International Journal of Latest Research in Humanities and Social Science (IJLRHSS)
Volume 08 - Issue 10, 2025
www.ijlrhss.com || PP. 39-46

Educative Leadership and the Integration of Traditional and Alternative Medicine for Comprehensive Global Health

Reynold J.S. Macpherson
Professor (Retired), University of Auckland, Auckland, New Zealand

Abstract: This paper explores how educative leadership might inform the integration of traditional and alternative medicines in comprehensive global health. It offers a four-part meta-ethical framework developed to customise practical theory building about educative leadership in diverse cultural, epistemological and moral contexts. It then applies the framework to traditional and alternative medicines with a view to their integration into global health systems. The paper argues that both educational and health systems must transcend reductionist models by integrating moral philosophies such as virtue ethics, care ethics, and relational ethics with systems-thinking and participatory governance. Through some international examples, the paper illustrates how culturally grounded leadership can foster equity, well-being, and systemic transformation. Readers are invited to consider how these integrative leadership principles can guide the incorporation of traditional medical knowledge into global health systems, ensuring respect for diverse moral, epistemological, and spiritual traditions. It is concluded that interdisciplinary dialogue is vital for building responsive, ethical institutions in an increasingly pluralistic world.

Keywords: Educative leadership, global health integration, traditional and alternative medicine, moral and ethical frameworks, cultural and epistemological diversity

Introduction

Major international reports (OECD, 2020, 2021; UNESCO, 2024) highlight how leading theories of educative leadership are grounded in distinct moral philosophies:

- **Transformational leadership** is rooted in virtue ethics, emphasizing moral character and the cultivation of shared values to inspire collective growth (Shields, 2010).
- **Instructional leadership** reflects rule-based deontology, stressing duty-bound obligations to uphold high teaching and learning standards (Hallinger, 2005).
- **Distributed leadership** draws on democratic ethics, promoting collaboration, shared authority, and mutual respect among stakeholders (Spillane, 2006).
- **Ethical leadership** aligns with care ethics, focusing on empathy, relational responsibility, and concern for the well-being of all community members (Shapiro & Stefkovich, 2016).
- **Adaptive leadership** is guided by pragmatic moral reasoning, valuing flexibility and responsiveness to complex and evolving challenges (Heifetz, Grashow, & Linsky, 2009).
- **Culturally responsive leadership** incorporates relational ethics and communitarian moral philosophy, prioritizing cultural identity, reciprocity, and interdependence (Khalifa, Gooden, & Davis, 2016).

These moral orientations are intertwined with deeper metaphysical and ontological assumptions about human nature, agency, and the meaning of leadership. As Taylor (1989) argues, moral frameworks are inseparable from the broader metaphysical visions that shape how individuals and cultures define what is good, who we are, and how we relate to others.

Understanding these foundational beliefs involves examining the epistemological and metaphysical orientations underlying leadership and organizational change. Burrell and Morgan's (1979) four sociological paradigms offer a useful framework for this purpose, each reflecting a distinct worldview that influences how leaders conceptualize knowledge, power, agency, and transformation:

- **Functionalism** emphasizes order, control, and efficiency. It aligns with technical-rational leadership approaches but often overlooks the relational and spiritual dimensions central to Indigenous and holistic worldviews (Durkheim, 1912/1995; Parsons, 1951; Wilson, 2008; Battiste, 2002).
- **Radical structuralism** foregrounds systemic inequality and institutional oppression, providing a critical lens on power dynamics. However, it tends to marginalize the metaphysical and spiritual insights found in many non-Western traditions (Apple, 1995; Shahjahan, 2005).
- **Interpretivism** focuses on meaning-making, cultural subjectivity, and human experience. It opens pathways for educational leaders to engage with diverse epistemologies and value systems, including Indigenous and non-Western perspectives (Denzin & Lincoln, 2018; Geertz, 1973; Chilisa, 2012).

