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- 'docendo ac discendo' - 'by teaching and learning'

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The International Journal of Clinical Skills looks forward to contributing positively towards the training of all members of the healthcare profession.

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Foreword

Surviving the Global Economic Crisis in the World of Clinical Skills

After a tremendously successful beginning, the International Journal of Clinical Skills (IJOCS) has had the pleasure of bringing together the international clinical skills community. Throughout 2008 the extremely positive response from both students and teachers has demonstrated the need for this quality peer reviewed Journal, whose remit is not only to publish research, but also to provide a centre point in the world of clinical skills.

The variety of papers published in IJOCS to date is in itself unique, many of which have been changing the way all healthcare professionals practice within the clinical arena. Only time will tell whether such change does ultimately lead to improved patient outcomes and quality healthcare; however, the remarkable feedback received from the many doctors, nurses and other professionals who read the IJOCS, encourages us to continue developing this exceptional resource.

As 2009 begins, countries all over the globe face what may be the worst economic outlook since the 1950's, hence it is prudent not only to be conscious of our spending habits, but also to consider how this may impact the teaching and learning of clinical skills – a vital part of healthcare. Many healthcare institutions have had to significantly reduce their educational budgets, which no doubt has a detrimental impact on the training of all professionals. Moreover, it is important not to lose sight of the fact that quality healthcare delivery is required to maintain healthy nations, which, in turn, can reduce financial burden.

Following the global financial crisis, the in-house publishing company for the IJOCS (SkillsClinic Ltd) has decided to launch the website www.clinitube.com in 2009. This will be a free website where professionals will not only be able to download clinical skills guidelines (the aim of the originally proposed Clinical Skills Lab – CSL), but also upload their own information and files onto clinitube.com so that other professionals can share these materials for free. At a time when resources are limited, clinitube.com will build an online community for the sharing of much needed resources.

In addition to our colleagues at clinitube.com, the IJOCS will continue to publish many articles which present novel research and offer readers comprehensive guidance on a variety of clinical skills subject areas, including effective teaching methodology. We hope our readers take advantage of this knowledge by disseminating the information, putting it into practice and benefiting from the numerous incentives.

We reflect with much enthusiasm, for what the IJOCS has achieved so far and look forward to what has begun.

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Lend me your watch and I'll tell you the time: the thorny issue of leadership in training healthcare professionals in counselling and communication skills

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Abstract

It would clearly be risible if someone were to ask you for the time, and you in turn asked them to lend you their watch so you could tell them. Much criticism has been levelled at counsellors who will not give a direct answer but rather turn questions back on their clients. Many teachers, subscribing to the Socratic imperative, may do likewise and assume the role of a conduit rather than a leader. Whether they do so through a belief in the process, or a lack of belief in their own leadership skills, they risk evoking frustration or even resentment.

We the authors make the following contentions: if the leadership of the teacher or therapist (as director or wise one) is reneged on in place of a laissez-faire client-centeredness, then are we willing to work *without goals or outcomes*, to set off on a journey without maps, and indulge in a relationship of pure *process*? Perhaps for the client or student who has made little contribution or sacrifice to be there, this may be acceptable. But in a time when students pay high fees, and clients of all services are increasingly charged, don't these groups have a right to receive a degree of direction from the professionals they encounter?

One assumes that even before Freud's day, people were helped by being listened to. But today, talking therapies have been subsumed into the 'toolkits' of many professionals and, as a consequence, have been substantially demystified. Clients may not know 'the answer' but tend to be more able to formulate their questions. And they deserve the respect implicit in the professional's honouring of their leadership commitment. Both teachers and clinicians therefore need to be able to address their own issues of power and influence, perceived expertise and validation of feelings and expectations. Professionals need to be accountable not only for what they can do, but also for what they *cannot* do. An honest understanding and acceptance of this does not preclude honouring a leadership role.

Introduction

We chose this topic for investigation because of an apparent and, to us, interesting dichotomy. Leadership is conventionally seen as pro-active [1]; whilst counselling skills are largely reactive [2]. We, the authors of this paper have led numerous counselling and communication skills units for a variety of health care professionals. We have tried, as far as possible to mirror the counselling process by encouraging group members to take responsibility for the pace and direction of the sessions. However, the business of managing such units seems to necessitate a tension between the two directives. Therefore examination of both the teaching and therapeutic process involved suggests there is valuable material for clarifying our perspectives and objectives within this work. Although we are, of course, giving personal judgements evidenced by our own experience, we find similar motivation outlined by Christine Webb [3].

