Perspectives and Debates

Learning about self: leadership skills for public health

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Abstract

As public health practitioners and as clinicians we are taught to care for our patients, and for our community members. But how much do we teach and learn about how to lead, manage and care for our colleagues, our team members and ourselves? This paper emphasizes the need for leadership learning and teaching to become an essential element of the practice of public health. The paper presents the author’s perspective on the leadership skills required for public health and describes a five-day intensive course designed to enable participants to develop these skills over time. The paper briefly covers leadership definitions, styles and types and key leadership skills. It mainly focuses on the design and ethos of the course, skills self-assessment, group interaction and methods for developing and refining leadership skills. The course uses a collaborative learning approach where the power differential between teachers, facilitators, guests and participants is minimized. It is based on creating an environment where any participant can reveal his or her stories, successes, failures, preferences and dislikes in a safe manner. It encourages continual, constructive individual reflection, self-assessment and group interaction. The course is aimed at the practice of public health leadership, with a particular emphasis on the leadership of self, of knowing oneself, and of knowing and understanding colleagues retrospectively as well as prospectively. The most important outcome is the design and implementation of participants’ own plans for developing and nurturing their leadership skills.

Significance for public health

The nature of public health is changing rapidly and increasing in complexity. These changes include major shifts in the burden of disease and the insatiable demands of clinical medicine swamping those of public health. Public health practitioners have failed over many years to systematically ensure that leadership and management skills are essential parts of public health training (as they are in MBAs for example). This paper describes an approach and an intensive five-day course to assist practitioners to develop the key leadership skills needed to improve public health, whether it be locally, nationally or globally.

Definitions and understanding of leadership

There are, of course, many definitions of leadership. These include the ability to guide, direct or influence people; the ability to inspire confidence and support among the people who are needed to achieve organisational goals; or an act that causes others to act or respond in a shared direction.1

As explained below, the differing perspectives and definitions, and the sometimes nebulous nature of leadership, make it confusing for many. Therefore, in the course we strongly encourage participants to explore, develop and share their own understandings and definitions of leadership – and to see if they change and evolve during the course of the subject and beyond.

I present my own understanding of leadership (below) but make it very clear it may only be useful for me and emphasize the need for every participant to have their own understanding: maximising our own potential as public health practitioners, and maximising our sense of worth and meaning that we draw from our lives; and maximising the potential of others and the sense of worth and meaning they draw from their lives.

In my experience it is clear that leadership and authority are not the same thing, and that many in authority are ineffective and potentially harmful leaders, whilst many who have little or no authority can be effective and inspirational leaders. I have been particularly attracted to Sinclair’s view of leadership as...an activity almost all of us do at some time or another. It is not the captains of industry type of leadership but the work we do as role models as teachers, parents, activists, organisers, spokespeople.2

It is a happy convergence when people in positions of authority and control of considerable resources also have strong leadership skills.
Appreciating styles and types of leadership

As mentioned above there is great diversity and perspectives of leadership and these are well described elsewhere. We present the evolution of leadership from transactional leadership to transformational leadership, transcendent leadership and then to servant leadership.

Transactional leadership entails reward for good work, and punishment/correction for poor work, where staff comply with rules and operational guidelines. There is little focus on the professional relationship between the leader and staff members. Transformational leadership involves establishing oneself as a model by gaining followers’ trust and confidence, by defining future goals, developing plans to achieve those goals and innovating, even when the organisation is generally successful. Charismatic leadership is a special type of transformational leadership, but as we constantly warn our participants that they need to beware of the overly (often narcissistic) charismatic leader. As Sinclair says It is not uncommon to find otherwise smart and well-educated people surrendering their doubts to the certainty of leaders.

Transcendent leadership involves collective decision making through dialogue and group consensus, and creative and divergent thinking. It highlights the imperative for leaders to be aware of their own weaknesses and biases and exercise self-regulation in order to align their values and intentions with their decision-making and actions.

