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Review Article

Micromanagement in health professions education: implications and mitigations strategies

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Abstract

Background: Micromanagement, characterized by excessive oversight, rigid control and limited delegation of tasks or decisions, coupled with overemphasis on compliance rather than focusing on achieving the desired institution' outcomes. It poses significant challenges in health professions education, where balancing the delicate boundaries between autonomy and accountability is essential.

Objective: This review aimed to explore the root causes of micromanagement, its effects on faculty members and institution growth, and the mitigation strategies in the context of health professions education.

Methods: The scoping review was conducted by analysing literature from PubMed, Scopus, and Google Scholar, focusing on peer-reviewed articles published between 2014 and 2024. Key terms included "micromanagement," "excessive control," "medical and health professions education," "faculty autonomy," and "leadership in education." Relevant articles were synthesized to identify major themes.

Findings: The findings revealed that micromanagement adversely affects faculty members by reducing job satisfaction, increasing burnout, increasing frustration, stifling creativity, and innovations, and as well leading to talent retention challenges. The root causes included lack of leadership training, leaders' fear of errors, performance pressures on leaders, and hierarchical cultures. Mitigation strategies included leadership training, fostering psychological safety, and promoting faculty autonomy through institutional reforms.

Conclusion: Micromanagement significantly undermines faculty members effectiveness and well-being and hinders institution growth in medical and health profession education context. Addressing this issue requires leadership training and development, institution reforms, targeted faculty support and cultural shifts. Policies promoting trust, autonomy, creativity, and innovation are essential for institution success and sustainable educational environments. Future initiatives should prioritize adaptive outcomes-oriented leadership models, evidence-based supervision practices, and faculty empowerment programs to mitigate the negative effects of micromanagement.

Keywords: Micromanagement, Autonomy, Medical/Health education, Autonomy, Delegation, Excessive control, Lack of trust.

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1. Introduction

Effective management is central to the success of any organization, shaping not only operational efficiency but also employee well-being and institutional culture.[1-3] Among the array of management approaches, micromanagement and macro-management stand out as two distinct methodologies that define how managers oversee tasks, delegate responsibilities, and maintain control over processes.[4] These approaches focus on varying levels of supervision and autonomy, significantly impacting organizational dynamics and outcomes.[3] The challenge for managers lies in discerning when to employ micromanagement to ensure accuracy and compliance versus when to adopt macro-management to inspire innovation and autonomy. Striking a balance between these approaches is critical to optimizing both employee performance and organizational success.[4]

Micromanagement is characterized by excessive oversight, rigid adherence to protocols, and limited delegation of responsibilities.[1] While intended to ensure compliance with institutional standards and minimize errors, micromanagement often has unintended negative consequences. Faculty subjected to micromanagement frequently reports reduced satisfaction, limited autonomy, frustration, and a diminished capacity to innovate, which in turn affects their ability to deliver high-quality education and contributes to achieving institutional goals.[5] Over time, the

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cumulative effects of micromanagement can lead to burnout, disengagement, and increased turnover, posing a threat to the sustainability of educational programs.[6,7] These dynamics not only harm individual faculty members but also undermine institutional effectiveness by stifling creativity, innovation, increasing turnover, and disrupting educational continuity.[8,9]

In the context of Medical and health professions' education faculty members are the backbone of educational system, contributing not only to the academic growth of learners but also to the advancement of institutional missions through quality work, innovations, research, mentorship, and administration.[10] Despite their significant role, faculty members often find themselves constrained by management practices that prioritize control over creativity and innovation.[11,12] Among these practices, micromanagement has emerged as a pervasive and detrimental issue in medical and health professions education institutions.

The hierarchical structure of medical and health professions education, combined with high-stakes performance pressures, creates an environment where micromanagement thrives.[9] Leaders and administrators, driven by the need to meet accreditation standards, program rankings, promotion, and research productivity targets, often resort to micromanagement as a means of maintaining control.[10] However, these behaviours often erode trust between faculty and leadership, fostering a culture of mistrust and dependency rather than collaboration, innovations, and empowerment.

Despite its widespread impact, micromanagement in the context of medical and health education has received limited scholarly attention, particularly regarding its effects on faculty members. Much of the existing literature focuses on learners or broader institutional outcomes, leaving a critical gap in understanding how micromanagement influences faculty members' experiences and productivity. Addressing this gap is essential, as faculty members are the backbone of educational programs, and their well-being directly affects the quality of teaching, assessment, adherence to quality standards, research, and mentorship they provide.