- **Radical humanism** emphasizes human consciousness, emancipation, and the critique of dominant ideologies. It aligns with transformative leadership practices rooted in moral and spiritual agency and supports the reclamation of non-Western and ancient moral philosophies in educational settings (Dei, 2000; Ngunjiri, 2016; Kincheloe & McLaren, 2005).

These paradigms broaden the ethical, epistemological, and metaphysical foundations of leadership theory. By acknowledging the dialectical relationship between ethics and metaphysics, scholars and practitioners can cultivate more culturally inclusive and philosophically diverse frameworks for developing practical theories of educative leadership.

To advance this inclusivity, I have proposed a four-part meta-ethical framework that synthesizes holistic pragmatism, relational ethics, virtue ethics, and key elements of postmodern ethical critique (Macpherson, 2025). This integrative approach is designed to support educative leaders in navigating morally and culturally complex environments with greater contextual sensitivity and responsiveness. The framework draws significantly from research undertaken in partnership to help pioneer school-based integrated health centres in UK secondary schools and from evaluations of Cornwall Foundation Trust's capacity to implement the UK government's mental health strategy for children and young people (Macpherson, 2013; Macpherson & Vann, 2019).

Readers are now invited to explore how this framework can inform the integration of traditional and alternative medical practices into global health systems, in ways that honour diverse ethical, epistemological, and metaphysical traditions.

The Moral Philosophies of Traditional, Alternative and Western Medicine

Traditional, alternative, and Western medical systems are each underpinned by distinct moral philosophies, shaped by their cultural, spiritual, and epistemological foundations. These systems embody differing conceptions of health, healing, and human dignity.

- **Traditional medicine**, often rooted in Indigenous knowledge systems, is guided by *relational ethics* and *communitarian moral philosophy*. It emphasizes harmony with nature, collective well-being, and respect for ancestral wisdom, viewing health as a balance among spiritual, social, and environmental forces (WHO, 2013; Wilson, 2008; Kirmayer, 2012).
- **Alternative medicine**—including practices such as homeopathy, naturopathy, and energy therapies—is typically grounded in *holistic pragmatism* and *virtue ethics*. It values individual agency, natural healing, and the cultivation of personal well-being through minimally invasive, self-regulating approaches (Baer, 2001; Jonas, 2005). Although some alternative practices draw upon traditional knowledge systems, the broader field of alternative medicine has evolved within contemporary wellness and consumer health industries (Adams et al., 2012).
- **Western biomedicine**, by contrast, is primarily structured around *principlism*—an ethical framework that integrates *deontological* and *utilitarian* elements. This model is articulated through four central bioethical principles: autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2013). These principles aim to guide clinical decision-making within a system that privileges objectivity, individual rights, and evidence-based practice.

Both traditional and alternative practices operate within epistemological frameworks distinct from Western scientific paradigms. They prioritize experiential knowledge, oral transmission, and community validation over empirical generalizability or randomized controlled trials. This divergence presents both conceptual and practical challenges to their integration into formal health care systems (Bodeker & Ong, 2005).

- **Epistemological Divergence**. Western biomedicine privileges quantitative evidence, replicability, and randomized controlled trials as the standard for medical validation. In contrast, traditional systems rely on community-embedded, experiential, and spiritual knowledge forms (Bodeker & Ong, 2005). This disparity can lead to tensions regarding what is recognized as legitimate medical knowledge, hindering the inclusion of traditional therapies within institutional frameworks.
- **Regulatory and Standardization Complexity**. Integrating diverse medical systems also raises complex regulatory issues, including licensing, quality control, accreditation, and intellectual property rights. These challenges are particularly acute in cross-cultural settings, where traditional knowledge is often communally owned and transmitted orally, making it difficult to codify within biomedical or legal systems (Langwick, 2011).
- **Ethical and Cultural Considerations**. Efforts to integrate must avoid epistemic colonization—the co-optation or marginalization of traditional systems by dominant biomedical models. Ethical integration

requires genuine community engagement, respect for cultural autonomy, and the development of participatory, culturally grounded governance structures (Waldram, 2000; WHO, 2013).