Servant leadership implies that the servant-leader is servant first… That person is sharply different from one who is leader first. A servant-leader focuses primarily on the growth and well-being of people and the communities to which they belong. While traditional leadership generally involves the accumulation and exercise of power by one at the top of the pyramid, servant leadership is different. The servant-leader shares power, puts the needs of others first and helps people develop and perform as highly as possible.

Why am I interested in learning about leadership: my own experience

In nearly 40 years of working in clinical and public health I have observed and worked with some great public health practitioners and some great leaders. Equally, I have witnessed some very poorly equipped leaders, who damaged the programs and the considerable resources under their authority. As a rule, they not only harmed the people who were working with them, but have also suffered themselves as well, usually by the simple fact they didn’t have the skills to cope effectively with the considerable challenges that leadership presents.

I have become intrigued by the issues of leadership — and my own learning has been greatly stimulated by my own experiences, especially ones where I felt I had failed as a leader. The first was as medical coordinator of a large Medicins sans Frontieres (MSF) team in eastern Sudan in 1985, nine years after medical graduation. The second occasion occurred when I was appointed as the inaugural Director of Country Programs for the Joint UN Program on AIDS (UNAIDS) in 1995. In the first instance, I was appointed as a leader mainly because I was a doctor (and male) and I had worked previously in eastern Sudan, and on the second occasion it was my experience as a technocrat who understood HIV programs that got me the job. But despite being 19 years post medical graduation, with two post graduate degrees, and experience in a number of leadership positions, I had had no training in leadership and management.

Setting up a new UN program overnight in fifty plus countries is no easy task at the best of times, and was made harder by the active hostility of the UN agencies that UNAIDS was meant to be coordinating. I was tyrannized by an over-loaded and negative email inbox, there seemed to be crises everyday, and my response was to work harder and harder. I was not coping well and felt I was drowning in my work because I had no structure or skills to manage complex issues or to manage my staff. In particular, I had little or no capacity to lead myself in times of considerable stress. In both cases I (and the staff reporting to me) would have benefitted enormously with training in decision making, planning, time management, prioritization, performance management and conflict management.

I continue to observe leadership closely and I am convinced that leadership and management skills must become core components of public health training. The lack of it manifests itself in the continued absence of a skilled and reflective leadership and management culture within many of the world’s preeminent health organizations, and in many national ministries of health.

As public health practitioners and as clinicians, our training focuses on care for our patients or solving problems in our communities. We have ignored teaching and learning about how to lead, manage and care for our colleagues, our team members and most importantly, for ourselves. As Bill Roper, a former Director of the US Centres for Disease Prevention and Control said in 1994…many senior executives in public health come into their positions with no formal training or real experience in leadership. My own career is surely an example of this phenomenon. Unfortunately, twenty years later, this is largely still the norm.

From my own experience, observation of leaders, the literature and the feedback from co-facilitators and students we have developed one way, and I emphasize this is just one way of categorizing leadership skills. These are now discussed.

Key leadership skills

These have been grouped, for convenience, into six domains with three or four skills in each. The list is comprehensive, but by no means exhaustive, and domains and skills can be substituted or adapted according to the participants’ needs, or according to differing social, economic and cultural settings (Appendix).

- Vision and decision making: creating vision; decision making; planning (including setting goals and prioritisation) and problem solving
- Communications: communication (including clarity and accuracy); oral presentations; advocacy
- Managing people: managing conflict; managing performance; mentoring and coaching; negotiating
- Technical capacity: intelligence gathering; technical credibility; evaluation
- Emotional intelligence I: reflection; self-awareness: self-regulation; time management (self-organisation)
- Emotional intelligence II: empathy; social skills; networking (influencing and relationship building); motivation

The design and ethos of the learning and teaching

Our teaching and learning has evolved since 2008, and includes the establishment of the subject Public Health Leadership and Management as a core subject in the Master of Public Health, as we understand this to be as important as the accepted core subjects of MPH courses such as biostatistics and epidemiology. The companion subject, an intensive five-day elective subject entitled Practice of Public Health Leadership is
the focus of this paper.

