Chapter 1

Why medicine needs moral leaders

A certain day became a presence to me;
there it was, confronting me – a sky, air, light:
a being. And before it started to descend
from the height of noon, it leaned over
and struck my shoulder as if with
the flat of a sword, granting me
honor and a task. The day's blow
rang out, metallic or it was I, a bell awakened,
and what I heard was my whole self
saying and singing what it knew: *I can*.

This book is about the moral challenges that confront medical leaders running the complex healthcare institutions on which we all rely. In the chapters to come I shall be discussing the issues that medical leaders have found to be morally troubling, what they have done to orchestrate an organizational response to their moral concerns, and the impact that leading healthcare organizations has upon them personally. In the course of my analysis of their experience I shall be suggesting a framework to conceptualize ethical action, discussing ways of understanding the ethics of healthcare organization, and proposing a new approach to developing ethical leadership.

Preventing or responding to medical harm, and associated worries about the capability or trustworthiness of colleagues, rank among medical leaders' foremost moral concerns. In the case of medical harm they know that they have important moral work to do, but also that however well they do it they cannot change what has happened. It falls to medical leaders to patch things together in the aftermath, to repair something irrevocably broken, and to endeavour to prevent the same harm happening again. In the case of colleagues, medical leaders are troubled by how to prove suspected poor clinical performance, how to weigh evidence that is contradictory, and what to do about unverifiable allegations that doctors deny. They are concerned about doctors who act contrary to clinical protocols but apparently get good results, and about doctors who deliver a good service to individual patients but take so long or spend so much that other patients suffer. They worry that their judgement of colleagues might be based on grounds of prejudice, or in questionable cultural

assumptions about how doctors should behave; they wonder whether they are siding with colleagues or failing to give them support, whether their standards are too low or too high and if they have 'drawn the line' in the right place. They sometimes take action knowing that colleagues are at risk of suicide, or aware of how colleagues' families will pay the price for professional disrepute.

But medical harm and the performance of colleagues are not medical leaders' only moral concerns. When I set out on this research, academic colleagues almost invariably predicted that medical leaders' main moral burden would be problems around resource allocation. (The healthcare professionals I work with who aspire to leadership roles more often anticipate that medical harm and colleagues' performance will be major sources of moral trouble.) Much moral challenge does arise from the perennial problem of stretching finite capacity over infinite demand, but this is a conundrum that is not just about money. There are far broader questions about matching assets to demand, because a health economy's assets comprise people, knowledge, buildings, infrastructure, cultures, systems, reputation, goodwill, and trust. Medical leaders have to consider all of these.

Sometimes an issue is (more or less) straightforwardly to do with money. Medical leaders see funds moving around the health system in ways that are not always responsive to patient needs, and it falls to them to use money wisely where they can. They face difficult questions about how to allocate drug budgets, resource new therapies, and pay for improvement projects, how to service organizational debts, reduce expenditure while not withdrawing services, and how to marry funded national or regional initiatives to unfunded local health demands.

The wider set of issues concerns systems, infrastructure, buildings and cultures. Medical leaders spend years negotiating priorities with different agencies so that, for example, elderly patients' health is accorded no less importance than that of people of working age, care for chronic disease is treated as no less important than acute care, and access to healthcare is improved for traditionally excluded groups. They look for ways of using information technologies to support patient care, but worry about privacy and confidentiality. They lead change in the face of public disquiet when plans for reorganizing hospitals and clinics involve modifying popular services. They are the object of anger and mistrust when they propose reorganizing services that are not as good as they ought to be. They simultaneously dislike and defend the moral necessity of fair bureaucracy, and they view corporate loyalty as both an asset and a potential liability.

An important dimension of moral leadership is making sense of all of this: creating a moral narrative that explains to the people whom leaders lead, and the people whom leaders serve, why it is better and not worse to do things in the ways that are eventually settled upon. Such moral narratives are not just explanations. They are also the form in which the knowledge of colleagues is pooled, the way in which situations come to be understood for what they are, the approach by which moral resolve is mobilized, the shape in which action is orchestrated, and the avenue through which organizations and individuals are rendered accountable.

Who this book is for

I hope I have made it possible to read this book without having to know anything at all about ethical theory, or anything about the internal machinery of the British National

Health Service. There are very few people who are familiar with both. The book is for clinicians thinking about leadership; for ethicists; for readers interested in healthcare organizations and how they work; for medical educators, trainees, or graduate students; and for those interested in what the day-to-day practice of professional ethics might look like.