While integration offers the potential for more comprehensive health care—particularly in areas like chronic disease management, mental health, and preventative care—it demands thoughtful, interdisciplinary approaches. Effective integration depends on the recognition of plural epistemologies, culturally sensitive policymaking, and frameworks that foster ethical dialogue across traditions. Ultimately, a respectful and inclusive approach can enrich global health systems by honouring the diverse ways humans understand and promote well-being.

Intersections between Educative Leadership and Integrated Medical Health Practices

Educative leadership and integrated medical health practices share several conceptual and practical intersections, particularly in their commitment to holism, intercultural competence, systemic transformation, moral reasoning, and inclusive stakeholder engagement. Both fields increasingly advocate for

- **Paradigm Shifts.** Away from reductive, technocratic models toward approaches that honor diverse values, knowledge systems, and practices.
- **Holism**. Models that acknowledge the interplay between moral, epistemological, metaphysical, and organizational dimensions.
- **Integration.** Departure from siloed, reductionist paradigms in favour of reflecting the multifaceted nature of human development and well-being (Kirmayer, 2012; WHO, 2013).
- **Collaborative leadership**. Partnerships across cultural and disciplinary boundaries, encouraging mutual respect and knowledge sharing between biomedical and traditional practitioners (WHO, 2013; Bezuidenhout et al., 2022).
- **Transformative leadership**. Systemic change through empowerment and ethical engagement, addressing power imbalances and promoting health equity (Frenk et al., 2010; Kickbusch & Gleicher, 2012).

To clarify, transformational and transformative leadership both emphasize change, ethical leadership, and the development of followers, but they differ in focus and scope. Transformational leadership, as defined by Burns (1978), seeks to inspire and motivate individuals toward higher levels of performance by aligning followers with a shared vision and fostering personal growth. In contrast, transformative leadership, articulated by Shields (2010), goes further by explicitly addressing issues of equity, social justice, and systemic change. While both models value moral purpose and empowerment, transformative leadership challenges existing power structures and works to reshape institutions in pursuit of greater social equity.

The adoption of systems thinking is another intersection between educative leadership and integrated medical health practices. Health is viewed as a complex, adaptive system with integrative governance frameworks that align diverse medical paradigms (de Savigny & Adam, 2009). The World Health Organization's Traditional Medicine Strategy 2014–2023 underscores the importance of system leadership in achieving universal health coverage by institutionalizing traditional medicine through appropriate policies, regulation, and evidence-based integration (WHO, 2013). These approaches require leaders who are not only culturally competent but also capable of navigating ethical, scientific, and political challenges in global health governance (Van Lerberghe et al., 2008).

Epistemological pluralism marks another key intersection. Educative leadership increasingly entails navigating intercultural dialogue and moral reasoning across Indigenous, Eastern, and Western traditions (OECD, 2021). This parallels the epistemic foundations of many traditional medical systems, which rely on oral histories, embodied practices, and spiritual worldviews—forms of knowledge historically marginalized by biomedical discourse (Adams et al., 2012). In both fields, effective leadership requires epistemic humility and intercultural competence, grounded in respect for multiple ways of knowing.

A strong orientation toward transformative practice and systemic change is shared in both fields. In education, leadership has evolved from hierarchical and managerialist models toward distributed, ethical, and culturally responsive frameworks (Shields, 2010; Khalifa et al., 2016; OECD, 2020). Similarly, global health is increasingly embracing patient-centered, integrative care grounded in local cultural and contextual realities (Bodeker & Ong, 2005). Leaders in both domains must be not only strategically adept but also morally grounded, capable of facilitating innovation across paradigms and institutions.

The integration of moral philosophy into professional practice represents another significant point of intersection. In education, ethical frameworks such as virtue ethics (MacIntyre, 1984), care ethics (Gilligan, 1982; Noddings, 2005), and relational ethics (Strike, 1990) are increasingly used to guide leadership decisions—emphasizing character, empathy, and attentiveness to the needs of others. Similarly, many traditional medical systems embed moral and spiritual principles—such as harmony, balance, and reverence for nature and elders—within their healing practices (WHO, 2013). These shared moral commitments offer fertile ground for cross-sectoral learning and collaborative development in ethical decision-making and relational accountability.