The *Practice of Public Health Leadership* course’s approach to teaching and learning leadership skills is based on the author’s experiences as a leader, teacher and follower, on Sinclair’s understanding of leadership, and on the transcendent and servant leader. It is also consistent with Jim Collins’ description of the exceptional level 5 leaders who combine fierce resolve and humility.

The intensive five days are based on co-facilitation and collaborative learning where the distance between teachers, facilitators, guests and participants is minimized. It is based on creating an environment where any participant can reveal their stories, successes, failures, preferences and dislikes in a safe manner; on continual, constructive reflection (what am I learning? what does this mean?); on self-assessment and on group interaction involving group presentations and assessments.

Facilitators’ role

The facilitators have to lead by example. It is their responsibility to create a safe environment to enable high levels of interaction where successes, weaknesses, failures and insecurities can be shared, discussed, and learned from as a group. Participants must be included, valued and validated. Feedback emphasizes that the collaborative and equalizing nature of the course avoids subservient relationships of teachers and students and enables participants to reveal, discuss and challenge previous perceptions about leadership.

From a recent course participant (Melbourne October 2015): *The best aspect was the development of a cohesive group, where it was safe to explore ideas, express vulnerabilities, learn. We were challenged by a range of incredible speakers with valuable experiences to share.*

The use of guest speakers

A key aspect of the course is to include several guest presenters. They come not only from the health sector but also from other fields such as business, community based organizations, politics, cuisine and education. This is to encourage participants to look beyond their known world for inspiration and learning. The guests are asked to reflect as openly and honestly as they can about their own experiences — successful and unsuccessful — and to share insights they’ve gained. Just as is the case for course participants, the speakers will only reveal their own experience if they are well briefed and feel they are speaking in a safe and trusting environment.

The role of participants

Participants not only work in groups to solve problems (see below) but provide daily reflections on the previous day, and they welcome and introduce the guest speakers and they facilitate a Question and Answer session with the guests after their presentations.

At the end of each day participants are also asked to rate and evaluate each session (using Google® docs online) and to provide additional comments — feedback which is discussed the following day and used to guide immediate changes in the program if required, and to guide the development of the course in future years.

Group assessment

Another essential aspect of the students’ learning is to encourage the development of group work skills as unavoidable elements of leadership (and membership, and followership). The reason is that virtually all public health now requires working in teams and groups. As Harvard Business School’s John Kotter says: *Leadership and management skills are required within an organisation, the mixture depending on what is needed (leadership for change, management for complexity). Given the rarity of exceptional leadership and management skills existing in the one person, a leadership/management team is needed.*

Each group develops respective scenarios to solve, and analyses what leadership skills will be required. They are encouraged to choose real issues which one of the team members may be facing in their workplace.

Before jumping straight in to solving the problem, the groups spend a considerable amount of time analysing and understanding the individual leadership skill strengths and weaknesses of all the team members. They then construct a picture of the team’s skills strengths and weaknesses. This has to be done with care and mutual respect.

Form another recent course participant (October 2015): *The assessment offered was different from the usual group work and encouraged...*
every member of the team to evaluate their own unique contribution to the project, resulting in increased creativity and a higher quality project. In most workplaces, people really only know each other prospectively, i.e. from when they meet. They have very little idea of each other retrospectively. They have little real knowledge of each others special history, talents, skills, strengths, weaknesses, likes, dislikes and preferences. So they potentially miss out on ever using those strengths, or understanding why someone may have a particularly strong opinion, or a fear or aversion to a particular issue.

Recent experience has shown that the more time the members of the group spend on really understanding each other retrospectively, and putting together a picture of the team’s overall skills (strengths and weaknesses), the better the group outcome, which in this case are the quality of group presentations, self-reported functionality of the group, and observed problem solutions. This is an element (Mutual Understanding) that should be added to Bruce Tuckman’s well-known Forming-Storming-Norming-Performing model of group development.12

Leadership of self

In taking the last two skills domains (emotional intelligence) which include reflection; self-awareness: self-regulation; time management, empathy; social skills; networking (influencing and relationship building); motivation and passion, it is clear that they relate much more to the self than to other people or to the organization or to technical issues.