What is leadership?

There are a multiplicity of leadership theories and approaches, and several may be relevant to leadership of a counselling and communication skills programme. Indeed, Northouse [4] suggests that

"…there are almost as many definitions of *leadership* as there are people who have tried to define it."

Northouse [5] distinguishes between definitions which view leadership as, *'the focus of group processes'* and which place the leader at the centre of group activities and those which conceptualize leadership from a *personality perspective*, a combination of traits or characteristics which certain individuals possess. It is the latter which enable some individuals to entice others to follow them, qualities which contribute to their credibility and even charisma (see below).

Other authorities define leadership in terms of *behaviour,* i.e. the things that leaders 'do', or are recognized as doing, while for other commentators, leadership is defined in terms of the *power relationships* that exist between leaders and those who are led, a psychological, sociological or quasi-political disparity which can be exploited for good or ill. For others again, leadership is a *transformational process* that moves people to accomplish more than would ordinarily be expected of them (as with 'inspirational' captains of sports teams); cometh the hour, cometh the man. There are still others who approach leadership from a *skills perspective* and focus on the capabilities (skills, insight and knowledge) required of effective leaders. That these should lead to advancement within the group presupposes a meritocratic imperative, or an awareness at least of how desperately these capabilities are needed. (How did the less popular Winston Churchill come to succeed Chamberlain as Prime minister in 1940 and not Lord Halifax? Let us be grateful that he was allowed to.)

In synthesizing the above, Northouse [5] suggests that, despite the many different ways in which leadership is conceptualized, the following components can be regarded as central to the phenomenon: first, leadership is a *process;* secondly, it involves *influence;* thirdly, it occurs in a *group context,* and fourthly, it involves *goal attainment*. In defining leadership as a *process,* Northouse is contesting the view that it is a collection of traits or characteristics that reside in the leader. Rather, the phenomenon of taking the leadership role is '*a transactional event*' which occurs between the leader and those who are led. In other words, this conceptualization of leadership is not linear or one-way, rather the leader both affects, and is affected by those whom s/he leads. Moreover one can question strongly whether leadership is restricted only to those who are formally designated as leaders. Potentially, leadership is open to everyone, particularly in our counselling and communication skills training groups where we explicitly attempt to create a democratic learning environment and consequently, and by definition try to abdicate the traditional leadership role.

For other commentators, however, our mere classroom presence renders this desideratum an unattainable ideal:

'The only way in which a group can be totally autonomous in forming its own learning environment, is if you encourage it to come into being as a leaderless peer group, from which of course, you are absent. To the extent that you advise the group in advance about values, ground rules, experiential exercises, you give it a hierarchical impulse.' (Heron) [6].

A matter of influence

Influence in its quotidian usage is a descriptor for the effect one person has on or over another. For Northouse [5] it is the second component of leadership which inevitably involves the use (or exploitation) of *influence*, and therefore becomes characteristic within *groups*. For Northouse, *'Influence is the sine qua non of leadership'* [7]. Put unambiguously, in the absence of influence, leadership does not exist. An interesting question to pose here, though, is whether we can live happily with the consequences of the exertion of such power. Robert Akaret writes wittily of how life maybe stranger than we think and we may be the authors of the unintentional outcome of purposive action [8].

Closely related to influence is the concept of power, which Northouse describes as *'the ability to affect others' beliefs, attitudes and courses of action'* [9]. Northouse [5] distinguishes between two kinds of power: *'position power',* which is the power a person derives from their rank in an organization; and *'personal power'*, which is derived from being seen as likeable and/or knowledgeable. Again, these are interesting statements for us to reflect on in relation to our leadership of counselling and communication skills groups. To be honest, while we may attempt to deny the status we hold through 'position power', we only reluctantly let go of influence held as a consequence of 'personal power'. In truth, we luxuriate in the thought that the group should regard us as both likeable and knowledgeable. And since group members effectively constitute the next generation of doctors and members of related professions, we cannot avoid raising the issue of power with them, since imbalances of power so demonstrable effect inter-professional and client-professional communications too:

'Power differentials in the medical encounter confound equal and adequate communication…Clearly the patient is the weaker in this situation and unless the clinician takes responsibility for monitoring the effect of this differential it might distort communication significantly, whether through deference, intimidation or fear.' [10].