This review aimed to explore the root causes, impacts on faculty members and institution growth, and strategies for mitigating micromanagement in medical and health professions education context. By synthesizing findings from recent studies, it provided actionable insights to foster supportive and empowering environments for faculty members. This review sought to contribute to the development of effective management practices that prioritize trust, autonomy, creativity, innovations, and collaboration, enhancing both faculty satisfaction and institutional success.

2. Root Causes of Micromanagement

Micromanagement in medical and health professions education stems from a complex interplay of structural, cultural, and individual factors, including:

2.1. Lack of leadership training

Many leaders and administrators in medical and health professions education ascend to leadership positions without formal training in management or leadership. These skills gaps often result in reliance on micromanagement practices (4). Also, without proper training in effective delegation techniques, leaders may struggle to strike a balance between oversight and autonomy, defaulting to excessive control.[4,8] Moreover, leaders and managers who lack training in adaptive supervision models may fail to tailor their management approach to individual faculty member needs, further exacerbating the impact of micromanagement behaviors.[4]

2.2. Performance pressures on leaders

Increasing demands for measurable outcomes such as accreditation standards, program rankings, recognition and research productivity place significant pressure on institutions and leaders.[13] These pressures are often translated into micromanagement practices.[4,10] Likewise, institutions prioritize performance indicators like examination scores, research funding, and student satisfaction surveys over faculty members' autonomy and innovations. This emphasis leads to frequent evaluations and strict adherence to institutional goals, which faculty members may perceive as excessive load and oversight.[4,10] Also, over-surveillance of faculty activities exacerbates the problems, particularly when administrators implement monitoring systems to track faculty compliance with institutional standards. These systems, although intended to ensure quality, often create a culture of mistrust and hinder faculty members' autonomy.[5] Additionally, faculty members are sometime pressured to conform to rigid expectations and short notice tasks in a brief period rather than explore creative approaches to teaching, assessment, and research.[8]

2.3. Leaders fear of errors

The high-stakes nature of medical and health professions education, particularly in clinical training settings, amplifies the managers and leaders' fear of errors.[13] This fear drives them to adopt micromanagement behaviours aimed at minimizing mistakes. Leaders often prioritize error prevention over autonomy, leading to excessive control of faculty members activities. While minimizing mistakes is important, this approach undermines faculty decision-making and reduces their ability to innovate.[10] Furthermore, an emotional burden on leaders, especially those internalize responsibility for errors may develop anxiety-driven behaviours, leading to over-monitoring and micromanagement.[4] These leaders may struggle to trust

faculty members fully, further perpetuating the cycle.[5] On top of that, in environments where leaders are held accountable for faculty members and institutional outcomes, fear of failure intensifies. This dynamic discourages delegation of responsibilities and tasks and as well reinforces rigid control mechanisms over tiny details.[2,8]

2.4. Cultural norms in medical and health professions education

Cultural norms within medical and health professions education often exacerbate micromanagement tendencies.[14] These norms include deeply ingrained beliefs about authority, tradition, and professional hierarchy like demonstrator, lecturer, assistant professor, associate professor, and professor.[14] Medical education has a long history of structured and hierarchical practices. While these traditions have value, they can also discourage adaptability, creativity, and innovations, fostering environments where micromanagement thrives.[10] Besides, some leaders often view deviations from norms as risks rather than opportunities for growth, creativity, and innovation and thus pressure subordinates to fully comply with their views and instructions regardless of the outcomes or consequences.[5]

2.5. Rigid organizational structures

Health professions' education has traditionally operated within rigid frameworks. These systems, while ensuring accountability and maintaining order, often create environments conducive to micromanagement.[13,14] In some institutions, decision-making is centralized, and authority is concentrated at the top, with senior leaders or administrators exercising control over decisions that could otherwise be delegated to faculty members.[10] Thus, as a result faculty members may feel undervalued or excluded from critical discussions and decisions, further perpetuating micromanagement behaviors within the institution.[8] Also, adopting a top-down leadership approach worsens the situation by putting emphasis on obedience and compliance rather than achieving the desired institutional outcomes, discouraging faculty members from voicing concerns or challenging decisions.[14] Moreover, junior faculty may feel pressured to conform to established practices, even when they hinder creativity and innovations.[5]

Table 1: Root causes of micromanagement

S. No.	Root Causes
1	Lack of Leadership Training and Development
2	Performance Pressures due to Increasing Demand for Measurable Outcomes
3	Leaders Fear of Errors and its consequences
4	Cultural Norms in Medical and Health Professions Education
5	Rigid Organizational Structures