Finally, **comparable challenges in governance, policy, and stakeholder engagement** are faced in both education and health systems. Leaders in both sectors must navigate complex, often contested networks that include governments, Indigenous communities, civil society, and private entities. The sustainability and legitimacy of reform efforts depend on inclusive and participatory processes. Conceptual frameworks such as Freeman's (2010) stakeholder theory and deliberative models of democracy (Gutmann & Thompson, 2004) offer valuable tools for managing competing interests and negotiating diverse moral perspectives in pluralistic settings.

In sum, the convergence of educative leadership and integrated medical health practices lies in their shared pursuit of inclusive, ethically grounded, and epistemologically pluralistic systems (Kirmayer, 2012). These intersections open pathways for rich cross-disciplinary dialogue and mutual learning, particularly as both fields seek to serve increasingly diverse and globalized populations.

Implications of Conceptual and Practical Intersections

Both educative leadership and integrating global health are, at their core, moral enterprises (McGregor, 2004). They involve normative judgments about what constitutes well-being, justice, and flourishing, and operate within systems that differentially value certain knowledge traditions and lived experiences. Moral philosophies such as virtue ethics, care ethics, and relational ethics offer powerful frameworks for reconceptualizing leadership—not as a matter of technical efficiency or bureaucratic compliance, but as a practice of ethical discernment, responsiveness, and responsibility.

In education, the shift from traditional instructional leadership to more transformational, distributed, and ethical leadership models reflects this moral reorientation (Burns, 1978; Gronn, 2002). Transformational leaders are not merely accountable for academic performance; they are tasked with fostering inclusive, equitable, and culturally sustaining environments. Similarly, leaders in integrative medicine must navigate the tensions between biomedical rationalism and Indigenous or traditional healing systems—systems that often prioritize reciprocity, spiritual wellness, and holistic balance over reductionist diagnosis.

At the heart of these evolving paradigms is a deeper metaphysical shift: a move from dualism to holism. Cartesian dualism, which has shaped Enlightenment science and colonial governance, separates mind from body, reason from emotion, and the individual from the community (Merchant, 1980). This ontological framework has deeply influenced both Western education and biomedicine, producing fragmented systems and hierarchical knowledge structures.

In contrast, many Indigenous, traditional, and non-Western epistemologies are rooted in relational metaphysics—worldviews in which knowledge, health, and learning emerge through interdependent relationships among people, land, spirit, and the more-than-human world (Wilson, 2008; Cajete, 2000). These ontologies challenge mechanistic and linear models, opening space for leadership approaches that are attentive to complexity, context, and connection (Shankar & Patwardhan, 2017).

In educative leadership, such metaphysical grounding supports culturally sustaining pedagogies that centre diverse worldviews and prioritize collective well-being (Paris & Alim, 2014; Zins et al., 2004). In health, it enables the integration of traditional systems—such as Ayurveda, Unani, and Māori rongoā—that understand illness and healing through ecological and spiritual dimensions.

From these shared moral and metaphysical foundations emerge four key capacities that could inform leadership across both education and health sectors:

1. **Epistemic Humility** – The recognition of the limits of one's own knowledge and an openness to other ways of knowing (Code, 1991). This is critical when working with traditional healers or engaging with culturally diverse communities in classrooms or clinics.
2. **Moral Reflexivity** – The ability to critically reflect on one's own values, assumptions, and positionality, especially when operating across cultural boundaries (Shapiro & Stefkovich, 2016).
3. **Intercultural Fluency** – The skill to respectfully navigate cultural difference with empathy, awareness of power dynamics, and a commitment to equity (Gay, 2010; Durie, 2004).

4. **Systemic Relationality** – A systems-thinking orientation that understands institutions and communities as interdependent, dynamic networks, and seeks to nurture balance, cohesion, and sustainability (Capra & Luisi, 2014).

