

Application of Hersey-Blanchard Situational Leadership Theory to Radiology Training

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INTRODUCTION

Leadership and mentoring are important concepts in modern medical education. Mentorship is often greatly valued in academic medicine, yet some faculty fail to realize that mentoring is the culmination of a leadership continuum that involves several complex steps. Implicit to this continuum is the fact that followers respond differently depending on their developmental state. This is well summarized in the theory of situational leadership.

The Hersey-Blanchard Situational Leadership theory (HB), developed by Paul Hersey and Kenneth Blanchard [1], argues that there is no single most effective style of leadership and that the best leadership framework effectively adapts to group tasks and the aptitude of the followers. The theory endorses four leadership styles: directing, coaching, supporting, and delegating. There are likewise four developmental levels of followers which describe the motivation/engagement and ability of the follower to perform a task. This presentation reviews the situational leadership theory and applies it to residency training.

METHODS

HB divides followers into four groups. The first follower group (D1) includes individuals who are high in enthusiasm but low in ability. These people are usually beginners in a career or new to an occupation. The D2 follower is also somewhat of a beginner but has increased ability to perform tasks with some autonomy. At the D2 stage, engagement wanes somewhat. When a follower progresses to D3, his or her ability to perform tasks has now advanced closer to autonomy, but motivation remains somewhat low as with the D2 follower. At D4, the follower is at the peak of ability, and engagement has returned to the level of the D1 follower

HB divides followers into four groups. The first follower group Leadership styles are designated S1 through S4 and correspond to the appropriate situation for each follower. The S1 style, directing, requires that the leader designates tasks for the follower and provides close supervision. This is appropriate for the D1 follower whose abilities are at a minimum. The D2 follower responds best to the S2 leadership style, coaching, while the D3 follower benefits greatest from the S3 style, supporting. Coaching and supporting are a continuum of emotional support for the follower to build esteem in the setting of decreased morale. This continuum also describes the decreased need for supervision which is at the minimum for D4 followers. The associated appropriate leadership style, delegating (S4), should be applied to the D4 constituent

Table 1: Follower Level

Style	Ability/Competence	Enthusiasm
D1	Unable	High
D2	Unable	Low
D3	Able	Low
D4	Able	High

Note. Adapted from *Situational Supervision: Applying Situational Leadership to Clinical Supervision*, by Bedford, C. and K.M. Gehlert, The Clinical Supervisor, 2013. 32(1): p. 57-58.

Table 2: Leadership Level

Style	Ability/Competence	Willingness/Confidence
Style 1 (S1)	Above Average	Below Average
Style 2 (S2)	Above Average	Above Average
Style 3 (S3)	Below Average	Above Average
Style 4 (S4)	Below Average	Below Average

Note. Adapted from *Situational Supervision: Applying Situational Leadership to Clinical Supervision*, by Bedford, C. and K.M. Gehlert, The Clinical Supervisor, 2013. 32(1): p. 57.

DISCUSSION

The new resident is low in medical knowledge but often high in commitment. Having little experience in practicing medicine, the new resident must be told how to practice and will require lengthier explanations due to knowledge deficits. This is described as the directing (S1) leadership style in situational leadership theory.

As the resident progresses to the D2 level, he or she will exhibit improved medical knowledge but still requires assistance in practicing medicine. The second-year resident is afforded some autonomy which corresponds to the sort of uneasiness/reduced morale of a D2 follower described by HB. To effectively teach this resident, the attending faculty member should employ more of a 2-way dialogue in which feedback is solicited from the resident while the attending physician maintains the final say in decision-making. This is the coaching leadership behavior, S2.

Supporting (S3) centers on praising motivation and is suited for the resident who is just beyond the midpoint of residency training and is becoming the D3 follower. The resident at this level has greater medical acumen, yet enthusiasm for tasks may wane. This may be the result of cumulative grueling work/call responsibilities and eagerness to practice independently.

As the resident approaches the end of residency, delegation (S4) of tasks is appropriate for residents near the end of training. As graduation approaches, the resident should be able to practice nearly independently and should no longer require much direction.

Table 3: Readiness Level

Style	Ability/Competence	Willingness/confidence
Readiness 1 (R1)	Unable	Insecure
Readiness 2 (R2)	Unable	Confident
Readiness 3 (R3)	Able	Insecure
Readiness 4 (R4)	Able	Confident

Note. Adapted from *Situational Supervision: Applying Situational Leadership to Clinical Supervision*, by Bedford, C. and K.M. Gehlert, The Clinical Supervisor, 2013. 32(1): p. 58.

CONCLUSIONS

Though these principles have been employed in businesses for decades since the original publication of Hersey and Blanchard's "Management of Organizational Behavior," physicians-in-training are often faced with a "one size fits all" training mentality in which faculty fail to tailor their leadership practices to individual followers. As the millennial generation filters into our practices, it will be incumbent upon us to adapt to styles of interaction and management to improve communication and maximize performance. The key to exploiting our full potential moving forward is to learn how to adapt in our roles as leaders to best fit the trainees we work with.

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