used for the meta-purpose of fostering a constantly getting better mindset, a culture of teamwork and collaboration and an adhocracy culture. I felt these were the ingredients for making KMMS a great place to work and elemental to catalysing the way I wanted to give KMMS colleagues a flat hierarchy structure. This was especially challenging to enculturate during the pandemic because so many new KMMS colleagues joined the team and immediately began working in a distributed and virtual format. I also worried that when we did eventually return to the workplace that ongoing social-distancing and infection control precautions would

render the space an ineffective white elephant. This was the case for a while but, as with many other lockdown legacies, is being rapidly ameliorated by the passage of time.

While exploring this epiphany I have discovered that subjectively many would agree with my sentiments that a physical workplace can positively and negatively affect how people feel about their work, the purpose it has and the agency they have in achieving that purpose. There is a distinct lack of evidence to support this belief at anything other than a basic level of psychological well-being and physical and mental health. The discipline of architecture and building design is increasingly aware of this gap, but there is no agreed taxonomy or unifying theory of healthy architecture yet. Further work here is needed to focus both on whether architecture can, or should, try to develop more rigorous theories of salutogenic spaces and whether the impact of those spaces results in healthier behaviours and cultures in the workspace.

Part 3: Pulling things together

9. Coherence Making

In this Part of my RBT, I shall assemble the lessons I have learnt during events I have described and the impact it had on me as a leader in medical education. Each of the next three chapters has a slightly different emphasis.

In this chapter (Chapter 9), I will not include any new epiphanies, instead I will use a narrative summary to draw out and begin the process of integrating some of the themes that have emerged through my analyses in chapters 5 to 8, which are central to this RBT.

In Chapter 10 I will describe some of the more internally focussed epiphanies I have had in response to this journey I have been on.

Chapter 11 concludes this RBT with a discussion about the study and its limitations and some recommendations following on from what my research has revealed.

I have used Fullan's theory of change leadership in education to provide a structure for my autoethnographic methodology and to direct my choice of epiphanies. I reported these personal experiences and then analysed them using theories and research drawn from a wide range of theories and research from various disciplines to examine and critique multiple aspects of my leadership journey. The analyses of different facets of my complex and interconnected roles were compared with already published work to grow what knowledge is available. Fullan (2020) brings everything together at this point by integrating four leadership capacities[9] into a single model:

1. Moral Purpose
2. Understanding change
3. Developing teams
4. Building deep knowledge.

Fullan (2020) asserts that the primary challenge that faces contemporary leaders of change in education is how complex change has become. As I simultaneously started my

[9] For completeness, see Appendix 7 for a short note about another concept, called Leading from the Middle which Fullan describes in this chapter. This concerns region-wide system-change and I felt it was not applicable to a single school and was beyond the scope of this RBT.

job at KMMS and this RBT, I had a huge sense of affinity for this perspective and it was one of the key reasons why Fullan's book held such attraction for me. Heifetz and Linsky (2017) characterise education as a traditional field with practitioners who prefer technical rather than adaptive change. I have given some historical and contemporary examples of how medical education might be even more conservative (Appendix 5). Even organisations that aspire to be innovative can exhibit resistance to adaptive change when they realise what is required to do so. Leaders trying to engineer adaptive change encounter resistance because it requires colleagues to question their beliefs and values, change their habits, take a risk and perhaps acknowledge that they are not as expert and competent as they might have thought they were. With these self-images at stake, it can be difficult to get buy-in from those who are required to change. In educational institutions this may include teachers, professional services colleagues, other teams, and other stakeholders. I was never in any doubt that setting up a medical school spread across two universities, relying on the support of the NHS, incorporating the input of a contingency medical school, meeting the requirements of the GMC, HEE, OfS and the expectations of a plethora of stakeholders, observers, benefactors, friends and other affiliates would be complicated. One of the things this RBT analyses is whether Fullan's model helped to reveal a distinct sociology of medical school leadership.

Narrative summary of Chapters 5 to 8

Chapter 5 focused on the articulation of our moral purpose in the form of a mission and vision and a set of values and how that impacted colleagues within KMMS and across our two universities. As I built the KMMS team, most aligned strongly with our moral purpose and I deliberately cultivated this enthusiasm. This also included those colleagues and teams we interacted with more widely. These tools were powerful and beneficial in persuading people of the necessity of the adaptive changes the medical school would catalyse. This was double-edged when we failed to be able to deliver moral purpose. I also described the personal impact of these occasions when we did not live up to our moral purpose as a moral injury. This was most obvious when KMMS aspirations were compromised by what seemed to be university orthodoxy regarding HR practices for KMMS.

Chapter 6 was about change management, in it I discussed some theories of change and adaptation to change. As an entrepreneur with an affinity for change, I felt like I thrived in the KMMS environment. I came to realise that change is perceived differently by everyone and not all change is welcome. KMMS continues to be a project in set-up phase: some parts have been delivered, but it is not yet complete and other parts are still in the planning stages. In Chapter 6 I focussed on how the initial project management structure impacted on one, vital, aspect of the school: our Digital First strategy and how this became a wicked problem requiring direct action to resolve. This seemed to be a serious consequence of an overly complex project management team, symptomatic of two institutions who were working in partnership, wanting equal amounts of influence across 12 different workstreams and the insufficient time I had to become culturally literate. The first issue was the atomisation of myriad pieces of work that needed to be completed within tight deadlines and too many stakeholders for consensus and discussion to be effective. This was worsened when I was unable to address some deep philosophical differences which emerged when we ran an exercise called a design sprint. This nearly failed and I realised that our fat plan and moral purpose had not reached all colleagues. A significant reason for this was because the two universities were organised differently, and one was undergoing significant change. What worked to disseminate our moral purpose in one had not worked in the other. My cultural literacy was not sufficient to recognise this and our resulting clumsiness in describing our aspirations for our IT projects was received badly as a result.

This led to Chapter 7 which discussed the relationships that change leaders must grow and maintain, their importance and the context within which they occur during change. The two universities created a structure which affiliated the medical school to a faculty-like entity in each. This had benefits and disadvantages and was heavily influenced by who led each faculty and was therefore the gatekeeper between the medical school and the wider universities and senior leadership. Due to the speed of the KMMS journey and the amount of work to be done, there has always been a sort of feverishness to the professional relationships which have developed. Many of my epiphanies demonstrated how some of my professional relations could approach an unmanageable level of

hyperactivity. Some, which involved very frequent interactions, became particularly intense and emotionally close. By this I mean that the shared experience with others was more intense due to things like the strength of our moral purpose, the complexity and speed of adaptive change and the scope of activity we were contemplating. The other aspect of these relationships was their fluidity. While trying to lead and manage change, I was not always able to control change in some of the most important personal or organisational interactions I had with the universities. This meant that I needed to adapt to change myself and that, over time, I became one of the most stable presences in the KMMS journey. My networks were complex, some overlapped significantly, some barely at all, some responded well to pride and enthusiasm for adaptive change that KMMS could catalyse, others regarded change of this nature with deep suspicion. The professional relationship I had with one individual captured many of the facets of this dispositional difference.

In the networks I worked within there were different rules, handicaps and beliefs and there were different rewards and consequences for transgressing these. Relationships had a different characteristic based on the context in which they occurred. I was surprised by how much a relationship with a service could change if the person who held a key post in that service changed. The most contrasting of these were the differences I navigated between the network of the immediate KMMS teams and our supporters and the network of university leaders, managers, administrators and professional support colleagues. The entanglement of all the relationships that KMMS and I needed to have resulted in a complex analysis. Cameron and Quinn's Competing Values Framework (2006) was very helpful in analysing one of the main binary differences between these various cultures – a tension between the medical school's apparent affinity for change and the wider universities' apprehension. I felt that the framework would typify the KMMS culture an Adhocracy, while the prevailing culture in the wider universities was either clannish or hierarchical (Part 2, Chapter 7, Competing Values, Competing Cultures, Box 19, p139) (above). I also reflected on this impact of the relationships I had with other, senior leaders in the universities by thinking about the KMMS flywheel (Part 2, Chapter 7, The medical school's relationships within two organisations, Box 18, p127). The idea of a KMMS

flywheel helped to describe how I thought I was more successful in finding common ground between the two cultures with Admissions and less so with Human Resources.