Participants are encouraged to share their experiences of how they look after themselves and how they nurture their own physical and emotional health. They are encouraged to be selfish to be generous – in other words to be effective leaders they need to spend time and effort caring for themselves. They are encouraged to consider the many elements that make up their lives as a whole, not just their work, and to include these aspects in their leadership development plans.13 The experiences shared in the course by the facilitators and guests emphasize the need to establish self-care practices in one’s early career to nurture effectiveness and durability in public health.

Learning and refining skills

How can participants develop and practise their leadership skills? This requires the construction of, and adherence to a considered plan. It might involve a host of the following ideas that are presented and discussed throughout the course:

- Ask others for feedback, for example if giving a talk, chairing or participating in a meeting (but they must make sure to ask for the feedback before the talk meeting starts, not after it has occurred);
- Ask colleagues or friends to review one’s written work;
- Find a mentor or coach, and mentor others if the opportunity arises;
- Observe and talk to people that one admires, especially those who acknowledge their weaknesses, not only their strengths;
- Create a supportive peer group across several organisations/disciplines of members who are interested in developing their leadership skills;
- Use the formal performance appraisal and development process to build leadership skills;
- Take up opportunities that might be available — special courses or groups, media training;
- Practice in other forms of performance such as theatre, music and sport;
- Write for peer reviewed publications; write opinion pieces;
- Give conference presentations;
- Read widely on leadership;
- Work on improving emotional intelligence (meditation, yoga, prayer, a course on emotional intelligence)
- Accept more responsibility, for example take project leader roles within one’s organisation;
- Apply for leadership roles outside the organisation in other aspects on one’s life: for example a community group, sporting or cultural organisation, a school board, or a local council. Great experience can be gained through volunteer roles which can offer: the practice of leadership, learning in other fields, learning from other people, new contacts and networks which may be increasingly useful as public health becomes even more multi sectorial, potential mentors.

As the final (and major) assessment, participants are asked to describe in detail their unique plan for developing their leadership skills over the next year or two (most choose one year). They are then contacted one year later to report on their progress.

From a recent participant (Melbourne 2014) followed up in 2015: I found the course and the assignment invaluable - it has impacted positively not only my work, but also on my life more broadly. As a result I think I am more self-aware, strategic, realistic, and positive.

From another recent participant (Melbourne 2014) followed up in 2015: I have progressed well with my leadership plans. One of the important leadership role I learned during the course was that I shouldn’t belly-ache about problems. But to rather find new ways to solve them. So far I have applied the following leadership skills at work, at home and in my community: learning to work without taking credit; motivating a team even when I am not the official leader; keeping an open mind to feedback; self regulation and self awareness; meditation and exercise (not as hard as I thought it was going to be).

But not all is rosy as another recent participant (Melbourne 2014) followed up in 2015. Describes: My leadership plans have progressed slowly (about 40%). Unfortunately I really struggled with motivation earlier in the year… Being overseas has helped and I intend to implement the remaining 60% when I get back!

Conclusions

The learning described in the paper is only an introduction. As Rowitz describes: we were all discovering that it takes a lifelong commitment to learning to master the tools of leadership. And this is only one way of developing leadership skills. The course was originally heavily based on the author’s experience and world view but this has been steadily reshaped by insightful and critical feedback from co-facilitators and students.

The learning is designed to engage, inspire and encourage participants to be lifelong learners and continue to invest time in developing their skills. As part of this they are asked to actively reflect on what they learned (and what they haven’t or should have!), and as mentioned above their final assessment is the development of a one or two-year plan of how they will further develop their leadership skills. A limitation is the fact that only one group to date has been followed up.

The intensive five days requires careful facilitation to ensure a collaborative learning approach in an environment where guests, participants and facilitators can share their learning in a meaningful and considered manner.

Done well, developing leadership skills is fundamentally about developing the skills to become a more effective health professional, a better colleague and a better person.
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