3. Effects of Micromanagement on Faculty Members

Micromanagement has far-reaching consequences for faculty members in medical and health professions education, including:

3.1. Reduced job satisfaction

One of the most immediate and significant effects of micromanagement is the reduction in job satisfaction among faculty members.[15,16] Excessive oversight and limited autonomy prevent faculty members from exercising their expertise and creativity, leading to frustration and disengagement.[4,17] Faculty subjected to micromanagement reported feeling undervalued and constrained, which diminished their sense of accomplishment and professional growth.[5,18] The inability to make independent decisions reduces faculty engagement and enthusiasm for their roles. Over time, this demotivation affects the quality of teaching, assessment, research, and mentorship provided by faculty leading to "erosion of motivation".[8,17] On top of that, constant scrutiny fosters a stressful work environment, where faculty feel pressured to meet unrealistic expectations without the freedom to approach tasks creatively.[10,19]

3.2. Burnout and emotional exhaustion

Micromanagement contributes significantly to faculty burnout, a phenomenon characterized by emotional exhaustion, depersonalization, and a diminished sense of accomplishment. Burnout among faculty not only affects their health but also compromises their ability to perform their roles effectively.[6] High-stress environments due to excessive monitoring and frequent reporting requirements create a sense of being constantly under surveillance, which exacerbates stress levels. Faculty who experiences micromanagement often report feeling emotionally drained, which affects their ability to cope with the demands of their roles.[8,20] Prolonged exposure to micromanagement can lead to anxiety, depression, and other mental health issues, further reducing faculty well-being and productivity.[10,11]

3.3. Stifled creativity and innovations

Micromanagement stifles the creativity and innovations required to adapt to the evolving needs of medical and health professions education.[19] Faculty members, restricted by rigid protocols and excessive oversight, are less likely to take risks or explore innovative approaches to teaching, assessment, and research.[21] As a result of fear of failure faculty members may avoid experimenting with novel teaching methods or research initiatives due to fear of negative repercussions from leadership.[10] Reduced Academic freedom and excessive emphasis on compliance with standards often limit faculty members' ability to develop creative and innovative solutions to educational challenges.[5,11] The stagnation of creativity and innovations among faculty members has an impact on institutional growth, as it hampers the ability to remain

competitive and adaptive to changes in medical and health professions' education.[8,21]

3.4. Decreased collaboration and trust

Micromanagement undermines trust and collaboration between faculty members and institutional leaders. The lack of trust inherent in micromanagement discourages open communication, collaboration, and teamwork.[21] Micromanaged faculty often perceive leaders as unapproachable or overly critical, which diminishes their willingness to engage in collaborative efforts and hence erode the faculty-leader relationships and productivity.[5,11] Furthermore, the competitive and rigid environment created by micromanagement can isolate faculty members, preventing the exchange of ideas and support among colleagues.[8,11]

3.5. Faculty retention challenges

High turnover rates among faculty members are a direct consequence of prolonged micromanagement. Institutions that fail to address micromanagement risk losing talented faculty members, which disrupts educational programs and increases recruitment costs.[10] Faculty who feels unsupported and undervalued are more likely to seek opportunities elsewhere, leading to frequent departures and institutional instability.[10] Departing faculty leave gaps in teaching, assessment, curriculum, research, quality requirement and mentorship responsibilities, placing additional burdens on remaining staff and exacerbating dissatisfaction.[5] High turnover rates negatively affect the institution's reputation, making it challenging to attract and retain top faculty talent.[8]

Table 2: Effect of micromanagement on faculty members

S. No.	Effect on Faculty Members
1	Reduced Faculty Members Job Satisfaction
2	Faculty Members Burnout and Emotional Exhaustion
3	Stifled Innovation and Creativity among Faculty Members
4	Decreased Collaboration and Trust between faculty and leaders
5	Faculty Retention Challenges

4. Strategies for Mitigation

Mitigating micromanagement in medical and health professions education requires systemic changes and targeted interventions to address its root causes, including:

4.1. Leadership training and development

Training equips leaders, administrators, and supervisors with the skills to balance the delicate boundaries between autonomy and accountability, oversight, and trust.[22] Also, training and development equip leaders with skills to manage subordinates effectively toward achieving institutional goals and as well provide them with safe space to innovate and excel in their work. Training programs should focus on effective delegation techniques, enabling leaders to assign responsibilities while maintaining accountability. This approach empowers faculty members and reduces micromanagement tendencies.[5] Additionally, leaders and supervisors should be trained to tailor their management styles based on individual faculty needs and competencies using "adaptive supervision models." Adaptive models promote collaboration and foster faculty independence, addressing the diverse challenges faced in academic and clinical settings. Furthermore, developing emotional intelligence among leaders can enhance their ability to build trust, empathize with faculty, and create a psychologically safe environment.[9,10]