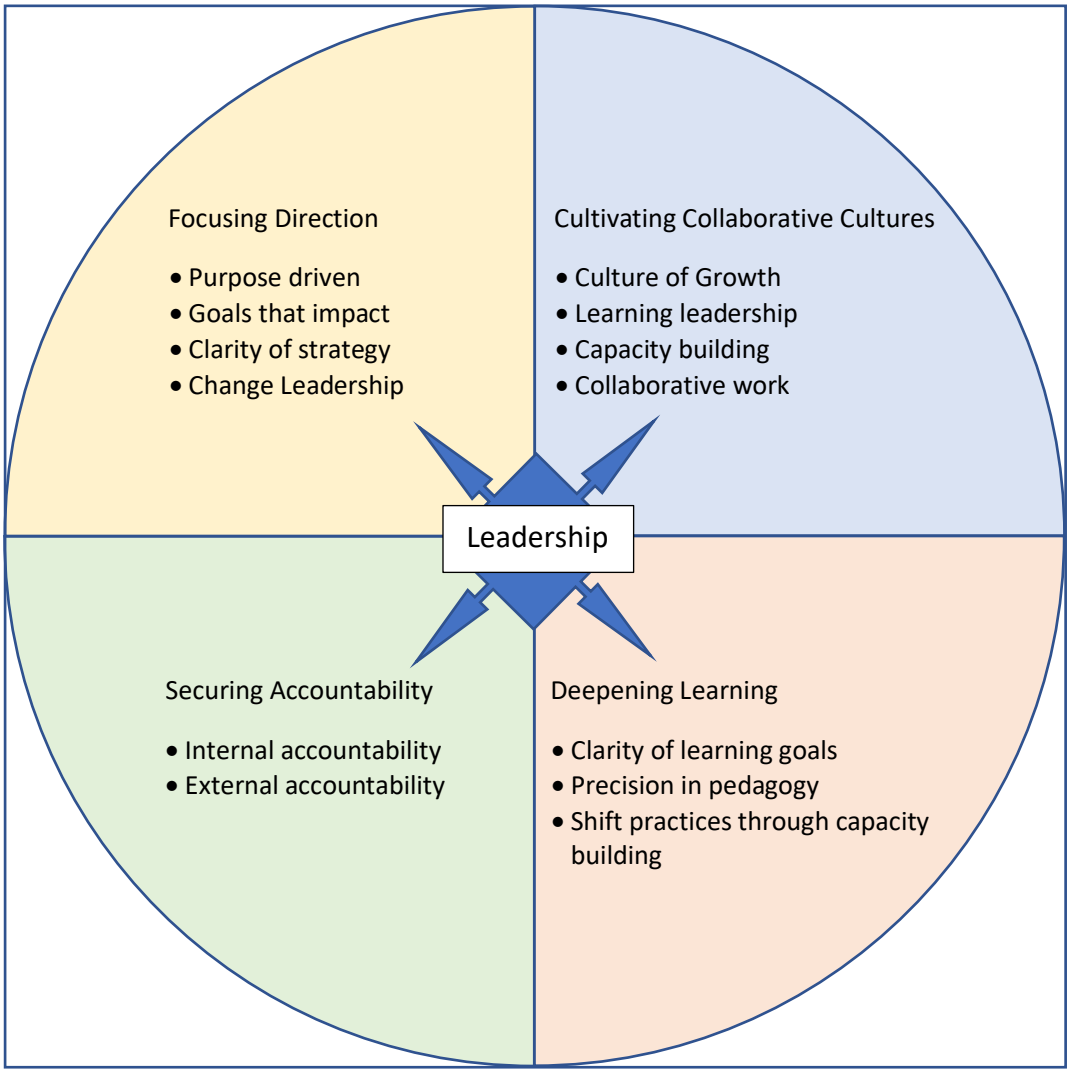
In Chapter 8 I started with the KMMS moral purpose and the theory of total institutions and ended with the construction of salutogenic, compassionate spaces. I considered how the architecture and physical structure of one of the KMMS buildings could be harnessed to facilitate the growth of the flat-hierarchy, multiprofessional teams I desired as well as the social practices of compassion and student-centredness I wanted to offer our students. While certain aspects of the design of the physical representation of KMMS were intended to unify our community, the COVID-19 pandemic, lockdown, working at home, social distancing and the resultant widespread adoption of hybrid working all mandated the increased electronic mediation of my leadership activities. The opportunities granted by my being involved in the design of the Pears Building allowed me to include design elements intended to foster for example, compassion and student-centeredness, serendipitously created a building that is much more flexible and adaptable to the new ways of hybrid working that many other medical schools are still coming to terms with.

Concluding Reflections

In considering the complexity of leading change, Fullan (2020) proposes a comprehensive and reasonably succinct framework for coherence in education with four, non-overlapping domains (Box 25).

He links the leader's tasks of *focusing direction* and *cultivating collaborative cultures* to a broad and deep definition of moral purpose which triggers leadership actions that catalyse collaboration. The moral purpose becomes a shared context which can be disseminated and jointly adopted. My epiphanies have demonstrated that moral purpose can be extraordinarily powerful and was very beneficial for me as leader of KMMS. It was not universally successful though and building the capacity of our KMMS team to grow, learn and collaborate has sometimes been more challenging than I anticipated because compromising such a strong moral purpose became injurious to me and to others at times.

Deepening learning is concerned with the pedagogic approaches the teaching team collectively adopt and abide by. The abundance of documentation for both university programme validation and GMC accreditation has mandated the first two elements of this domain while the fluid nature of responsibilities and roles during the expansion of the team during start-up has helped to shift practices. Our mission and value to innovate in medical education have always tacitly and explicitly set the expectation that the pedagogies we deployed in KMMS would foster deep learning for our students.



Box 25: The Coherence Framework for Education

(Abridged from: Fullan, 2020, p. 121)

The fourth domain, *accountability*, has been one of the strongest influences on our development, and the framework's dichotomy of internal and external accountability does not do justice to the complex web of accountability within which KMMS has been

established. The oversight of two universities, a joint programme approval process and the need to satisfy the GMC accreditation process have been prime considerations for us throughout our journey. As we emerge from the pandemic and feel more secure in our undergraduate teaching programme, we have begun to discuss what KMMS' research endeavour might look like. Still further accountabilities and answerabilities have emerged during this conversation.

Fullan (2020) advises that a leader's task of making everything coherent is never done and Chang (2008) recommends that an autoethnographic researcher should intend to gain a cultural understanding, especially in the analysis of the behaviour of the researcher in their cultural context. The dual purpose of being a good change leader and the reflection required to write this RBT has facilitated my gaining some cultural understanding and returns to one of my very earliest themes, why I chose to adopt an autoethnographic methodology and pattern of research. Chapters 5 to 8 have each explored a different topic in detail and concluded with some final reflections. These multiple analyses have enabled me to include an eclectic range of subject areas. From these, a series of theoretical themes emerge which are grounded in my experiences and which I feel tell some important parts of my story as a leader of educational change. The themes also reveal the unique benefit of the way in which I have taken advantage of this exceptional occurrence (Box 26).

1. The risks and benefits of the strong moral imperative I felt personally and cultivated for the school.
2. My uncertainness in some of the decisions I made.
3. The variety of reactions that I and the medical school evoked in the wider university communities and the relationship management I deployed to manage this.

Box 26: The three themes that emerge from my research

If my experiences are reproducible and common to other medical school leaders, then perhaps there is a basis for suggesting that there is such a thing as a sociology of medical school leadership.

10. Leadership for Change

My reflections in prior chapters have tended to focus on my actions to manage or change external factors to which I was reacting. In this chapter I shall have a greater inward focus on my own nature as a leader and my leadership inclinations and talents. This focus is led by Fullan's framework and Chang's (2008) advice to enhance reflexivity in autoethnographic work by actively considering what has been included and omitted.

As I summarised in Chapter 3, Qualitative Research Methods in Educational Leadership (p.28-33) (above), Fullan (2020) and Keating et al. (2017) recommend that leaders need to develop a metacognitive focus that helps them to recognise moments when they need to be brave. Thankfully courageous leadership is not an innate characteristic which leaders have or do not have. Courage can be cultivated, and Fullan (2020) provides several vignettes of courageous leadership in his book. I feel that some of my actions and behaviours have been courageous and I regret not being more courageous in my pleas for a more nuanced approach to the HR requirements for KMMS. Reardon (2007) agrees with Fullan that courage is a characteristic of good leaders, and she expands upon this to describe how leaders can practise their "calculated risk taking" (p. 58). She even offers some tips to help to make a courageous decision more likely to succeed. The key from both is that with experience in making courageous decisions, leaders become better at making these decisions and better at achieving successful outcomes.

Epiphany 15: Interview

It was May 2022, and I was an external member of an interview panel for a leadership post in post-graduate clinical education and training. It was only the third time since the strict social distancing measures of Plan B were relaxed on 27th January 2022 that I visited central London, and it still felt strange to take the train and walk through St Pancras station. I still had some Lateral Flow Tests and I'd checked that I was negative before setting off that morning. I was one of the few masked passengers on the train. In the interview room we sat more than 1 metre apart, but closer together than I had in many other recent meetings, and we discussed our plan for the interview. We agreed that one of the panel members was going to ask about leadership style and we all anticipated answers along the usual lines of the

candidates' best attempts to demonstrate that they were collegial and collaborative without being a pushover, while at the same time attempting to reassure us that they were not a tyrant in waiting. The question was asked of all candidates, and I was initially very appreciative when one of the candidates had a different answer about how they varied their leadership style according to context. They described their opinion that leadership style is a set of external behaviours and, like any behaviour, these can be learnt and deployed at will to some degree.

After the interview, the more I thought about this and discussed the proposition with colleagues the less I liked it. Blanchard, Zigarmi, and Nelson (1993) described this concept of deploying a particular leadership style according to context and called it Situational Leadership®. Like any projection of self to others, leadership is the performance of a set of behaviours but, as Goffman (1961) described, the motivations behind those behaviours are informed by internal considerations that may be conflicting or may even result in behaviours that seem to be irrational unless we understand those motivations. On the other hand, Fullan (2020) describes a leader with moral purpose who is always authentic and an expert in courageous risk taking. I have chosen my next epiphany and my Hogan Personality Inventory™ (Hogan & Hogan, 2007) (Appendix 1) to offer an insight into my own innate leadership style. I have also considered Chang's (2008) recommendations that researchers should consider including episodes that have not been touched on yet (my internal self) and my relationships with others (leadership as a reflexive behaviour).

Epiphany 16: My Leadership Style

As I was having one of my regular professional mentoring sessions which were part of my first 18 months in post, my mentor stated that they had spoken to several senior colleagues about me, my role and the KMMS project. They reported that one very significant individual needed to be pressed but eventually acknowledged that I would not be able to do my job and deliver the school without upsetting people.

Less than a year later a professional development opportunity gave me the chance to complete a Hogan Personality Inventory™ (HPI) (Appendix 1). As with many such psychometric tests, I saw elements of myself reflected in the report and liked a lot of what I read. I was reassured to see many elements of Fullan's (2020) threefold framework and an

affinity for his metacognitive behaviours reflected in what the Inventory labelled as my strengths. I was equally glad to see a lack of indicators that I am a pathological Heroic Leader. I was less enthused to read that I can seem easily annoyed, critical, argumentative, indifferent and stubborn. Certainly, it confirmed that I can be "tough, hard-nosed and stubborn" if I feel strongly enough about something.