Examples from practice further illuminate these principles. In Aotearoa New Zealand, initiatives like Whānau Ora in health (Durie, 2003) and Te Kotahitanga in education (Bishop et al., 2009) demonstrate how leadership grounded in Māori relational values can support more equitable outcomes. Similarly, Brazil's Unified Health System (SUS) has incorporated traditional therapies through mechanisms of participatory governance, affirming a commitment to intercultural leadership and epistemic justice (Giovanella et al., 2018; Paim, 2013). These cases show that moral and metaphysical integration is not merely conceptual—it is a practical imperative in increasingly multicultural and transdisciplinary contexts.

Conclusions

Bridging moral philosophies and metaphysical paradigms across sectors reveals a shared pathway toward more just, responsive, and holistic forms of leadership. Whether in schools or health systems, effective leadership in the 21st century must transcend narrow disciplinary confines and engage with the ethical and ontological dimensions of human well-being. Such an integrative vision holds transformative potential for building institutions rooted not only in evidence and efficiency, but also in wisdom, empathy, and deep respect for the diverse moral worlds we inhabit.

In the 21st century, global challenges such as climate change, health inequities, cultural erosion, and epistemic injustice call for new paradigms of thought and leadership. Two seemingly distinct fields—educative leadership and integrative medicine—have emerged as critical sites for developing holistic, ethical, and inclusive responses to these complex issues. While educative leadership shapes the values, knowledge systems, and relational dynamics within institutions, integrative global health seeks to reconcile biomedical science with traditional and alternative healing systems grounded in non-Western metaphysical worldviews.

This paper examines the intersection of these domains, arguing that moral philosophy and metaphysical paradigms offer fertile common ground for reimagining leadership and healing. In education, ethical frameworks such as virtue ethics, care ethics, and constructivism provide foundational principles for leading with empathy, moral responsibility, and a commitment to communal well-being. These approaches are particularly resonant in diverse or Indigenous contexts, where relational leadership and inclusive practice are essential.

Likewise, traditional and alternative medical systems are rooted in metaphysical understandings of health as a dynamic balance between body, spirit, community, and environment. These systems emphasize harmony and interconnectedness, challenging the reductionist tendencies of Western biomedicine and promoting a broader, more relational view of healing.

Despite their disciplinary differences, educative leadership and traditional healing share several core ethical and ontological commitments. Both are grounded in the principle of interconnectedness, expressed through Indigenous and Eastern philosophies such as Ubuntu and Confucianism. Both emphasize holistic development—seen in the alignment between educational movements that promote social-emotional learning and ecological citizenship, and healing systems that view well-being as ecological and spiritual as much as physical. Reciprocity, care, and compassion are central in both domains, linking the ethics of leadership with the ethics of healing. Ancient wisdom traditions—such as Stoicism, Taoism, and Māori cosmology—further support an integrated view in which knowledge, virtue, and health are co-constitutive.

Viewing leadership as a form of healing reframes the leader's role as one of restoring balance, cultivating growth, and attending to the moral and emotional needs of a community. Models such as transformative and distributed leadership echo the roles of traditional healers—figures who guide, listen, and mediate dissonance with relational wisdom. Educators who draw on holistic or Indigenous leadership paradigms engage not only in institutional management but also in moral and cultural stewardship.

Central to this integration is epistemological pluralism. Just as integrative medicine legitimizes oral traditions, spiritual knowledge, and experiential insight alongside empirical science, educational leadership must embrace diverse ways of knowing in curriculum design and policymaking. This pluralism affirms the importance of cultural epistemologies, enabling practices that are scientifically grounded while also culturally responsive.

Educational and healthcare institutions alike can be understood as moral ecosystems—spaces where structural justice, cultural diversity, and spiritual meaning intersect. Leaders within these systems are called to act with care, justice, and humility. Initiatives like Aotearoa New Zealand's Whānau Ora and tribal education-health partnerships in Native American communities exemplify how integrative approaches can support culturally grounded, equitable outcomes.