The risk in trying to satisfy so many different audiences is, of course, failing to satisfy any. I have tried to set out my argument in such a way that it will make sense to anyone who comes to the question of moral leadership in medicine without a background in healthcare ethics, medical sociology, or medical management. Readers may therefore find that less is taken for granted than is usual in texts firmly located in a single discipline. Ethicist readers will no doubt find it odd that I identify 'Bernard Williams' as a 'philosopher'. UK clinical leaders may find it equally odd to encounter an explanation of the familiar nuts and bolts of medical managerial life in the British National Health Service (henceforth, NHS). I hope that these peculiarities will be forgiven.

Most of the chapters in the book are concerned with explaining what I think moral leadership in medicine consists of, where we observe it, and how we might think about it. My hope is that morally thoughtful people working in healthcare will recognize their world in these chapters, and will also find the arguments helpful for thinking about how to refine their own ethical expertise. For those who observe healthcare from some external vantage point, I hope that the portrait of moral leadership I present here will afford insight into the moral challenges that clinicians face, and the intellectual and emotional resources they invest in resolving them.

This book is, I think, a sympathetic portrayal of clinicians' worlds. It is one that may not satisfy critics distrustful of the power of the professions. But I have tried to understand what moral challenge looks like to clinicians who genuinely believe they hold their patients' best interests in mind, are committed to running fair and effective public organizations, and who are endeavouring to do what good they can in frequently difficult circumstances.

Some parts of the book offer more detailed theoretical arguments than clinicians or students will find edifying, and I expect that readers will choose to focus on sections relevant to their interests and needs. Philosophers, ethicists, educators and the sociologically inclined may find the fuller argument helps to resolve doubts about the force of my claims, helps to point up my arguments' implications, or helps to iron out conceptual difficulties.

How this book came to be written

My portrait of moral leadership draws on research into the moral experience of medical directors leading hospitals and primary care organizations in the NHS.

I carried out detailed, in-depth interviews with NHS medical directors, purposively selected from a range of healthcare organizations. These organizations were of different sizes, some large and some small. They had different sorts of patients, from affluent, settled, predominantly white, middle-class town and countryside populations to poor, transient, predominantly minority ethnic, working-class, city dwellers. The organizations had different public profiles, some with long-standing support from their local communities and others with reputations that had had to be rebuilt after well-publicized failures of care. They were located in different geographical regions across the UK.

My sample of twenty-four organizational leaders was tiny – microscopic – by comparison with the number of subjects recruited to a clinical trial and the number of respondents

required for quantitative social research. However, the sample size is not unusual in qualitative research. More to the point, it is about twenty-four times the size of the average sample used in philosophical theorizing, which depends heavily upon the philosopher's own experience and intuitions. Taking as its focus the moral experience of medical leaders across a wide range of different organizations, this is in fact one of the most extensive in-depth studies of moral leadership in medicine to date.

Interviewees were promised anonymity and almost all spoke very frankly about sensitive and contentious issues. This has entailed some care in discussing data containing confidential information [1–3].[1] A degree of artifice has been used to conceal the identity of participants and those to whom they referred. In some of the cases that I discuss in forthcoming chapters I have withheld telling detail, and in other cases I have changed it.

The most problematic detail to change is the sex of interviewees. The majority of UK medical directors are men, and interviewees recruited from among the minority of women were potentially far more easily identifiable. My sample of twenty-four medical directors included five women. In order to conceal my female participants' identities, I retained roughly the same proportion of men and women when reporting the data but have arbitrarily changed the gender identity of interviewees. Doctors may be male or female as their names suggest, but equally they may not. Interview transcript should never, therefore, be read as an example of specifically male or female thought, speech or action.

The interesting question that is raised through making such a change is whether male and female medical directors had a different outlook or were inclined to do things differently. I came to the conclusion that the medical leaders I interviewed did not differ significantly in their approach. This is partly because the men in my study reasoned and acted in ways that are consistent with theories of morality that – ironically – were initially based in understandings about how women's moral experience differed from men's. I touch on this point again in Chapter 6, when I consider how the data in this study inform our understanding of moral practice.

A list of the participants' pseudonyms and a description of the type of organization they worked for is included as an addendum at the end of this chapter.

What morality and leadership mean in this book

The words moral, ethical, leader and leadership will appear throughout this book with almost tiresome frequency, so it would be as well to make clear from the start how I intend to use them. Getting at the meaning of these common words is no simple matter, however.