At the time I acknowledged both the feedback via my coach and the results of the HPI as self-evident truths. However, while some things have gone well and the medical school is clearly successful, some things have been unexpectedly hard, for example, Human Resources in all its forms and my significant doubts about the open-plan offices in the Pears Building.

Ericsson (2009) requires feedback to be an elemental part of the deliberate practice process. Fullan (2020) encourages leaders to get this feedback from the success of the contextualised decisions they make. My HPI suggests that I can evaluate myself in terms of my accomplishments. It also suggests that I can be self-critical and concerned about being evaluated but responsive to coaching and feedback, even though my reserved nature may make people think that I am indifferent to what others think of me and my stubbornness when pushed may make me seem resistant to coaching.

How did I grow and develop as a leader?

Kegan and Lahey (2009) describe how many years of research support the theory that everyone undergoes a multi-level trajectory of mental development throughout their adult life. Keating et al. (2017) describe learner-leaders who adopt a growth mindset and see setbacks as markers for areas of development. This is also one of the core behaviours of medical clinical leaders (Faculty of Medical Leadership and Management, 2020). The heart of this work is an examination of how some of the exceptional episodes of my leadership of KMMS helped to catalyse my development as a leader in medical education. These have been presented in a non-chronological order, but I experienced them during some key transitional moments of my development. Kegan and Lahey describe three important stages which they term, the socialised mind, the self-authoring mind and the self-transforming mind. At each of these stages, or plateaus, different behaviours can be

observed (Box 27). Many models of the acquisition of expertise also describe an incremental journey with noticeable stages[10].

The socialized mind:

Team player who seeks direction so follows their leader faithfully. Aligns with and is reliant on leaders. Their behaviours are shaped by definitions and expectations of personal environment.

The self-authoring mind:

Drives agendas while learning to lead. Has their own compass and frame. Can solve problems independently. Has sufficient judgement and authority to step back from the social environment to make personal evaluations about external expectations. Sense of self is aligned with personal belief system, ideology or code. Can self-direct, take a stand when something is personally important, set limits and create and regulate their own boundaries on their own behalf.

The self-transforming mind:

This leader leads to learn, they can hold multiple contradicting positions and analyse the interdependent problems those present. They can step back and reflect on the limits of their own ideology or personal authority and see that any one system of organising things is partial. They hold onto these multiple systems rather than force everything into one. They are more tolerant of contradiction and opposites. They appreciate that internal consistency is not the same as wholeness or completeness and try to align with the dialogue of opposites rather than either side.

Box 27: Three plateaus of adult mental development

(Abridged from: Kegan & Lahey, 2009, pp. 14-20)

At various points in this RBT I have reflected on things that went well and things that did not. For example, in Chapter 6 I discussed how design sprints did not perform as we

[10] Ericsson, Prietula, and Cokely (2007) and Gladwell (2008) famously described how becoming an expert can take up to a decade of focused and reflective practice.

expected them to, and in Chapter 8 I reflected on my doubts about my decision to have an open plan design in the Pears Building. On multiple occasions my epiphanies have prompted me to reflect on the impact of a strong moral purpose and how dangerous it can be to make assumptions that all colleagues will be equally motivated by that. I feel that the data I have presented here about my leadership choices and the motivations that underpinned those, as well as artefacts such as my Hogan Personality Inventory™, provide reassurance that I do not consider myself to be what Myatt (2012) described as a Hero Leader. I feel that I have much greater affinity for Keating et al.'s (2017) recommendation to regard episodes when things do not go well as signposts for areas for development.

Concluding reflections

During this journey, I've often reflected on whether various aspects of my style of leadership were appropriate for what KMMS needed or if the difference between my preference for leading an adhocracy simply clashed too much with the hierarchical, or clannish, nature of universities. My reflections for this RBT have also made me wonder if my ardent leadership with moral purpose contributed to any of the resistance we have encountered. These self-doubts were especially vexing when I was thinking about Situational Leadership® (Blanchard et al., 1993). My aim throughout has been to be an authentic leader but should I have been more nuanced in the way I displayed my preferred leadership behaviours? To me, authenticity means consistent transparency, self-awareness, and ethical behaviour. The fact that these behaviours are important to me is affirmed by my HPI and my preparedness to upset people if I think something is important enough. I believe that any leader who is dishonest, immoral or lacking in commitment is quickly found out. I seek to be a role-model for ethical and effective leadership, and I develop this by developing my expertise at nuancing my contextualised decisions. Many personality tests highlight how extremes of any behaviour can be unhelpful – openness and honesty in communication might be a cardinal feature of authentic leadership that inspires trust and credibility, but it can be overplayed and result in antagonism and hostility. My HPI highlights that I may tend to fall into this trap. It's all very well having a strong ethical code, a clear sense of what is right and wrong and acting in accordance with my values and beliefs, but overly rigid adherence to these principles

can be counterproductive. At least every time I encountered resistance or hostility in the medical school sphere, I could comfort myself with the reassurance that at least one person I worked with recognised that I couldn't do my job without upsetting some people some of the time.

11. Conclusion

Summary of the study

In Chapters 1 and 2 I discussed some aspects of my personal biography that led up to this piece of work. I considered some of the advantages and deficiencies of qualitative and quantitative methodologies and described my active desire to try a methodology that was new to me as much as it was to the theme of leadership research. In making this choice I hoped to catalyse my own personal, professional and scholarly development and document that here.

My literature review in Chapter 3 demonstrated that there is limited information available about leadership in medical education, and what exists is dispersed and disparate. The existing literature about the national culture of UK medical education often reflects events and management strategies occurring under adverse conditions. Given the paucity of reliable information from previous new medical schools, I felt that my personal context was a unique opportunity to contribute to what is known about leadership and change in medical education by conducting a single-site field study of this exceptional occurrence. Possibly this could extend as far as proposing that there is such a thing as a sociology of leadership in medical education. Ethnographies are common in education but autoethnography is not as frequently used, both approaches are uncommon in leadership research, and I described the rationale for my autoethnographic methodology. The chapter concludes by proposing that I could avoid some of the pitfalls of other autoethnographic studies and optimise the rigour of this work by trying to achieve some outcomes which I suggested would be relevant to evaluating this work (Part 1, Chapter 3, Autoethnography, Box 8, p71) (above).

In Chapter 4 I described some ways in which KMMS was informed by the UK culture of medical education while deliberately seeking to be an agent of adaptive change (Heifetz & Linsky, 2017). I provided some background context for my new role and grounded the start of the ethnographic aspect of this work in my earliest experiences with KMMS and some key individuals and interactions. This introduced my method of reflecting on epiphanies which were chosen to exemplify some of the cathartic experiences and

realisations I was having. I recounted and reflected on some aspects of my early days with KMMS because it was immediately apparent that they were significant, but also some events that I expected to be much less significant than they were. For example, the construction of an expensive and specialised teaching facility for anatomy was uncontroversial because colleagues external to the medical school expected such a facility to be a pre-requisite of a new medical school, whereas a request for a much less expensive digital attendance tool produced much more debate because it was unexpected and not thought to be necessary. I described my realisation that some organisations may not want adaptive change and must be persuaded that it is the right thing to do and how it was my job as leader to be persuasive.

In Chapters 5 to 8 I used Fullan's (2020) structure to conduct a holistic analysis of my leadership. Each theme was analysed separately, and the model helped me to select discrete and meaningful epiphanies from years of potential experiences. The continual evolution of the relationships between and within KMMS as well as the two universities meant that a wide range of events vied for my attention. My choices about what to include were informed by Fullan's theory of leadership for change and the validity of my choices was further enhanced by my use of Chang's (2008) suggested considerations for autoethnographic research. My epiphanies aligned with Fullan's model, demonstrating that it performs well in the world of UK undergraduate medical education. This is important to note, because the model is mostly derived from research in secondary education change leadership. Moral purpose and developing a KMMS flywheel were the two most high impact actions that I deployed. I reflected on how medical school leaders should always keep in mind the total institution nature of a medical school and how every aspect of the school, from its physical environment to the centredness of all members of staff, be that student or patient, or person, will influence the school's culture and the graduates that it produces. I also reflected on my experiences involving two parts of the universities which seemed to be most challenged by the innovations required for KMMS in Human Resources and Digital Learning. Both departments needed additional resource as well as support and opportunities to understand the different expectations placed on them by KMMS.

I then reviewed and integrated these chapters in Chapter 9. My cumulative conclusion was that they all seemed to work together. The themes and phenomena revealed by my separate epiphanies are not commonly examined in relation to each other and it is their combination in this chapter which informs and enriches this autoethnography and which forms part of the original contribution this research makes. I tied together several strands and described three themes that emerged from my analysis (Box 26) (above).

In Chapter 10 I reflected on my own characteristics as a leader using one piece of anecdotal feedback I received and a psychometric analysis of my leadership strengths, values and challenges. It became clear to me that while strong moral purpose and authenticity were important to me personally, there are multiple, valid models of leadership and different leaders will adopt different models. This RBT has also recorded my transition into my role, and I reflected on the developmental journey this entailed for me personally. I framed this development as a transition from one plateau of mental development to another.