Interdisciplinary curriculum design also benefits from this convergence. Educational programs that incorporate traditional ecological knowledge, mindfulness, and intercultural health literacy not only enhance student engagement but also foster competencies essential for global citizenship and planetary well-being. These approaches illustrate the transformative potential of aligning leadership with holistic health principles.

Yet significant challenges persist. Meaningful integration of leadership and healing must avoid cultural appropriation by ensuring respectful, reciprocal partnerships with knowledge holders and a steadfast commitment to epistemic justice. Institutional structures—often siloed and driven by performance metrics—can resist metaphysical or ethical discourse, making systemic change difficult. Navigating these barriers demands not only creative and courageous leadership but also openness to fundamentally different ways of knowing and being.

Moving forward, there is a pressing need for a new integrative framework—one that unites leadership and healing through ethical pluralism, epistemological humility, and ecological consciousness. Such a vision invites collaboration among educators, health practitioners, Indigenous leaders, and scholars to co-create inclusive, sustainable, and healing-centred systems of learning and care.

References

[1]. Adams, J., Andrews, G., Barnes, J., Broom, A., & Magin, P. (2012). *Traditional, complementary and integrative medicine: An international reader*. Palgrave Macmillan.
[2]. Apple, M. W. (1995). *Education and power* (2nd ed.). Routledge.
[3]. Baer, H. A. (2001). *Biomedicine and alternative healing systems in America: Issues of class, race, ethnicity, and gender*. University of Wisconsin Press.
[4]. Battiste, M. (2002). *Indigenous knowledge and pedagogy in First Nations education: A literature review with recommendations*. National Working Group on Education and the Minister of Indian Affairs Indian and Northern Affairs Canada.
[5]. Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). Oxford University Press.
[6]. Bezuidenhout, L. M., Borry, P., & De Vries, J. (2022). *Global health research ethics: A casebook*. Springer.
[7]. Bishop, R., Berryman, M., Cavanagh, T., & Teddy, L. (2009). Te Kotahitanga: Addressing educational disparities facing Māori students in New Zealand. *Teaching and Teacher Education, 25*(5), 734–742. https://doi.org/10.1016/j.tate.2009.01.009
[8]. Bodeker, G., & Ong, C.-K. (2005). *WHO global atlas of traditional, complementary and alternative medicine* (Vols. 1–2). World Health Organization.
[9]. Brookfield, S. D. (2005). *The power of critical theory: Liberating adult learning and teaching*. Jossey-Bass.
[10]. Burns, J. M. (1978). *Leadership*. Harper & Row.
[11]. Burrell, G., & Morgan, G. (1979). *Sociological paradigms and organizational analysis: Elements of the sociology of corporate life*. Heinemann.
[12]. Cajete, G. (2000). *Native science: Natural laws of interdependence*. Clear Light Publishers.
[13]. Capra, F., & Luisi, P. L. (2014). *The systems view of life: A unifying vision*. Cambridge University Press.
[14]. Chilisa, B. (2012). *Indigenous research methodologies* (2nd ed.). SAGE Publications.
[15]. Code, L. (1991). *What can she know? Feminist theory and the construction of knowledge*. Cornell University Press.
[16]. de Savigny, D., & Adam, T. (Eds.). (2009). *Systems thinking for health systems strengthening*. Alliance for Health Policy and Systems Research/World Health Organization.
[17]. Dei, G. J. S. (2000). Rethinking the role of Indigenous knowledges in the academy. *International Journal of Inclusive Education, 4*(2), 111–132. https://doi.org/10.1080/136031100284849
[18]. Denzin, N. K., & Lincoln, Y. S. (Eds.). (2018). *The SAGE handbook of qualitative research* (5th ed.). SAGE.
[19]. Durie, M. (2003). Providing health services to Indigenous peoples: A combination of conventional services and Indigenous programmes is needed. *BMJ, 327*(7412), 408–409. https://doi.org/10.1136/bmj.327.7412.408
[20]. Durie, M. (2004). Understanding health and illness: Research at the interface between science and Indigenous knowledge. *International Journal of Epidemiology, 33*(5), 1138–1143.
[21]. Durkheim, E. (1995). *The elementary forms of religious life* (K. E. Fields, Trans.). Free Press. (Original work published 1912)
[22]. Freeman, R. E. (2010). *Strategic management: A stakeholder approach*. Cambridge University Press. (Original work published 1984)