So, the group is the arena in which leadership emerges, and a number of forces can be identified, over and above the quality of the group leadership per se, which have a major influence on group processes. Among these factors are the willingness of group members to participate, the level of cohesiveness within the group and whether or not the group shares common values. As *Tom Douglas* argues, the influence of these forces is easy to see:

'…whatever power a group has flows from the energy of its members, so almost without question the degree of participation of a group's members dictates how well it is able to work towards its goal. (Moreover) …a group which is riven with dissension has to spend all its time trying to heal breaches and soothe its members, so little energy or time is available to do the work it was set up to do. Alternatively, if the cohesion of a group is too great, it may be too smug, thus preventing it from doing very much.' [11].

Douglas' comments are worthy of reflection in relation to our experiences of leading counselling and communication skills groups. Although these are 'student-selected-units' (SSUs) and therefore optional, some group members are open about the fact that they have made such a selection because they thought it would be easy *(it isn't!)* or because they were not sufficiently well-organized to get their applications for their first choice SSU in on time and have selected the counselling option as a second or third choice. The 'energy' of such group members can be variable and, if not tackled, can lead to conflict and to the splitting of the group into pro- and anti- factions. Conversely, some groups seem to get on so well that no-one is willing to risk 'rocking the boat' by giving other group members constructive critical feedback (for fear of sabotaging the harmony). In such groups, the potential for learning is compromised by group members' desire to be 'nice' to each other [12].

In our view, being able to transform both of these situations as and when they arise is a key leadership skill, and one which should be developed further. If one has a natural tendency to avoid conflict, one may find the vitality necessary to turn such situations around elusive. The necessary ingredient to counteract this, charisma, is well expressed by English:

'The power to inspire, or model a new response by example, is the wellspring of a leader whose authority has been called 'charismatic'. The dynamism of a leader who has such charisma is bestowed on him or her by his or her followers. It refers to his or her social status.' [13].

The power to inspire

Should leadership be conceptualized in terms of the personalities, traits or characteristics which set leaders apart from others? On this matter, English proposes a social constructivist response:

'On the matter of whether leaders are born or 'made', perhaps it is most accurate to say that leaders have to be born like everyone else, but everything after birth is cultural and interactive (or 'made'). Portraits of leaders from biographies, autobiographies, diaries, journals and other sources reveal that leaders engage in a purposive construction of self, that is, they actively engage in creating the persona they want to become and what they perceive potential followers want and need them to be. The evidence also suggests that when a particular persona (or 'mask') is no longer effective or accepted, they engage in altering their persona to comply with the new requirements, dynamics, and situations involved with leadership.' [14].

The answer according to English would seem to be that we should (each and all!) construct an inspirational persona for ourselves. Does this feel too much like acting? Does it conflict with the core counselling requirement of 'genuineness' (Rogers, 1980) [15]? Perhaps if we return to Northouse's [5] argument, this fear may be put into context.

Northouse's fourth and final element typifying the leadership imperative includes attention to goals. For Northouse, *'leadership occurs and has its effects in contexts where individuals are moving toward a goal.'* [7]. Northouse emphasizes the role of the leader in directing groups of individuals towards accomplishing a particular task or end. However, in the context of leading a counselling and communication skills group, and arguably, in relation to all adult education, the role of the leader is not so much to direct the group towards the achievement of predetermined goals, but rather to create a context in which learners become actively engaged in goal-setting for themselves. As Hazel Johns argues,

'Studies of adult education…suggest that adult learners…come with a very wide range of intentions, experience and learning abilities; that, in order to succeed, they need to share in the setting of goals; and that to optimize their learning they must be actively engaged in learning strategies, and not be passive recipients of someone else's wisdom or un-wisdom.' [16].