Limitations

One of the strengths of this RBT, and a natural consequence of my method, is its focus on a single participant and the use of self-disclosure and a reflexive analysis of selected epiphanies to explore culture and society and to tell a story. The scope of these epiphanies has only included my viewpoints and experiences, so this is also a limitation because my conclusions are personal and subjective. This RBT has offered a unique opportunity to analyse my leadership from an immersive and phenomenological stance, but it could only ever be a partial account of all my experiences. While structuring, analysing and interpreting data for an autoethnography begins the moment the author starts, and continues until the final t is crossed and i is dotted, the act of ending may leave the author-researcher with the feeling that the end has been the result of an arbitrary decision rather than because a natural endpoint has been reached. Over several years of fieldwork, I had thousands of experiences, and I was highly discriminating in the episodes I chose to highlight. By providing details about the experiences which I have chosen to form my conclusions I have tried to make my perspectives clear, and I hope that in the process some of my positionality will be apparent. Extracting meaning from qualitative

research is an iterative and reflexive process. Antonakis et al. (2004) propose several contextualising criteria which need to be considered in evaluating whether a researcher's analysis of a leadership phenomenon is generalisable across heterogenous situations. They acknowledge that their list is not comprehensive, but this RBT has incorporated all but one of their important features: national culture, the strategic nature of my leadership, the characteristics of the organisations and the physical and virtual mediators of my leadership.

The significant feature of leadership research which Antonakis et al. (2004) identified and which this RBT does not address is gender. Gender is a recognised theme of a lot of research in medical education (Sharma, 2019; Tsouroufli, 2012) and its absence here may be a significant weakness. It is well known that there are many fewer women in academic leadership positions than men (van Helden, den Dulk, Steijn, & Vernooij, 2023). Maclean (2016), whose work analysing the impact of the neoliberalisation of higher education I referred to in Chapter 7, notes that this disproportionally affects female academics, as well as other groups, in an intersectional way. Autoethnography is the story of a person, and I and the people I have worked with all have a gender identity. My gender has remained fixed throughout this study. It has not felt to me that gender was a significant factor in my experiences and a specific reflection on my gender was not triggered by any of my epiphanies or by Fullan's (2020) structure. Fullan, as far as I can tell, and I both identify as men, and a counterfactual analysis of autoethnographic fieldwork is not easy to experience or describe. Other researchers might have had different experiences or perceptions to the ones I have described, or the perspective of a different gender may have resulted in different interpretations to the ones I have offered here.

During many of the experiences I have recounted here, my job presented personal and professional challenges. Some situations have tested my moral and ethical code. Like many autoethnographers and ethnographers I have felt that I had to exclude some of the most powerful experiences for reasons of confidentiality or ethical research. This may have lessened the potential of this RBT, and readers will form their own opinion as to whether I have been sufficiently disclosing, however I have felt brave in selecting some of the epiphanies I did choose to include. I have needed to focus on the epiphanies I

considered most significant as an illustration of an important feature of my leadership journey. A lot of editing and consolidation was required to stay in line with the scope of this work as an RBT and all of this has affected its nature.

Further research to build on this study might focus on improving its findings by studying the impact of gender or by situating it in a medical school with a single host institution, things that this RBT has not touched on. Studies with these objectives in mind could identify how these alternative contexts could produce different outcomes.

Discussion

This discussion will review the overall intent of my research, the outcome of the methodological approach taken and some of the implications of my analyses. My intention for this autoethnographic work was to provide a scholarly, autobiographical analysis of my transition into the role of a leader in medical education. Over the greater than intended time it has taken to write this RBT (now approaching 6 years) I have reflected on many more experiences than I originally anticipated having to choose from. It has been a highly emotional and affecting task which has been wearing at times and required courage to see through to this stage. My dual roles as Dean and a Consultant in Intensive Care have been more than full time and, at times, writing this RBT has felt overwhelming and I have longed for the greater immersion in the research, the enhanced peer support that might have been available and fewer external distractions that a full-time PhD might have offered.

An observational ethnography or a quantitative study would have produced a very different type of work and, most importantly, would have had a very different impact on my own journey. There was an intentional vulnerability in using a method that was unfamiliar to me and not common in the field of leadership research. I feel I have revealed a lot of myself in the story of my leadership of KMMS over the past 6 years and situated this story in the culture and society of KMMS and the two universities. The exposure of myself has not come close to reputationally risky disclosures that have threatened my mental health as described by Edwards (2021). I made these personal disclosures about my experiences, learning and growth in the name of research. As I have written, redrafted and edited, I have reflected more deeply on this part of my biography than any other

phase of my professional career. Pace (2022) succinctly describes the risks of conducting autoethnographic research: the fetishization of novelty, overt advocacy of favoured agendas, confirmation bias and subjective selectivity leading to a lack of reliability or reproducibility. At worst the result can be a self-promoting, haphazard, journalistic hagiography that the author manipulates to present themselves as they choose (Walford, 2021).

When it comes to the document that is ultimately submitted for assessment, Doloriert and Sambrook (2011) reflect on the difference between presenting a thesis as part of a process rather than as a final product and Sparkes (2002) described how, even though an autoethnographic dissertation was awarded a first-class degree, it was still labelled as self-indulgent. To counteract these risks, I defined my overarching goals for this RBT above (Part 1, Chapter 3, Concluding Reflections, Box 8, p71) (above) and I have conscientiously tried to address these throughout. Demonstrating how I have made an original and distinct contribution to the subject of leadership in medical education in a format that aligns sufficiently with the paradigm of a thesis has been more challenging.

This RBT was elemental to, and reports on, my transition into my role, and it was only as the overall picture became clear that the output came into focus as well. I have been able to define some of the key moments of my development as a leader and the three themes that emerged from my analysis (Chapter 9, Concluding Reflections, Box 26, p171) (above), especially the benefits and risks of Moral Purpose, the role of reflection in dealing with uncertainty and how I learnt from that and the need to cultivate productive and extensive relationships. I hope that this study of my leadership of KMMS will be useful because an analysis of the issues and phenomena that I faced may be transferable to other, similar situations. I hope that this RBT will go some way to improving the acceptability of this type of qualitative research in medical education. Future researchers may wish to use this method for further work in this field and I would be fascinated to read further autoethnographic research from future new medical schools.

An autoethnography should have aesthetic value as well as an academic value. Interested readers may simply wish to better understand the KMMS journey and the unique challenges I have faced. Start-up enterprises attract motivated, passionate and

entrepreneurial people whose enthusiasm can insulate what goes on inside the enterprise from the outside world. I sought and undertook my role with relish. I already knew, and it has been further reinforced for me over the past few years, that I am excited by new and innovative projects, and that I have an affinity for adaptive change over technical change that some people do not share. As Goffman (1971) described, workers present themselves and their activities from moment to moment and may adjust their behaviours to control the impressions that others form of them. This means that if we do not tell our story then others may come to their own conclusions in seeking to explain what they observe about us. This was therefore an opportunity for me to publicly reflect after the moment on the intentions underpinning my actions and the context within which I took those actions. Hopefully my examples will raise awareness of some of the many explicit and tacit issues that may be encountered in opening KMMS.

Recommendations

As an exploration of leading change in medical education this research has added to what is known in this field. By using an uncommon methodology, new perspectives and insights have been gleaned. Through the actions of self-disclosure, reflexivity and storytelling I have analysed some aspects of my growth as a leader of change in education as I tried to influence the social characteristics of a new medical school such as its moral purpose, its relationships and its physical as well as cultural manifestations. The novel insights produced are a set of understandings which have few comparisons in education or leadership, medical or otherwise. I hope this has resulted in the generation of some new perspectives of how and why clinical, medical, educational and academic leadership can shape the trajectory of a new medical school and has described some of the ways in which complex, interacting phenomena affect individual leaders and organisational structures.

Antonakis et al. (2004) described how leadership behaviours are contextualised by both the leader and their environment and Northouse (2013) accounted for this with such granularity that he describes 15 different methodologies which can be used to conduct leadership research. In seeking to make generic recommendations that are transferable to other medical education leadership situations, it is difficult not to dilute their usefulness. My research supports early engagement with the wider university, strong relationships

with all stakeholders, dialogue and concentrated pieces of project work, involving students and service users, to address defined challenges. Leaders with similar strengths and values to mine who are managing major change from within established, clannish and hierarchical university cultures, would be well advised to consider if their values are going to come into conflict with the values of their employer and strategies to mitigate for this. In doing so they should consider the merits and demerits of the three themes I identified through my research (Chapter 9, Concluding Reflections, Box 26, p171) (above). These include how a strong moral purpose can widen differences between new and established cultures, the importance of reflection and consultation and the impact of sustained change on new and established professional relationships.

The results from a single-site, fieldwork study are not grounds for creating a new theory of sociology of medical education leadership. This study has demonstrated that there are significant differences between the epitome of clinical medical leadership and some of the leadership behaviours which are more typical of hierarchical university orthodoxy. Leading a new medical school is complex and crosses many traditional disciplinary boundaries. Setting up a new school is a challenge that is likely to attract people who prefer adhocracies and managing adaptive change. The complexity of my role and the multiple and sometimes competing guises I have needed to adopt tended to steer my growth as a leader in way that did not foster my inculcation into university orthodoxies. The leader needed for successful delivery of a new school needs to have the skills and aptitudes to work in high-pressure environments, they need to think strategically, embrace teamwork, pay attention to detail and remain calm under pressure. More than this, they need a vision for the school, and it is helpful if this aligns with that of the host university. I found I needed to have the ability to accommodate working in different environments between my roles as a colleague to other KMMS team workers, a member of the wider universities, a clinician and as a catalyst for adaptive rather than technical change. My research has offered insights into moments of conflict between the typical leadership behaviours of these different roles and demonstrated that leaders in medical education need to have some chameleon-like abilities to move between them.