4.2. Fostering psychological safety

Psychological safety is a critical factor in mitigating micromanagement, as it encourages faculty to take risks, share ideas, and learn from mistakes without fear of retribution. Institutions should adopt open door policies and establish regular feedback mechanisms, such as grand meetings, structured dialogues, or faculty forums, to facilitate transparent communication between faculty and leaders.[10,12] These forums can help address concerns and foster mutual understanding.[5,23] Leaders should also emphasize learning from errors rather than penalizing them. A growth-oriented approach to mistakes fosters resilience, creativity, innovations, and trust among faculty members. Moreover, leaders have to adopt inclusiveness and collaboration by encouraging a collaborative decision-making approach to ensure that faculty members feel valued and supported. Psychological safety is enhanced when leaders actively seek input from faculty members and involve them in key decisions.[10]

4.3. Promoting faculty autonomy

Restoring and promoting faculty autonomy is essential for mitigating the adverse effects of micromanagement. Empowering faculty to take ownership of their work fosters innovation, engagement, and professional satisfaction.[23] Through streamlining Administrative Tasks, institutions can reduce unnecessary bureaucratic processes and reporting requirements that limit faculty's ability to focus on meaningful activities such as teaching, assessment, curriculum design, quality requirement, research, and mentorship.[8] Also, establishing clear expectations and boundaries for faculty responsibilities helps avoid unnecessary oversight and provides clarity about the scope of their autonomy. Over and above that, acknowledging faculty contributions through formal recognition programs, incentives and rewards reinforces their value and encourages an independent decision-making approach.[10]

4.4. Building a culture of trust

A culture of trust is fundamental to reducing micromanagement. Leaders have to prioritize building relationships with faculty that are based on mutual respect and shared goals. Encouraging faculty members to take on leadership roles within their departments can foster a sense of ownership and collaboration. Faculty-led committees or task forces can help balance top-down and bottom-up decision-making approaches.[23,24] Institutions should prioritize transparency in policies and decisions that affect faculty. Clear communication about institutional goals and expectations builds trust and reduces feelings of surveillance. On top of that, developing mentorship programs between leaders, administrators and faculty fosters a collaborative atmosphere and reduces the perception of hierarchical control.

4.5. Institutional reforms

Systemic changes at the institutional level are necessary to address the structural and cultural factors that perpetuate micromanagement. Institutions should revise policies that inadvertently encourage micromanagement, such as rigid compliance metrics or excessive reporting requirements and instead, policies should emphasize outcomes that align with faculty development and innovation. Providing support and professional development opportunities to faculty members, such as workshops or sabbaticals, enables faculty to enhance their skills and confidence, reducing the need for excessive oversight.[10] Also, institutional reforms may include appropriate leaders monitoring and accountability mechanisms by implementing systems to monitor, evaluate and report leadership behaviours through well established and clear channels, ensuring that supervisors are held accountable for fostering supportive and empowering environments for their subordinate faculty members.[8,18]

Table 3: The mitigation strategies of the negative effects of micromanagement

S. No.	The Mitigation Strategies
1	Leadership Training and Development
2	Fostering Psychological Safety for Leaders and Faculty Members
3	Promoting Faculty Autonomy to enhance Creativity and Innovations
4	Building the Culture of Trust between faculty members and institutional leaders
5	Institutional Reforms

5. Conclusion

The root causes of micromanagement in medical and health professions education are multifaceted, encompassing lack of leadership training, hierarchical organizational structures, performance pressures, leaders fear of errors, and cultural norms. The effects of micromanagement on faculty members are profound, ranging from reduced job satisfaction and burnout to stifled innovation and retention challenges. Addressing these root causes requires systemic reforms, targeted leadership training and development, and as well a shift in institutional culture to prioritize faculty autonomy, collaboration, creativity, and innovation.

6. Source of Funding

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7. Conflict of Interest

None.