[23]. Freire, P. (1970/2000). *Pedagogy of the oppressed* (30th anniversary ed.). Continuum.
[24]. Frenk, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, T., ... &Zurayk, H. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet, 376*(9756), 1923–1958. https://doi.org/10.1016/S0140-6736(10)61854-5
[25]. Gay, G. (2010). *Culturally responsive teaching: Theory, research, and practice* (2nd ed.). Teachers College Press.
[26]. Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Harvard University Press.
[27]. Giovanella, L., Mendoza-Ruiz, A., Pilar, A. C. A., Rosa, M. C. D., Martins, G. B., Santos, I. S., Silva, D. B., Vieira, J. M. L., Castro, V. C. G., Silva, P. O. D., & Machado, C. V. (2018). Universal health system and universal health coverage: assumptions and strategies. *Ciencia &saudecoletiva*, *23*(6), 1763–1776. https://doi.org/10.1590/1413-81232018236.05562018
[28]. Gronn, P. (2002). Distributed leadership as a unit of analysis. *The Leadership Quarterly, 13*(4), 423–451. https://doi.org/10.1016/S1048-9843(02)00120-0
[29]. Gutmann, A., & Thompson, D. (2004). *Why deliberative democracy?* Princeton University Press.
[30]. Hallinger, P. (2005). Instructional leadership and the school principal: A passing fancy that refuses to fade away. *Leadership and Policy in Schools, 4*(3), 221–239. https://doi.org/10.1080/15700760500244793
[31]. Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership: Tools and tactics for changing your organization and the world*. Harvard Business Press.
[32]. hooks, b. (1994). *Teaching to transgress: Education as the practice of freedom*. Routledge.
[33]. Jonas, W. B. (2005). The ethics of complementary and alternative medicine. *The Journal of Law, Medicine & Ethics, 33*(2), 224–231. https://doi.org/10.1111/j.1748-720X.2005.tb00597.x
[34]. Khalifa, M., Gooden, M. A., & Davis, J. E. (2016). Culturally responsive school leadership: A synthesis of the literature. *Review of Educational Research, 86*(4), 1272–1311. https://doi.org/10.3102/0034654316630383
[35]. Kickbusch, I., & Gleicher, D. (2012). *Governance for health in the 21st century*. WHO Regional Office for Europe.
[36]. Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry, 49*(2), 149–164. https://doi.org/10.1177/1363461512444673
[37]. Langwick, S. A. (2011). *Bodies, politics, and African healing: The matter of maladies in Tanzania*. Indiana University Press.
[38]. MacIntyre, A. (1984). *After virtue: A study in moral theory* (2nd ed.). University of Notre Dame Press.
[39]. Macpherson, R. J. S. (2025). Bridging moral philosophies and metaphysical paradigms: rethinking educative leadership for diverse organizational contexts. *Ethics and Education*, 20(2–3), 319–342. https://www.tandfonline.com/doi/full/10.1080/17449642.2025.2495508
[40]. Macpherson, R.J.S. (2013). Evaluating three school-based integrated health centres established by a partnership in Cornwall to inform future provision and practice, *International Journal of Educational Management*, 27(5), 470 – 504.
[41]. Macpherson, R.J.S. and Vann, B.J. (2019). Cornwall Foundation Trust's capacity to implement the government's children and young people's mental health strategy, *International Journal of Educational Management*, 33(6), 1442-1456. DOI:10.1108/IJEM-02-2019-0039
[42]. McGregor, D. (2004). Coming full circle: Indigenous knowledge, environment, and our future. *The American Indian Quarterly, 28*(3–4), 385–410.
[43]. Merchant, C. (1980). *The death of nature: Women, ecology, and the scientific revolution*. Harper & Row.
[44]. Ngunjiri, F. W. (2016). Living and researching from a faith-full perspective: The quest for meaning. *International Journal of Qualitative Studies in Education, 29*(5), 620–631. https://doi.org/10.1080/09518398.2015.1065740
[45]. Noddings, N. (2005). *The challenge to care in schools: An alternative approach to education*. Teachers College Press.
[46]. Organisation for Economic Co-operation and Development. (2020). *Schooling redesigned: Towards innovative learning systems*. OECD Publishing. https://doi.org/10.1787/259b53f2-en
[47]. Organisation for Economic Co-operation and Development. (2021). *Leading education for global and inclusive societies*. OECD Publishing. https://doi.org/10.1787/3666be03-en
[48]. Paim, J. (2013). The Brazilian health system: History, advances, and challenges. *The Lancet, 377*(9779), 1778–1797. https://doi.org/10.1016/S0140-6736(11)60054-8