A global proliferation of new medical schools is likely in the coming decades. Haakenstad et al. (2022) calculated that there was a global shortfall of 6.4 million physicians in 2019 and UK government policy seems to be moving towards a further expansion of medical school places (Grove, 2022; NHS England, 2023; Phillips & Mansfield, 2022; Royal College of Physicians, 2021). Universities glamorise having a medical school and behave as if having a medical school confers an elite status. Fullan (2020) talks about moral purpose, a school having a soul and courageous leadership. In medical education this emotional traction is necessary to bring parts of the host university on a journey to becoming a more outward looking institution with a civic mission that recognises the expanded role of responsibility for the future health of the nation that having a medical school entails. There are about 130 universities in the UK, some of these specialise in disciplines such as the arts, sport or agriculture. There are currently about 44 medical schools, including those yet to be fully accredited such as KMMS. If the scale of expansion suggested by recent reports is to be achieved this would require an additional 12 to 30 new schools, depending on how much of the expansion is absorbed by established schools and how big any new schools turn out to be. The possible scale of expansion could put having a medical school within reach of over half of the universities in the UK which have a broad portfolio of programmes. This would make having a medical school a much less elitist aspect of a university's portfolio. This is also a time when the economic environment for Higher Education in the UK is parlous, and the cost of a new medical school might be seen as a liability rather than an asset for some institutions. This scale of expansion will create a significantly increased level of demand for new medical school leaders. I was surprised by some of the challenges faced by a contemporary medical school dean. When I sought advice, it was clear that it was not always useful to speak to my peers in established schools and there is little information available elsewhere about new medical schools that could have forewarned me. I know for certain that many of the challenges I faced were also faced by my contemporaries in other new schools that opened in the same period. Some of the insights from my research may provide novel perspectives which could be helpful for future Deans, their mentors, supporters or coaches, and offer an opportunity to reflect on how they would manage and lead through the highs and lows of this role. It may also provide insights for non-medical colleagues who are leaders in institutions

considering the prospect of opening a new medical school and search committees recruiting Foundation Deans of the future.

Finally, three organisations are closely involved in supporting new medical schools: the General Medical Council (GMC), the Medical Schools Council (MSC) and NHS England (NHSE). Each of these organisations will be strongly invested in trying to ensure that the risks involved in such a significant undertaking as opening a new medical school are mitigated. My research has demonstrated that if this includes peer and near-peer support and mentoring as well as more formal routes of support via governance and accreditation processes, this is likely to be beneficial for all leaders regardless of their individual characteristics.

Appendices

Appendix 1: My Hogan Personality Inventory™

HOGAN

LEADERSHIP FORECAST SERIES

SUMMARY

RESULTS-BASED OVERVIEW OF STRENGTHS, VALUES, AND CHALLENGES

Report for : Chris Holland

ID: HG973795

Date : 03.8.2020

pcl opening minds

INTRODUCTION

This report summarises Mr. Holland's results from the Hogan Personality Inventory (HPI), the Motives, Values, Preferences Inventory (MVPI), and the Hogan Development Survey (HDS). The report is organised in five parts: (1) Performance Strengths from the HPI results; (2) Values and Drivers from the MVPI results; (3) Performance Challenges from the HDS results; (4) Career Development tips from across the assessment results, and (5) a tabular summary of these results.

The HPI concerns Mr. Holland's overt strengths as they normally appear in an interview or an assessment center. These characteristics are the basis for the impression he makes on others, and they influence his typical style of social interaction and his reputation among his peers. The MVPI concerns his core values and goals, and the activities that give meaning to his life. These are key drivers—what he desires, strives to attain, and his sense of identity. His values influence his preferences and determine with whom he affiliates and what he appreciates. The HDS concerns behavioural tendencies that could potentially undermine or inhibit Mr. Holland's performance. These tendencies emerge when he is tired, pressured, or feeling insecure, or when he lets down his guard. They may impede his effectiveness and erode the quality of his relationships with customers, colleagues, and friends.

These results provide a comprehensive, valid, and in-depth summary of Mr. Holland's strengths, values, and challenges. The report is designed to help understand his performance potential, and any barriers to achieving it. While reading this information, please keep in mind three things. First, it is possible that not every statement will accurately describe how he thinks about himself. Second, everyone has strengths and weaknesses, and there are positive and negative performance implications of any score. Third, focus on the overall themes of the report rather than any single detail. Although the report may seem to contain contradictions, this is the result of the report combining two perspectives: (a) what you see in an interview (HPI); and (b) what you see after prolonged exposure (HDS).

This report can be used in three ways. The report provides: (1) a snapshot of Mr. Holland's interpersonal performance; (2) a way to evaluate the fit between his values and those of an organisation; and (3) a primer for thinking about performance improvement. Interpret his results in terms of his own career aspirations and goals rather than in absolute terms. A frequently asked question concerns “Can behaviour change?” The “yes” response entails knowing what should be changed, deciding to make a change, and then knowing how to change. The information provided in this report will be helpful in this regard.

PERFORMANCE STRENGTHS

Personal Impact
Low keyed and seemingly relaxed, Mr. Holland will not mind letting others be in charge and generally will avoid the "political behaviour" that is sometimes necessary to advance in an organisation. Because he tends not to seek leadership roles, his career promotions most likely will be based on technical competence rather than maintaining a high profile within the organisation. He appears friendly, outgoing, and approachable, but is willing to listen and let others talk.

Interpersonal Skill
Independent and self-reliant, Mr. Holland seems unafraid of confrontations and is probably willing to give others negative feedback. He does not mind taking unpopular positions, enforcing rules, or holding others accountable. These characteristics are useful for work involving quality control, maintaining standards of performance, and dealing with difficult people. Flexible and spontaneous, Mr. Holland will be able to change directions quickly, work on several problems at the same time, and will not mind being interrupted. He will be comfortable using new and/or non-standard procedures to solve problems, and will probably be willing to challenge rules and take risks. These characteristics are important for jobs in fast-paced environments with changing priorities and possibilities for failure.

Working and Learning Style
Mr. Holland tends to be reflective and self-critical. As a result, he is usually vigilant regarding mistakes, concerned about being evaluated, responsive to coaching and feedback, and works in bursts of energy. These characteristics are useful in research activities, and as a stimulus to productivity and hard work. Mr. Holland is open-minded, curious, and imaginative. He understands the big picture, thinks quickly on his feet, has ideas for solving problems, and is comfortable with unstructured work that entails design, invention, or change. He is receptive to new ideas and values finding better ways of doing things. This is particularly important in jobs that require creativity, problem solving, strategic planning, and leadership. Mr. Holland is bright, knowledgeable, and up-to-date concerning current issues and technology. He also seems self-disciplined, achievement-oriented, and productive, and should enjoy pursuing tasks to completion. He will value training for himself and others, will seek opportunities to grow and develop, and will want to apply the latest relevant knowledge to the work setting. These characteristics are important for most jobs.

VALUES AND DRIVERS

Achievement Motivation

Mr. Holland prefers to put business before pleasure, he avoids distractions and activities that waste time and money, and he believes in maintaining professional appearance and conduct at work. Mr. Holland is keenly interested in career advancement, he evaluates himself in terms of his accomplishments, hates wasting time, and wants to make an impact on his organisation and his profession. Although Mr. Holland appreciates positive comments on his performance, he is reluctant to engage in self-promotion, and prefers to wait for others to notice his accomplishments.

Social Interests

Mr. Holland appreciates the company of others, but he also enjoys his private time and looks forward to it. He probably prefers to work alone—as opposed to working on a team—and he doesn't like spending time giving others feedback. He prefers the company of close friends to that of strangers. Mr. Holland enjoys assisting and developing others, especially those who need the most help. He helps others because it is the right thing to do. He also thinks it is important to pay attention to staff morale, communicate with staff regularly, ask them for feedback, and to encourage and support their efforts. Mr. Holland enjoys change, variety, innovation, and diversity, and he dislikes tradition, custom, formality, and uniformity. He seems willing to experiment and challenge convention in the name of possible progress.

Entrepreneurial Values

Mr. Holland seems to have a sensible attitude toward money; although he appreciates its value, he is not preoccupied by compensation issues. He judges himself in part by income potential, but he also takes pride in family, friends, and leisure time activities. Mr. Holland has a reasonable attitude toward risk-taking versus risk-avoidance; he will take a chance when the payoff seems to warrant it, but avoids risk for its own sake. He values safety but understands that little in life is perfectly safe.

Decision Making Style

Mr. Holland seems to strike a balance between form and function in decision making. He wants equipment to look good but also to perform reliably and efficiently. He understands the trade off between elegant style and durable performance and uses it in making decisions. He seems to enjoy solving problems, analysing issues, and understanding what is going on in the world. He is comfortable with technology, and he dislikes making decisions without being able to examine the relevant background information—his preference is to make decisions based on data rather than intuition.

CHALLENGES

Reactions to Others

Mr. Holland seems to be an energetic and enthusiastic person, but one who tends to be easily annoyed or disappointed with other people's performance. As a result, he may seem somewhat irritable, critical, and willing to give up on people or projects. He seems insightful about people and knowledgeable about politics, but vigilant and alert for signs of mistreatment. When he thinks he has been wronged, others may see him as critical and argumentative. Although Mr. Holland is confident and willing to accept challenges, he might threaten colleagues who are more risk averse. Mr. Holland is a person who can take the heat without wilting. Because he is so private, others may perceive him as not listening, indifferent to feedback, and remote. Unless he tells them, others will rarely know when he thinks something is wrong or could be done better. Nonetheless, he has doubts about others' competency, dislikes being pushed, and when he is annoyed, may procrastinate and seem stubborn and hard to coach.

Personal Performance Expectations

Others may see Mr. Holland as mannerly, polite, and unassertive. He seems reserved, socially appropriate and understated. He seems somewhat hesitant to call attention to himself. Mr. Holland seems smart, creative, and somewhat unorthodox in his thinking. Others will notice that his ideas seem unconventional, unusual, and unpredictable. These tendencies are important for problem solving, but over time, others may find some of his ideas impractical, unrealistic, or unworkable.

Reactions to Authority

Mr. Holland seems somewhat tolerant and flexible, but may be inconsistent in his standards for evaluating others' work, being sometimes too strict and other times too lenient. He seems independent and self-reliant, and may become tired quickly when working as part of a team.