The philosopher Bernard Williams described an ethical consideration as one that 'relates to us and our actions the demands, needs, claims, desires, and, generally, the lives of other people' [4(p12)]. To an ethicist, this vague and expansive definition makes some sense. But for newcomers to the field it simply begs the question 'so what exactly are we talking about when we talk about morals and ethics?' In the following section I hope to give a reasonably lucid account of what people mean when they use these words, and how I will use them, before I go on to explain how morals and ethics apply to leaders and leadership in medicine.

[1] On privacy, see reference 1. On cases in bioethics, see references 2 and 3 .

What 'moral' and 'ethical' mean

The moral philosopher turned bioethicist Judith André once observed that confusion and disagreement in bioethics is fuelled by the illusion that all who come to the debate share a common academic language [5(p42)]. Clinicians, social scientists, lawyers and philosophers all enter the fields variously known as clinical ethics, medical ethics or bioethics schooled in their own disciplines. One problem that then arises is that the use of the words of 'morality' and 'ethics' are different in medicine, sociology, law and moral philosophy.

I start with common usage among doctors who were, after all, the main subject of this inquiry. Use of the term morality or ethics in medical circles generally follows informal conversational conventions. 'Morality' refers to issues such as abortion that wider society conventionally treats as 'moral' issues. But when these same issues involve professionals, as they do in managing patients' requests for termination of pregnancy, 'ethics' is the preferred term. Practitioners speak of 'professional ethics' rather than 'professional morals'; and generally label poor professional behaviour 'unethical' rather than 'immoral'. However, particularly depraved behaviours attract the epithet 'immorality' all the better to register deep disapproval or disgust. Overall, then, 'ethics' seems to be thought more suitable for what doctors ought to do because they occupy special roles, while 'morality' is preferred for talking about fundamental and enduring human concerns or for uttering strong condemnation.

'Ethics' may thus mean any of the following to medical professionals: medical-ethical principles and concepts; professional codes; the practices that implement medical-ethical conventions; and the personal values carried into the professional domain. To work through one example, the ethical principle of 'respect for autonomy' is said to account for the ethical concept of 'informed consent'; requirements of informed consent are embedded in professional and organizational codes; there are ethical practices around 'consenting patients', which can be performed for better or for worse, and about which judgements of performance can be made; and professionals may experience moral satisfaction when they 'consent' their patient well.

In the social sciences, the terms 'morality' and 'ethics' are used to refer to the conventions or conventional behaviours that a particular group treats as 'good' or 'correct'. Social theorists themselves rarely advocate any particular code of conduct. They are by and large more concerned with understanding how groups settle what is 'good' or 'right' among themselves.

The social phenomenon of 'morality' and 'ethics' interests social theorists because it is a distinctive means of governing individual and group behaviour. Members of social groups – and hence also social theorists – typically distinguish between behaviour procured by force, behaviour that is compliant with formal codes such as law, behaviour that is produced by informal codes such as morality or etiquette, and behaviour that comes from merely wanting to be nice to one another. How groups distinguish between force, law, morality, friendship and altruism is a complex matter, not least because the boundaries between the various categories overlap and are apt to move around. What is morality one day may become law the next, what some treat as a rule of etiquette may look to others like ethics, and so on.

What is special about morals and ethics, however, is that when groups label certain issues as 'moral' or 'ethical' these issues assume a particular gravity. 'Moral' and 'ethical' discussions are believed to be about matters of great import. Moreover, when issues

are thought to be 'moral' or 'ethical' in nature, they elicit and give licence to strong sentiments of approval and disapproval.

From a social scientific perspective, however, so-called 'moral' conflicts may be no more than factional disagreements between social groups and sub-groups. The business comes to be badged as 'morality' because one side in a conflict sees some advantage in persuading themselves and others that there is something particularly precious at stake. 'Claiming the moral high ground' turns ordinary disagreements into righteous crusades. Writing about ethics in nursing, for example, sociologist Daniel Chambliss argued that ethics talk is frequently an expression of conflict between powerful interest groups such as doctors and nurses, or nurses and managers: 'what could be described as political arguments or turf battles are translated into moral terms and become "ethical problems"' [6].

Finally, moral philosophy starts its inquiry into morality with questions about the form that morality takes. Moral philosophers treat morality as a special case. What makes 'morality' different from other aspects of human experience and relationships? For moral philosophers, what is special about 'morality' is that it concerns what we *ought* to do in relation to others, and thus also how we reason about what is right or good. Moral philosophy has tended to treat morality as rule-like, with moral considerations applying in similar fashion to all rational persons who find themselves in similar situations.