References

1. Yıldız Y. Micromanagement in management literature: a conceptual framework. *J Int Econ Finance Trade*. 2024;2(1):32–40.
2. Wale H. Delegating: sharing or transferring responsibilities or authority from a superior to a subordinate [Internet]. Corporate Finance Institute; 2023. Available from: https://corporatefinanceinstitute.com/resources/management/delegating/
3. van de Ridder JM, DeSanctis JT, Mookerjee AL, Rajput V. Micromanagement Creates a Nonconducive Learning Environment for a Teaching Team. *J Grad Med Educ*. 2020 Oct;12(5):639–40.
4. DiGangi, J. The anxious micromanager. Article from Harvard Business Review. 2023. Available from: https://hbr.org/2023/09/the-anxious-micromanager
5. Mookerjee, A., Li, B., Arora, B., et al. (2022). Micromanagement During Clinical Supervision: Solutions to the Challenges. Cureus, 14(3), e23523. https://doi.org/10.7759/cureus.23523.
6. Mookerjee A, Li B, Arora B, Surapaneni R, Rajput V, Van de Ridder M. Micromanagement During Clinical Supervision: Solutions to the Challenges. *Cureus*. 2022;14(3):e23523.
7. Akram Z, Sethi A, Khan AM, Zaidi FZ. Assessment of burnout and associated factors among medical educators. *Pak J Med Sci*. 2021;37(3):827–32.
8. Harden RM. Stress, pressure and burnout in teachers: is the swan exhausted? *Med Teach*. 1999;21(3):245–7.
9. Goldstein G, Atkinson J, Alarcon L, Blair E, Chartash D, Clark C, et al. Strategies to recognize and mitigate mistreatment of medical students Practical Advice Paper. *Educ Health (Abingdon)*. 2024;37:260–4.
10. Avolio BJ, Gardner WL, Walumbwa FO. Authentic leadership theory and practice: origins, effects, and development. *Organ Dyn*. 2019;48(3):234–44.
11. Lee J, Ahn S, Henning MA, van de Ridder JM, Rajput V. Micromanagement in clinical supervision: a scoping review. *BMC Med Educ*. 2023;23(1):563.
12. Ryan S, Cross C. Micromanagement and its impact on millennial followership styles. *Leadersh Organ Dev J*. 2024;45(1):140–52.
13. White RD Jr. The micromanagement disease: symptoms, diagnosis, and cure. *Public Pers Manage*. 2010;39(1):71–6.
14. Cunha MPE, Rego A, Gonzalez M, Ribeiro N. Understanding the drivers of managers' behaviors: A meta-analysis of past experiences and role modeling. *J Manage.* 2021;47(3):719–46.
15. Bélanger JJ, Edwards AM. Beyond leadership: The role of organizational culture in influencing micromanagement. *J Occup Organ Psychol.* 2020;93(3):605–27.
16. Yang Y, Yang Y, Xiong Y. How and when micromanagement stifles employee voice: The roles of moral disengagement and leader-member exchange. *Pers Rev.* 2019;48(5):1404–22.
17. Leong M. Leadership styles and its impact on employee morale: an exploratory study [Internet]. Northridge (CA): California State University, Northridge; 2019. Available from: https://scholarworks.calstate.edu/downloads/7h149t04j

18. Sethi A, Ajjawi R, McAleer S, Schofield S. Exploring the tensions of being and becoming a medical educator. *BMC Med Educ*. 2017;17(1):62.
19. Delgado O, Strauss EM, Ortega MA. Micromanagement: when to avoid it and how to use it effectively. *Am J Health-Syst Pharm.* 2015;72(10):772–6.
20. Lee J, Kim H, Kang J. The dark side of clear instructions: Micromanagement and self-determination. *J Organ Behav.* 2021;42(2):231–49.
21. Zhang Y, Bartol KM. Linking empowering leadership and employee creativity: The influence of psychological empowerment, intrinsic motivation, and creative process engagement. *Acad Manage J*. 2010;53(1):107–28.
22. Maslach C, Leiter MP. Understanding the burnout experience: recent research and its implications for psychiatry. *World Psychiatry*. 2016;15(2):103–11.
23. Smith S. Are you a micromanager? Risks and rewards [Internet]. American Management Association; 2019. Available from: https://www.amanet.org/articles/are-you-a-micromanager-risks-andrewards/
24. Huang CY, Chiu WC, Lee CC. Centralization hurts agility: The moderating role of open communication. *J Bus Res*. 2021;125:147–55.
25. Landry L. How to stop micromanaging your employees [Internet]. Harvard Business School Online; 2020. Available from: https://online.hbs.edu/blog/post/how-to-stop-micromanaging
26. Martin R, Epitropaki O, Erdogan B, Thomas G. Relationship-based leadership: Current trends and future prospects. *J Occup Organ Psychol.* 2019;92(3):465–74.

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