CAREER DEVELOPMENT

When Strengths Become Weaknesses; Feedback for Mr. Holland

Mr. Holland tends to be somewhat defensive and may take things personally. As such, periodically remind him to lighten up and perhaps even practice stress management. In view of his tendency to be somewhat passive in social settings, Mr. Holland would benefit from training (assertiveness and/or public speaking)--if needed for the current or future job--to enhance his willingness to speak up and take initiative. He should be reminded to talk regularly with his coworkers, to ask them questions, and seek their advice. The goal is to get Mr. Holland to achieve a balance between the social and technical aspects of work. Mr. Holland can be tough, hard-nosed, stubborn, and easily annoyed by others' shortcomings or lack of performance. In these situations, his first impulse is to confront the person directly. Work with him to be more patient with others, think about the impact of his words, and try to choose the most diplomatic course of action. Because Mr. Holland sometimes doesn't pay attention to details, encourage him to make a list each day of things to accomplish. Be sure there is a system in place to follow-up on loose ends and commitments to customers and coworkers. He should make a special effort to complete tedious tasks and be sure to gather enough information before making important decisions. Although he is imaginative and visionary, he may become easily bored with routine tasks; help him remember to stay with tasks until they are finished. He values being well-informed and will proactively seek training opportunities. Realise that he may become frustrated when they are not available. Moreover, he will enjoy setting his own performance goals because he is very achievement oriented.

Dealing with Derailment Tendencies

- First, remember Mr. Holland's strengths--when he is at his best, he is a resolute and independent person who is not easily cowed or intimidated, and one who can take the heat during difficult times.
- Second, after important meetings, have him check with others to make sure he got the same message they did. He can rely on social consensus as a guide to action.
- Third, help Mr. Holland recognise that his frankness and independence are desirable qualities in some situations, but they may prevent him from listening to feedback; he needs to be aware of this and make extra efforts to profit from the coaching and advice of others.
- Fourth, point out that his tendency to be somewhat focused and preoccupied can affect his ability to enroll people in his ideas and build a team.
- Finally, although he may prefer to work alone--especially when he is under pressure--encourage him to get out of his office and talk with his staff each day. This may be difficult for him at first, but it is a very important way for him to show concern.

SUMMARY OF PERSONALITY ASSESSMENT SCALES

SCALE	%	SCALE INTERPRETATION
Hogan Personality Inventory		
Adjustment	11	Concerns composure, optimism, and stable moods.
Ambition	28	Concerns taking initiative, being competitive, and seeking leadership roles.
Sociability	46	Concerns seeming talkative, socially bold, and entertaining.
Interpersonal Sensitivity	14	Concerns being agreeable, considerate, and skilled at maintaining relationships.
Prudence	30	Concerns being conscientious, dependable, and rule-abiding.
Inquisitive	95	Concerns being curious, imaginative, visionary, and easily bored.
Learning Approach	74	Concerns enjoying formal education and actively staying up-to-date on business and technical matters.
Motives, Value, Preferences Inventory		
Recognition	25	Desire to be known, seen, visible, and famous.
Power	89	Desire for challenge, competition, achievement, and success.
Hedonism	30	Desire for fun, excitement, variety, and pleasure.
Altruistic	97	Desire to serve others, to improve society, and to help the less fortunate.
Affiliation	6	Need for frequent and varied social contact.
Tradition	25	Concerns for morality, family values, and devotion to duty.
Security	45	Need for structure, order, and predictability.
Commerce	42	Interest in earning money, realising profits, and finding business opportunities.
Aesthetics	54	Interest in the look, feel, sound, and design of products and artistic work.
Science	100	Interest in new ideas, technology, and a rational and data-based approach to problem solving.
Hogan Development Survey		
Excitable	86	Concerns being overly enthusiastic about people/projects, and then becoming disappointed with them.
Sceptical	92	Concerns being socially insightful, but cynical and overly sensitive to criticism.
Cautious	58	Concerns being overly worried about being criticised.
Reserved	97	Concerns lacking interest in or awareness of the feelings of others.
Leisurely	95	Concerns being charming, but independent, stubborn, and hard to coach.
Bold	40	Concerns having inflated views of one's competency and worth.
Mischievous	60	Concerns being charming, risk-taking, and excitement-seeking.
Colourful	48	Concerns being dramatic, engaging, and attention-seeking.
Imaginative	96	Concerns thinking and acting in interesting, unusual, and even eccentric ways.
Diligent	38	Concerns being conscientious, perfectionistic, and hard to please.
Dutiful	17	Concerns being eager to please and reluctant to act independently.

Appendix 2 – The utility of qualitative methodologies in healthcare research.

Dikomitis (2016) vividly describes some of the reactions she has encountered as an ethnographer who conducts research in medical spaces. This is despite multiple examples of how qualitative methodologies can support and enhance our understanding of the results of quantitative research studies.

In the late 1990s a seminal article was published which described the risk that US citizens were taking by receiving care from one of the best healthcare providers in the country (Lesar, Lomaestro, & Pohl, 1997). The authors reported a high, and increasing, risk of medication errors for patients in their hospital. Further investigation demonstrated that this was not a unique phenomenon and a national review culminated in the report "To Err is Human" (Institute of Medicine, 2000). It had a global impact and resulted in significant changes and adoption of safety practices across many healthcare systems which found that their patients were equally at risk. One significant change was the rapid deployment of computerised physician order entry (CPOE) systems for drug prescriptions (Koppel, 2005). Koppel conducted an ethnographic study on the impact of CPOE on stress levels in junior doctors and found that it increased stressful events and did not prevent drug prescription errors. Silverman (2007) describes how Koppel's study was targeted with attempts to discredit it and the ethnographic methodology it used and how Koppel became one of a long line of qualitative researchers who has explained that the strength of qualitative research is "its ability to depict what happens in situ" (p. 91). This feature of qualitative research is frequently used by those who are against qualitative research as evidence of a key methodological weakness and a reason to deny uncomfortable findings. The chain of events which followed the publication of Koppel's study led to outcomes such as an examination of the relationship between health information technology providers and their ethical obligations as partners in the provision of healthcare (McCray, Glaser, Koppel, Langlotz, & Silverstein, 2016; McGreevey, Hanson, & Koppel, 2020). This story demonstrates how qualitative, ethnographic research can change the focus of a debate from the search for a technical solution to an adaptive solution by reframing a question in unexpected ways that require new theories to unpick what has been observed. The initial quantitative research proposed a much simpler but retrospectively

dubious idea that a technical solution could catalyse a quick fix for a complex social and cultural challenge with real-world consequences.

Appendix 3 – Technical and Adaptive Solutions

Heifetz (1994) initially described and then worked with Linsky to expand on two sorts of change which they named technical and adaptive (2017). Technical change can be brought about by experts applying what they already know to a challenge which fits the mould of something they have encountered before, and for which established processes and policies are suitable. They contrasted this with what happens when experts encounter a novel challenge. They argue that in these circumstances, experts need to learn more about the challenge and adapt or innovate to surmount it. They called this adaptive change. The incremental process of the empirical, positivist and quantitative scientific model may compel technical solutions as opposed to adaptive solutions which require discovery or invention of new solutions. Heifetz and Linsky (2017) went even further suggesting that traditional and hierarchical organisations might avoid using qualitative research methodologies because these were perceived as being less rigorous, even though these might be better methodologies for supporting the journey to adaptive solutions.

Appendix 4 – Pedagogy of human anatomy

In most of the recent reviews of the various options of how to teach anatomy, maximising the utility of the time devoted to anatomy learning and teaching has been an important consideration. Although it is not yet clear how Brexit will affect how the Bologna Process applies to UK Higher Education (HE) qualifications, the Process has agreed that Medical degrees are expected to offer 5500 hours of learning. There have always been competing demands on this time in undergraduate medical programmes, which have frequently been characterised as battles for curriculum time between traditional, elemental and core subjects which underpin the existential bedrock of what it means to be a medical practitioner and newer subjects, some of which may not stand the test of time.

The GMC "sets out what newly qualified doctors from all medical schools who award UK primary medical qualifications must know and be able to do" (2018, p. 2) in order to enter the UK Foundation Programme and be safe and competent practitioners. There are many valid methods to ensure that students acquire the anatomical knowledge and understanding required for graduation and safe practice. The GMC states that graduates must possess the ability to apply "the principles and knowledge relating to anatomy" (p. 21), and that this must extend to the extremes of age, in children and young people and during pregnancy and childbirth as well as common and important disease processes. This is a very broad outcome that dissecting a single human cadaver cannot hope to solely achieve and so all dissection components of any PMQ programme must be complemented by other learning and teaching opportunities to gain the necessary anatomical knowledge. All UK medical schools have a multimodal approach to teaching anatomy that includes prosections and other resources, with Anatomage tables, plastinated specimens, anatomical models, videos, e-learning, clinical imaging, simulation and virtual body all mentioned in the literature.

The GMC has also published an accompanying text, Practical Skills and Procedures (General Medical Council, 2019) which makes no reference at all to anatomy or dissection. The Royal College of Surgeons of England published an advisory National Undergraduate Curriculum in Surgery (2015) and the Anatomical Society published an advisory anatomy syllabus for undergraduate medicine (Smith et al., 2016) neither of which makes any

reference to dissection. Any derogation from time spent performing dissection may reduce the acquisition of this craft skill, but the utility of spending large amounts of time dissecting large tracts of adipose or connective tissue to properly expose an important anatomical structure or relationship between structures is increasingly doubtful in an overcrowded curriculum. Furthermore, the craft skill of dissection may only be useful for a minority of students who go on to specialise in surgical disciplines. Counter to this, many anatomy teachers point to the meta-learning of professionalism, patient care and respect that result from the dissection experience as important outcomes. The experience of human cadaveric dissection is unquestionably cathartic for novice medical students although, as Dueñas, Kirkness, and Finn (2020) described this does not always happen in a positive way.