[49]. Paris, D., & Alim, H. S. (2014). *Culturally sustaining pedagogies: Teaching and learning for justice in a changing world*. Teachers College Press.
[50]. Parsons, T. (1951). *The social system*. Free Press.
[51]. Shahjahan, R. A. (2005). Spirituality in the academy: Reclaiming from the margins and evoking a transformative way of knowing the world. *International Journal of Qualitative Studies in Education, 18*(6), 685–711. https://doi.org/10.1080/09518390500298188
[52]. Shankar, D., & Patwardhan, B. (2017). AYUSH for New India: Vision and strategy. *Journal of Ayurveda and Integrative Medicine, 8*(3), 137–139.
[53]. Shapiro, J. P., & Stefkovich, J. A. (2016). *Ethical leadership and decision making in education: Applying theoretical perspectives to complex dilemmas* (4th ed.). Routledge.
[54]. Shields, C. M. (2010). Transformative leadership: Working for equity in diverse contexts. *Educational Administration Quarterly, 46*(4), 558–589. https://doi.org/10.1177/0013161X10375609
[55]. Spillane, J. P. (2006). *Distributed leadership*. Jossey-Bass.
[56]. Strike, K. A. (1990). The ethics of teaching. *Review of Research in Education, 16*, 371–406.
[57]. Taylor, C. (1989). *Sources of the self: The making of the modern identity*. Harvard University Press.
[58]. United Nations Educational, Scientific and Cultural Organization. (2024). *Global education monitoring report 2024/5: Leadership in education: Lead for learning*. UNESCO Publishing. https://doi.org/10.54676/ZNLI9227
[59]. Van Lerberghe, W., Evans, T., & Rasanathan, K. (2008). *The World health report 2008: Primary health care – now more than ever*. World Health Organization.
[60]. Waldram, J. B. (2000). The efficacy of traditional medicine: Current theoretical and methodological issues. *Medical Anthropology Quarterly, 14*(4), 603–625. https://doi.org/10.1525/maq.2000.14.4.603
[61]. Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Fernwood Publishing.
[62]. World Health Organization. (2013). *WHO traditional medicine strategy: 2014–2023*. World Health Organization. https://apps.who.int/iris/handle/10665/92455
[63]. Zins, J. E., Weissberg, R. P., Wang, M. C., & Walberg, H. J. (Eds.). (2004). *Building academic success on social and emotional learning: What does the research say?* Teachers College Press.

Bio

Reynold Macpherson completed his PhD at Monash University, served as a Senior Lecturer at the University of New England, and was Associate Professor at the University of Tasmania. He was then Professor and Director of the Centre of Professional Development at the University of Auckland before being appointed as CEO of Waiariki Institute of Technology. He was appointed Foundational Chancellor, CEO and Professor of Strategic Management at Abu Dhabi University. Since retirement he has been engaged in a range of international consultancies. He has published 17 books and 90 research articles.

Patient and Public Involvement Statement

It was not appropriate or possible to involve patients or the public in the design, or conduct, or reporting, or dissemination of the research.