Kant gave 'morality' a very restrictive definition, at least in terms of the form that it took. He argued that true morality was a conscious decision to do the right thing, solely out of a concern to do one's duty. Moral philosophers after Kant have, however, been rather more liberal in their definitions of the form morality takes. The issue continues to be debated, but most moral philosophers converge on seeing morality as guidance on important domains of human behaviour, guidance that is rational, primarily concerned with lessening harm or evil, and binding on everyone [7].

If we are all of us bound by the same moral considerations, working out exactly what our moral obligations are becomes a critically important, and highly contentious, task. In this context, the word 'ethics' takes on a quite specific meaning: it is reasoning about the content of our moral obligations, where it has already been agreed that morality is a rational code binding on everyone. Ethics is the study of the question of what exactly our moral code of conduct ought to be, and why. For example, ought we to do only what produces the most pleasure and the least pain for the largest number of people, or should we unwaveringly follow absolute rules, such as always telling the truth, regardless of the consequences?

However, a significant group of philosophers, Bernard Williams among them, have also argued that ethics should be treated as a much more wide-ranging inquiry into the question 'how should one live?' Ethics, they argue, should not be treated as parasitic upon definitions of morality.[2] They question the assumption that the question 'how should one live?' is always best answered by referring to universal moral obligations or general moral duties. Instead, they invite us to consider a multitude of possible reasons for acting. Because so many different reasons may be brought to bear, these philosophers are inclined to accept the possibility that different people may justifiably decide to do different things for different reasons in roughly similar circumstances.

Which brings us – at last – to what I mean by 'moral' and 'ethical' in this book.

[2] I am referring here to a broad group including virtue ethics, narrative ethics, care ethics, feminist ethics and responsibility ethics.

First, I follow the conventions familiar to clinicians and social scientists and will be using 'moral' and 'ethical' as almost – but not quite – interchangeable.

Second, I am sidestepping difficult questions posed by moral philosophers about whether there are some 'universal' moral propositions and what deserves to be labelled 'moral', simply because for current purposes it is not necessary to answer them. This book is about the issues that medical leaders identified as the morally troubling stuff of medical management. That some managerial troubles are *experienced* as moral or ethical troubles is in my view a good enough reason to include them in a study of moral leadership.

In very large part, what was troubling about the issues medical leaders discussed was that they entailed attempting to realize conflicting and equally important values. Some medical leaders' moral troubles concerned life and death decisions about patients, and would probably be viewed as 'moral' issues by most observers. Other troubles could undoubtedly be mapped onto their organizational turf battles. But while I think it is helpful to be aware of how 'claiming the moral high ground' can be a useful tactic in turf wars, I am disinclined to redefine particular moral arguments as 'really' turf warfare, or 'really' anything else. Whether issues are 'truly' moral issues is a matter of interpretation: a matter about which philosophers, social theorists, clinicians, and managers may quite legitimately differ.

All of the moral issues that I write about in forthcoming chapters fall easily within Bernard Williams's sense of the 'ethical'. They also fit well with philosopher Margaret Walker's explanation of what makes certain responsibilities 'moral responsibilities' below:

> [W]e are most likely to invoke the notion of moral responsibility in cases where the stakes are high, or cases where dependability or dereliction is apt to reflect on character, or cases where we know we are relying entirely on the informal system . . . where there are no official judiciaries or enforcers. [8]

Third, and perhaps most importantly, what I am really interested in is what medical leaders *do* when moral trouble is in the offing. A great deal of the discussion in medical ethics is about what people should *decide* when they are confronted with a moral fork in the road. But that is not what it is like in medical management, as we shall see. Medical leaders have to realize that there is a problem, work out what it is, and come up with potential solutions, before they can make momentous decisions about what might be the optimally ethical option to pursue. And then, the truly difficult moral work often starts after decisions have been made about which way to go, in seeing the whole business through to its end. How decisions come to be necessitated, and how they are subsequently implemented, may be what matters most to building ethical healthcare organizations.

What 'moral leadership' means

Whatever their formal position, all healthcare professionals have an interest in understanding moral leadership, and sometimes an obligation to undertake it.