Consequently, a significant part of the communication and counselling skills programme is negotiated within the group, and many decisions (including the timing and duration of the sessions) are decided by the group as a whole. In this respect, the group might be considered as representing an example of what English refers to as *'distributed leadership',* [13] i.e. where leadership functions are shared between a number of people, rather than held by just one individual. We are aware however, that this might be considered an over-simplification and would point to the subtle shaping of the group's direction that inevitably follows from the involvement of a group leader.

Aveline observes perceptively that: *'Each session of the group presents the leader with dilemmas as to intervention, dilemmas to which there are not certain answers but where the choices that are made form the direction that the group takes. The leader has to try and fine-tune the group so that it moves neither too fast nor too slow, the former being alarming and the latter boring….Other dilemmas are the balance between exploring situations outside and inside the group….'* [17].

The issue of whether to explore issues inside or outside of the group is particularly pertinent to leading a communication and counselling skills training group. Learners are encouraged to speak openly within the group. At the same time, individuals are able to speak with either of us on a one-to-one basis if issues arise which are difficult for them to share with their colleagues. They deserve an acknowledgment of their apprehensions or problems. Moreover, our own apprehensions lest we 'rock the boat' should not release us from the duty to meet a straight question with a straight answer.

Ethnocentrism

Globalization, one of the key factors affecting change in higher education in recent years, has created a need for those who lead groups of learners to become knowledgeable in relation to cross-cultural awareness and sensitive to both overt and implicit preconceptions in relation to learners from different cultures. Where a significant proportion of the learners are overseas students, we need to be particularly aware of ethnocentrism, both our own and that of other group members, in order to ensure that learners from other cultures are not disadvantaged.

Ethnocentrism is defined as: *'…the tendency for individuals to place their own group (ethnic, racial or cultural) at the centre of their*

observations of others and the world. People tend to give priority and value to their own beliefs, attitudes and values over and above those of other groups. Ethnocentrism is the perception that one's own culture is better or more natural than the culture of others. It may include the failure to recognize the unique perspectives of others. Ethnocentrism is a universal tendency, and each of us is ethnocentric to some degree.' [18].

In recent years, for example, the belief that the democratic principles of the West are superior to the beliefs of other cultures has led to a failure to understand the complexities of other cultures, resulting in much grief on the international stage, the macrocosm. In the microcosm, in the context of leading a learning group:

'Ethnocentrism can be a major obstacle to effective leadership because it prevents people from fully understanding or respecting the world of others. For example, if one person's culture values individual achievement, it may be difficult for that person to understand another person whose culture emphasizes collectivity (i.e. people working together as a whole). Similarly, if one person believes strongly in respecting authority, he or she may find it difficult to understand a person who challenges authority or does not easily defer to authority figures.' [19].

It is worth reminding ourselves that the assumption that people in distress are helped by talking about their distress is by no means universally held. Moreover, without exception, ***all*** of the leading counselling theorists are middle-class, white European or North American males, and this is hardly a representative cross-section either of today's society or of the communication and counselling skills group membership. Furthermore, in both medical and nursing education, one may find oneself an outcast through embracing heterodox views, which may include the primacy of listening skills and the importance of the talking therapies in all health and allied professions.

In support of this position, writers such as Burnard have persuasively argued that, *'…the skills described as "counselling skills"…have wider applications outside of the counselling relationship and can be used to enhance professional practice in any branch of the caring and health profession.'* [20].

Moreover, as Kurtz, Silverman and Draper point out: *'Over the last 25 years there has been considerable pressure from professional medical bodies throughout the world to improve the training and evaluation of doctors with regard to communication skills… Simultaneously, medical schools are being asked to reduce the factual burden on learners as the potential knowledge base of medicine increases exponentially year by year. They are being encouraged to change the medical school curriculum to focus more thoroughly on certain core skills and areas of learning, (of which communication is one) while providing a series of options for learners to choose from in less essential subjects.'* [21].

Our hope is that, through academic leadership of these areas, appreciation of the relevance of communication and counselling skills to the practice of medicine will grow sufficiently to enable them to move from the 'fringes' of healthcare education to the mainstream. This may necessitate a cultural shift on the part of some medical educators, and no less so on the part of communication and counselling skills trainers, who may need to more willingly embrace the leadership role both inside and outside of the training room.

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