The best available review of the impact of the advances in Computer Aided Instruction (CAI) or Computer Assisted Learning (CAL) on the teaching of anatomy was produced as a Best Evidence in Medical Education (BEME) review in 2017 (Losco, Grant, Armson, Meyer, & Walker). Their conclusion was that a blended approach was the most common approach globally and that there were "a number of high-quality studies supporting the use of CAI/CAL as a teaching intervention over traditional methods and even partial replacement of dissection with CAI/CAL." (p. 234). Since the BEME review Heather, Chinnah, and Devaraj (2019) found that students' academic performance when taught using virtual reality (VR) or augmented reality (AR) technologies was at least equal to that of students taught using conventional methods. All the studies they reviewed found high levels of student satisfaction for VR/AR teaching methods.

Over the past decade technologies to aid CAI/CAL learning and teaching in anatomy have proliferated and evolved. Anatomage Tables (Anatomage, 2020) have become one of the most recognisable products on the market. They are employed by the Royal College of Surgeons and the Royal College of Surgeons in Ireland which has greatly added to their credibility as a learning and teaching tool. In a survey of UK medical schools (The Medical School Application Guide, 2020), 4 schools (Birmingham, University of Buckingham, Lancaster Medical School and University of Central Lancashire School of Medicine) specifically mention that they use Anatomage Tables in their undergraduate programmes.

Anatomage Tables have many advantages, they avoid the costs and logistics of obtaining cadaveric materials. The table deliberately replicates a cadaver trolley and demonstrates data in a 1:1 life-size scale. The table presents a full 3-D rendering of real patient data which can be manipulated in many ways. The idea that an undergraduate experience of dissecting a single cadaver provides some sort of common reference point from which the student will orientate themselves to all other anatomical knowledge that they acquire during their programme and the rest of their professional life is clearly untenable. Anatomage Tables therefore have the advantage that each Table can be loaded with different cadaver data sets and can include a digital library of pathological cases as well as radiology reports, comparative analyses, medical device demonstrations and many more functionalities. Many of these functionalities are available at additional costs which reflect the costs associated with acquiring the necessary high-quality images.

The Tables are each the size of a medical dissection trolley and contain high-specification visual display hardware, there is a version that can be wall mounted available at a higher cost. Anatomage uses the phrase “virtual dissection table” to describe its product. Anatomage Tables do not provide the same kinaesthetic experience of dissection that actual dissection does, and learners do not perform actual dissection. Instead, “dissection” occurs using software to digitally manipulate the images shown by the table. This has led educators to question why, when considering CAI/CAL approaches to teaching anatomy, the technological representation of a human body needs to be restricted to a 3ft by 6 ft table.

All of the functionalities of high-quality images that can be manipulated to demonstrate 3-D relationships are now available through standard library e-resources such as Acland’s Video Atlas of Human Anatomy (Acland Anatomy, 2021) and these resources often integrate better with other Virtual Learning Environment (VLE) functionalities which allow student quizzes, attendance, engagement and other learner metrics to be tracked and recorded (Britain & Liber, 2004). Technologies now exist which do not restrict the representation of anatomy images to a 2-D screen such as Visible Body (Visible Body, 2021) or 3D Organon’s virtual reality software (3D Organon, 2021) which uses Oculus Rift

VR goggles; other VR platforms are also available. These technologies do not require the dedication of large amounts of space to fixed resources such as Anatomage Tables.

In the near future, point of care 3-D printing is likely to become feasible in the clinical environment to better aid clinical care (Materialise, 2021), and 3-D printed models for anatomy teaching are already available in the UK (Anatomy Stuff, 2021). Currently these educational models cannot be printed direct by users but as costs fall it is likely that the technology will be available for educators with access to original clinical imaging data to use this data to create highly realistic 3-D prints of human anatomy for educational purposes, subject to appropriate ethical and consent permissions.

Cost of an Anatomy Facility

The Anatomy Learning Centre (ALC) for KMMS was proposed as a modification to existing plans for a large (17,000 sq. m) combined Science, Technology, Health, Engineering and Medicine (ST-HEM) building planned by the university for many years before the award of UG medicine places to KMMS. Due to the stage of planning that the project team had reached, it was proposed to repurpose a planned underground carpark for the ALC. After discussions with BSMS staff, a visit to another new medical school which also decided to build an anatomy facility and a review of the pedagogy of anatomy teaching (above), KMMS decided that the opportunity costs of our ALC were not unreasonable in the context of a £64 million pound budget for the overall building in which the ALC would be built. Despite this, there were large costs associated with the specialist equipment required to embalm and store cadavers, to prepare and maintain specimens and to provide a highly specialised teaching space that integrates cadaveric teaching with clinical imaging methods such as ultrasound, modern library resources for anatomical sciences and with near-peer surface anatomy and small group teaching.

Adopting an approach to education that would have dispensed with cadaveric methods would have been costly too. As an example, an Anatomage Table (Anatomage, 2020) costs about $75,000 USD with tax and import costs additional to this. For medical schools with established cadaveric programmes the costs of wholesale change are not yet justified by any pedagogic gain. Of course, for new medical schools this calculation is different.

What would this decision do to KMMS' Reputation?

In the UK, medical degrees are mostly termed Bachelor of Medicine and Bachelor of Surgery (BM BS), or some variant such as MBBS or BM BCh. Prior to 2013, Southampton Medical School awarded a Bachelor of Medicine degree (BM), but since 2013 has awarded a BM BS degree. While all medical practitioners require a level of knowledge and understanding in anatomy, it is often argued that as a Bachelor of Surgery degree, PMQ programmes should ensure that graduates possess one of the basic skills of surgical practice: a degree of expertise in the craft of dissection as well as a specified level of anatomical knowledge and understanding.

Many critics of arguments for changing or reducing the approach to teaching anatomy in PMQ programmes often state that the anatomy component of the Intercollegiate Membership of the Royal College of Surgeons (MRCS) post graduate professional exams is the most often failed component of these exams (Gogalniceanu, O'Connor, & Raftery, 2009). This even made it into the popular press in 2014 where it was argued that a lack of adequate anatomy teaching for undergraduates was placing the supply of postgraduate surgical trainees at risk (Cooper & Gray, 2014). It is arguable whether it is the responsibility of medical schools to ensure that their graduates have advanced, specialised knowledge in a subject that enables them to pass a postgraduate exam which the minority of their graduates will even attempt and for which there are extensive resources and courses available.

The Student Room (TSR) is one of four websites owned and run by a UK-based company called The Student Room Group. TSR was started in 1999 and is intended to be an online community and social learning website which can connect students and help them make informed choices about their education, avail of peer support for their learning and discuss aspects of life as a student in the UK. TSR has many subject and pedagogy specific asynchronous discussion boards one of which is an extensive thread where past, current and future medical students discuss the relative merits of different approaches to anatomy teaching (The Student Room, 2021). The Medical School Application Guide website surveys which UK medical schools use cadaveric methods to teach anatomy (above). This survey uses responses from medical schools, medical school website data

and surveys of current students and is not entirely accurate. The website survey for 2019/2020 reports that 16 out of 41 UK medical schools offer some form of dissection by students, 13 use prosections (of which 3 offer an optional opportunity to do some dissection to a limited number of students), 2 specify that they use both approaches, 5 use no dissection or prosections and 3 did not respond. Noticeably this is an increase in the number of medical schools that do not use dissection, since the 2014 article that identified Plymouth and Exeter as having "no cadaver-based teaching whatsoever in their core curriculums". A situation that the current medical school Dean has chosen to reverse.

It was our experience at KMMS that some of our applicants were influenced by our cadaveric dissection offer to make an application to us and/or convert to a conditional firm offer. However, this was not significant enough to mean that we were at risk of not filling all our places on our programme. Anecdotally, based on our feedback from our open days, this tended to feature as a factor for applicants coming from a background of having parents who were medical practitioners.

Postgraduate medical education

If human dissection is not essential for undergraduate medical education are there other reasons why a cadaveric anatomy facility could be of benefit?

The two university campuses where KMMS is based are in the city of Canterbury and locating an Anatomy Learning Centre (ALC) facility on the Eastern edge of the county meant that there would be new and significant opportunities for postgraduate and professional training courses in an area of the country which had not previously had them. Enhancing the learning, training and education opportunities for postgraduate and clinical learners as well as undergraduate students would help build a clinical education community in Kent and Medway. The fixed costs of ensuring that the facility would be suitable for these smaller-scale and postgraduate programmes are not significantly increased above what was required for the medical school and can be minimised by engaging early in the process with local and national postgraduate surgical trainers to consult with them as to their requirements for such a space.

Appendix 5: Cultural and historical context of medical education in the UK

By the early 1800s there were three distinct professions that performed the duties of a Doctor as we would currently recognise them: Physicians, Surgeons and Apothecaries. Whilst these professions had different training processes, usually apprenticeship in style, there was a lot of overlap in what individual practitioners offered their patients across the country. One of the first attempts to formalise and coalesce the professions was when the Association of Apothecaries and Surgeon-Apothecaries of England and Wales was formed in 1812 (Gillam, 2017). The Association championed a bill, the Apothecaries Act, which was passed in 1815. This created a licencing process for surgeon-apothecaries, who were generalists in medicine, surgery and midwifery – what we would approximate to a General Practitioner today. The number of medical schools offering this licence proliferated and an imbalance between the number of new surgeon-apothecaries and other medical practitioners, namely physicians and surgeons, began to emerge. Three Medical Acts were passed by the UK parliament between 1858 and 1886, and the cumulative effect of these was to require an examination accredited by the newly constituted General Medical Council for admission to the singular profession of medicine. This examination was preferably taken at the end of a programme of education specified and delivered by a university. After these Acts were passed all medical schools that were previously independent of universities underwent a rapid process of subsumption into university structures and the license offered by the Association of Apothecaries and Surgeon-Apothecaries of England and Wales became redundant, much to the chagrin of future specialists in General Practice who had to wait until 1952 and the creation of a Royal College to reacquire the level of professional recognition that the Association had provided. This move to university association also played a major role in the demise of Kent's first medical school, the Army Medical School at Fort Pitt in Rochester (Bowen, Whiston, & Cooper, 2022).