It is an unoriginal (but nonetheless accurate) observation that officially designated leaders frequently fail to lead well, or indeed lead at all. Equally, people who are not officially designated leaders may play a significant leadership role, visible in the way that they steer groups towards accomplishing desirable goals. It is helpful to keep in mind this distinction between the position of leader and the activity of leadership. When I use the term moral leader and moral leadership in this book I mean to refer to people doing

the activity of moral leadership. Some will be formal leaders, doing moral leadership. Others will become informal moral leaders, because in the absence of anyone else stepping up to the mark their own moral leadership is all there is.

Moral leadership in medicine does not mean being a doctor. Potentially any member of a healthcare professional group is liable to be called upon to play a moral leadership role. Neither does it mean having a senior role in the professional hierarchy. Junior staff may sometimes have to confront moral problems unseen or ignored by their seniors. And finally, moral leadership in medicine does not mean being the doctor who is best able to do 'applied ethics'. It will become clear why this is so from Chapter 2 onwards, when we begin to look at the processes through which ethical commitments come to be enacted.

Moral, or indeed ethical, medical leadership means being astute to the moral connotations of all that is involved in providing care, determining where action is needed, identifying situations where action is needed to improve or maintain the moral quality of care, and orchestrating the activity of other people to provide a morally appropriate response when one is required. Moral leaders will frequently orchestrate by example: creating the ethical tone of an organization through the quality of their moral awareness, and the quality of their response to morally challenging situations.

This book is based on research into the moral experience of doctors who were, in fact, the officially designated leaders of the medical workforce within their organization. I studied them because it was the most practical way of researching the phenomenon of moral leadership. But this approach does invite a tricky question: were the leaders I talked to *able* moral leaders, those to whom one should look for examples of medical leadership?

The difficulty in answering one way or another is that we have no agreed criteria against which to measure them, or indeed anyone else. To judge competence, or even better, expertise, is to judge the skill exhibited within a particular practice. To judge the skill, we have to understand the practice. But I undertook this research precisely because we do not fully understand the practice of moral leadership.

So what claims can I make about the quality of the moral leadership I discuss here? One alone: the features of moral leadership that I consider in forthcoming chapters have been distilled from leaders' reflections on their moral experience. These leaders were respected by other leaders for their moral wisdom. Their reflections have supplied us with a useful framework for thinking about how to do moral leadership. They do not, however, supply a ready reckoner on how to be good.

Why medicine is a (fairly) special case of morality and leadership

It is said to have been St. Basil of Caesarea who founded the first 'proper' hospital around AD 360 [9]. Hospices, hospitals, clinics, 'polyclinics', community health centres, local surgeries, managed care organizations, medical aid networks – healthcare organizations of remarkable diversity – have since grown up to serve medicine's ends. For centuries, care organizations have been potent symbols of our frailty, of our determination to overcome our afflictions, and of the attitudes that societies hold towards assisting some of their most vulnerable members.

The medical care that organizations exist to provide is nothing if not (to recall Bernard Williams) a response to 'the demands, needs, claims, desires, and, generally, the lives of other people' [4(p12)]. Medicine is, on this reading, an intrinsically moral activity. As bioethicist John Harris noted, the ways in which we provide care 'demonstrate the value that we place on one another's lives and display the respect that we believe we owe to each other'

[10(p1)]. There is almost nothing that happens in medicine that is not a moral issue. Even interventions freely chosen by competent healthy adults – cosmetic surgery, contraception, genetic testing for example – are fit topics for moral analysis. There is a sense, then, in which medicine and morality are so inseparable that leadership in medicine is, for better or worse, inevitably a form of moral leadership.

If to lead in medicine is to lead a moral enterprise, it is also, often, to lead a moral enterprise in which the everyday moral world is turned upside down. As sociologist Daniel Chambliss observed,

> In the hospital it is the good people, not the bad, who take knives and cut people open; here the good stick others with needles and push fingers into rectums and vaginas, tubes in to urethras, needles into the scalp of a baby; here the good, doing good, peel dead skin from a screaming burn victim's body and tell strangers to take off their clothes .... The layperson's horrible fantasies here become the professional's stock in trade. [6(p12)]

Many ordinary moral understandings – about what is permissible, what is shameful, what is perverse, what is pleasurable, what is cruel and what is kind – must simply be set aside for the purposes of conceptualizing medical care. The special moral understandings that apply to medicine suggest that moral leadership here is a special case. It is perhaps akin to moral leadership in a war zone, another arena where ordinary moral understandings are temporarily suspended.

The need to sidestep conventional moral thinking in order to provide medical treatment affects healthcare professionals in two, paradoxically opposite, ways.

One reaction is to become impervious. Professionals who deal with death, disorderly bodies and unruly minds on a daily basis might be forgiven for forgetting how odd the moral world of medicine is. The assumptions that dominate life outside it – about what is dignified, who is in control, what is valuable, who is vulnerable – can all too easily disappear from view. The opposite reaction is to become hyper-vigilant in relation to moral concerns. Consciously or otherwise, healthcare professionals counter the risk of going morally adrift by looking for moral anchorage. This can come in the form of dogmatic reliance on some basic moral principles, in anxious scanning of the environment to identify moral trouble, and sometimes both. Counterintuitively, perhaps, some people seem to adopt both of those strategies at once: becoming both impervious to day-to-day indignities, and also intensely aware of the scope of their moral responsibilities.

In the peculiar moral world of medical care what the moral issues are may not always be obvious; potential moral troubles are obscure; and potential moral troubles are everywhere abundant.

Moral leadership is about doing, not just deciding

This book is not just about making moral decisions. It is about doing moral behaviour to build ethical organizations.

This focus on enactment sets it apart from the mainstream of medical ethical discussion. Normative medical ethics is concerned with what decisions ought to be made; and empirical medical ethics mostly looks at how professionals approach decisions. This is of course to simplify a much more intricate picture. My point, though, is that most medical ethics treats moral decisions as the chief object of interest. Discussion concentrates on what people should, or could, or did, decide about something morally important. In the case of

empirical ethics, discussion may start with how people come to a decision, and it may end with how they communicate it. But 'big' moral decisions remain the core concern.

I am not uninterested in big decisions and how they are justified. But if we think of morality as being mostly about making decisions we risk overlooking all of the surrounding, equally important, aspects of moral life in which moments of decision are embedded. If we overlook these elements, we will fail to ask and answer some important questions. What does it take to notice that 'something moral' is going on? How do people make sense of the 'something moral' that is going on? What is the range of possible responses to the 'something moral'? How do we narrow them down? How does one decision lead to another? How does the way we *act out* our decisions affect their 'moral goodness'? How do we influence the moral actions of others? How do we manage our moral identity? These questions are all part of my account of moral leadership.

Although it is not a particularly endearing word, in forthcoming chapters I use the term 'enactment' and its variants (enacting, enacted) to refer to the totality of the moral or ethical process. I think of 'enacting' as a form of 'moral artistry', a creative process that relies upon perception, knowledge, social skill, and creative imagination. The process starts with sensing that something 'moral' may have to be dealt with, right through to assessing whether one is a morally good person for having done things as one did [11–13].[3]

On charismatic, transformational, distributed, and connective leadership

What is a good leader? There is already a vast literature on leadership in general, and a burgeoning literature dealing with ethical leadership in particular. The search for an answer to the question of leadership has produced a regal parade of new 'leadership paradigms'. In recent decades the medical leadership industry has rejected 'charismatic' leadership, embraced 'transformational' leadership, moved to favour 'distributed' or 'shared' leadership and flirted with 'connective' leadership. So what can this book offer that is different?

This book is an account of only one dimension (moral) of one kind of leadership (medical). I am not convinced that it is helpful to treat every aspect of leaderly activity, across the gamut of human endeavour, as a single behavioural phenomenon captured in description of a single paradigm – leadership. Moral leadership may not be the same phenomenon as strategic leadership, and leadership in medicine may not be the same phenomenon as leadership in banking. Whether or not I am right to be sceptical about the existence of the phenomenon of leadership-in-general, I do think it is worth trying to understand the phenomenon of moral-leadership-in-medicine. So that is where I start.

Each of the paradigms that I listed has elements in common with the model of moral leadership that I describe. None of them tells us in concrete terms, however, what moral leadership is about or how it actually gets done. That is exactly what this book sets out to explain. It addresses the issues that medical leaders identified as being the stuff of moral leadership. And it looks in detail at exactly how moral leadership appears to work, paying attention to the actual behaviours that supported the pursuit of moral goals. I have argued that morality in medicine is a special case of morality, and I suspect that so too is medical leadership a special case of moral leadership. I have argued that what is of critical importance is what we do about moral challenge, not just what we decide.

[3] The term enactment is also used by Cribb; see reference 11. Since MacIntyre the notion of enactment has been used in narrative ethics, but the meaning often left unspecified: see reference 13 for Macintyre and 13, p. 5, for one example.