In the space of the next thirty to forty years, similar processes mandated specification and credentialing of programmes of medical education in other countries. The Flexner report on medical education in the United States and Canada (Flexner & Pritchett, 1910) described what became called the Flexnerian model of medical education which became

the majority approach to teaching future doctors in the developed and anglophone world for most of the rest of the 20th Century. The Flexnerian model of two years of pre-clinical biosciences learning followed by three years of clinical apprenticeship represents the starting point of any model of pedagogic innovation in descriptions of medical programmes to this day.

This also required great change in universities in welcoming their new medical schools. Until now, university faculty had taught medicine as an abstract, scholarly pursuit which formed a normal part of a gentleman's rounded education which also included philosophical and literary studies. Faculty, often called "Mediciner", were not clinical practitioners and were often polymaths who taught medicine as well as other subjects (Comrie, 1927, p. 140), they often had academic rank and titles but were not members of the profession of medicine. This process of grafting professional medical education into university structures was patchy and heterogenous. In America the move to a university based medical education was also influenced by the perception that practitioners were conflicted by the need to maintain a private practice and the lack of income from education. Johns Hopkins Medical School was formed in 1893 and was the first US medical school to employ full-time and tenured professors. In England, Lord Haldane was asked to lead a Royal Commission to review University Education in London (Haldane et al., 1913). As part of its review, the Commission reflected on how the education of doctors needed to be better integrated into a conventional university architecture but recognised that the educators who provided these newly university-based educative programmes needed to bridge the divide between clinical and academic practice. Medical educators lacked credibility if they were not in clinical practice, but this specific domain of expertise and practice did not sit well with established norms of recognition of academic rank and career progression. The Royal Commission recommended Clinical Chairs in Medicine should become a normal feature of the university medical school but recognised that universities could not deal with the Faculty of Medicine on the same lines followed in the case of other Faculties, such as those of Arts and Science. Lord Haldane noted that there was not a standardised description of what should be the measure of excellence that resulted in such recognition and deplored the fact that other members of the academic

community even denied that such a step was necessary for teachers of such an important subject. To this day medical schools are organised in widely differing ways and their location within the universities which award their degrees is hugely variable too (Wynford-Thomas, 2012).

Sixty years after the Medical Acts set this process in motion, a Professor of Medicine at St Mary's Hospital, George Pickering, published a lecture in the British Medical Journal (1956) reflecting on what the purpose of medical education had become. Pickering was a well-regarded clinician, researcher and educator. Medical students and postgraduate trainee doctors sought out the opportunity to learn and be taught by him and full-time academic chairs in Clinical Medicine were still regarded as a modern innovation. In his lecture Pickering reflected on many issues which were, in his opinion, still impeding the delivery of high-quality and fit-for-purpose medical education, which would produce the medical practitioners required by a National Health Service which was still less than a decade old.

Pickering went on to have a seminal impact on the educational environment of the United Kingdom in the second half of the 20th Century (McMichael & Peart, 1982). In addition to many advances in the understanding of the physiology of blood pressure and clinical science, he was closely involved in the creation of two new medical schools in the 1970s (Nottingham and Southampton) and the creation of a coherent and standardised network of over 300 post-graduate medical education centres in many district general hospitals. These two advances alone transformed the undergraduate and postgraduate education and training environment of the UK.

Appendix 6: Organisations with minds and souls

This is a summary of how three major approaches to organisational theory and practice try to account for minds and souls: Scientific Management (Taylor, 1911), the Shingo Model™ (Utah State University, 2021) and Experience-Based Co-Design (EBCD) (Bate & Robert, 2006). I have chosen these three examples because I have referred to scientific management elsewhere in this RBT and the Shingo Model™ and EBCD are both widely used in healthcare, education and healthcare education environments.

Scientific Management

In the decades after Taylor (1911) described the principles of scientific management, the literal nature of his approach, often neglecting the human experience, became somewhat distasteful and the term fell out of favour. With the incorporation of theory and evidence from the social and behavioural sciences the term has become more widely used again, particularly in the domains of quality improvement and innovation science where the contribution of users and participants is increasingly valued, design sprints being one example of this. These disciplines often advocate a consistent and relentless focus on the core business, or the business' True North, and an equal openness to understanding the user experience and a willingness to change because of that understanding. This clearly has echoes of Fullan's (2020) mind and soul.

The Shingo Model™

The Shingo Model™ (Utah State University, 2021) describes a philosophy of operational excellence and emphasises the importance of the relationship between leaders and their teams with advice to ensure that culture, behaviours and guiding principles are just as important, understood and displayed as tools and systems. The Shingo Model™ emphasises the importance of the relationship between leaders, managers and workers in the term "going to the gemba". In the context of Lean approaches to quality improvement, this means going to see where the organisation does the real work that creates value, asking questions about what you see and doing this in a respectful manner towards workers and the people who consume the organisation's product. The emphasis on respectful inquiry highlights the necessity of a healthy underlying relationship between leaders and their colleagues.

Experience-Based Co-Design

Businesses are driven by sales to customers and measure their success in building relationships using that metric. Providers of less customer focused, and more service user orientated, transactions also need ways to prioritise and evaluate successful relationship building. Experience-Based Co-Design (EBCD) (Bate & Robert, 2006) is a healthcare improvement methodology which incorporates a philosophy and activities intended to develop relationships between producer and user built on mutual respect and trust. EBCD was further developed as a King's Fund project and adopted by The Point of Care Foundation (2013). Green et al. (2020, p. 64) describe EBCD as "participatory action research that involves service users... It integrates ethnographic research and service design methods with the principles of consumer engagement to improve patient care and provider experiences of care." Bate and Robert (2007, p. 42) emphasised the importance of the "inclusion of the user or consumer as co-designer in the whole development process, from design to implementation". One of the key contributions that service users make is highlighting to the service managers and providers critical "touch points" (p. 53) and one of the most important aspects of a touch point is the emotional response it engenders in service users because this aids in deepening the understanding that leaders and managers have of the service they offer.

Appendix 7: The problem with healthcare knowledge

Williams and Lau (2004) describe how some medical schools with long histories and where the Flexnerian model of medical education still holds sway, still contest the implication that education might happen without large amounts of time spent engaging with learning activities described by objectives from the lower end of Bloom's Taxonomy (Englehart, Furst, Hill, & Krathwohl, 1956). The GMC has mandated "the deliberate reduction of factual knowledge and the replacement of didactic teaching" (2004, p. 92) with newer approaches in undergraduate medical education.

The absolute necessity of doing this was illustrated by Stanford University School of Medicine (2017) which reported that 153 exabytes (one exabyte = one billion gigabytes) of healthcare data was produced in 2013 and that this was estimated to be increasing at a rate of at least 48 percent annually. In a later report (Stanford University School of Medicine, 2020b) they describe a fundamental change occurring in healthcare and that physicians and medical students felt underprepared to implement the new knowledge and technologies which are emerging due to a lag in their education and training. With this exponential rate of increase in the amount of healthcare data the concept of medical knowledge half-life has become popular as a way of describing the challenge of staying up to date and current. First described by Machlup in 1962 (Charette, 2013), although this may be apocryphal, it is the length of time it takes for 50% of what you know to become out of date. The phrase was in use in medical education journals in 1975 and was then estimated to be five years (Emanuel, 1975). The term was popularised by Arbesman (2013), and identified as a particular challenge in healthcare. The half-life of the truth of the conclusions of medical studies about hepatology was calculated to be much longer, 45 years, in 2000 (Poynard et al., 2002). Poynard et al. demonstrated that it is rarer for a fact (a truth) to be disproved than it is for clinically useful knowledge to be superseded by new knowledge and understanding. The half-life of the total corpus of useful medical knowledge seemed to fall consistently during the 21st Century with Sepúlveda Martín-J. (2016) predicting it would be 73 days by 2021. With this rate of production and superseding of the didactic content of a medical programme by new knowledge, Fullan's advice (2020) that educators should focus on providing their students with opportunities

for deep learning (Box 28) is very pertinent and has been one of the key objectives of medical educators for quite some time now. It was an essential precondition for us that we would incorporate measures to support our students in learning in this way from the outset.

- Sticks with you for the rest of your life
- Connects with passion
- Team related
- Significant for the world
- Involves higher-order skills

Box 28: The constituent features of deep learning

(Fullan, 2020)

Appendix 8: Leading from the middle

In the same chapter that Fullan (2020) discusses a leader's role in coherence making, he also introduces a concept and a tool he refers to as "leadership from the middle" (LftM). This tool is intended to guide and lead reforms at state and national level and has been used in education systems around the world. The rationale for the tool is that entirely bottom-up innovation frequently fails because it is so granular as to be unable to be applied to other challenges, whereas top-down innovation fails because it becomes too complex and arbitrary. He argues, therefore, that there is a point in the middle where these tensions are manageable and claims that liberating the middle is the key to achieving desired change. The tool is intended for use in school education systems where the middle corresponds to geographical regions (districts or counties for example) made up of multiple schools all being led by a single department at government level. The liberation that the model advocates is allowing groups of schools to act as freely as possible to deploy policies which are local priorities. The role of the regulator is to ensure that these clusters of schools operate within boundaries which are set by the networks of interaction within which they collaborate. The inter-relationship between the different groups, all of which contribute to holding each other accountable through a system of self and peer review, results in flexible, distributed and decentralised control, rather than top-down and rigid control. It would have been artificial and possibly incorrect to force the LftM tool into the context of a single school, and many aspects of the scope of the concept are beyond the remit of this single-site field study, so it was not considered in this work.

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