ADDRESSING THE HEALTHCARE LEADERSHIP CRISIS:
CONSTRUCTING, TESTING AND APPLYING MODERN LEADERSHIP THEORY

A Dissertation in
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by
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ABSTRACT

Leadership is practiced in dissonant manifestations of our ambiguous cultural understanding of what leaders are and what they do. The leadership field labors in a definitional quagmire that has produced a surfeit of theories and research about leadership. Nevertheless, it remains unclear what a leader is, and what behaviors, roles, and actions qualify as leadership, and which do not. This dissertation was inspired by the perception of a compelling need to define leadership better and obtain a greater understanding of how leadership can be developed and effectively practiced.

I describe in this dissertation a process by which a theory of leadership was conceptualized, constructed, situated in the literature, tested, and applied to the practice of leadership. This process was recursive, dynamic, and incremental. The initial theory, constructed through the use of a qualitative study, was refined several times throughout the process to reflect the ongoing flow of information and insights realized at different stages of the dissertation. It is a powerful theory that provides valuable insights into leadership, but it is also a dynamic theory that will grow and evolve as additional research provides new insights into its principles.

Constructed using Grounded Theory methodology, Dynamic Leadership Theory (DLT) proposes that leadership is defined as changing the cognitive processes of individuals or groups. Constructive leadership is leaders’ infusion of positive, aligned meaning. Ineffective leadership occurs when leaders fail to affect an individual’s or group’s meaning or purpose. Destructive leadership occurs when leaders diminish or destroy meaning. Leadership is a dynamic process that can occur in networks, as an emergent phenomenon, and that changes frequently depending on the circumstances and individuals involved. Leadership is dependent on relationships, communication, positivism, resilience, and self-efficacy as the means by which leaders infuse meaning into a group.
These principles were tested by the quantitative analysis of a survey of 308 healthcare leaders in Central Pennsylvania. Of the theory’s five hypotheses, three were confirmed and two were partially confirmed. Relationships were found to be significantly correlated with Constructive Leadership. Communication, positivism and resiliency were found to be powerful moderators of the association between relationships and Constructive Leadership. Self-efficacy was shown to be a significant moderator of the effects of these three variables on relationships. Significant covariation between communication, resilience and positivism allowed them to be combined into a single variable, which in turn resulted in a more parsimonious but statistically robust model of DLT. The revised theory provides crucial insights into the effective practice of leadership, the ways in which leadership can be ineffective or destructive, and ways in which leadership can be developed.

DLT provides important contributions to the field of leadership. It defines leadership based on a cognitive ontology in a way that allows for the construction of a comprehensive theory of leadership. It describes a spectrum of leadership manifestations, from Constructive to Ineffective to Destructive, which allows a better understanding of how different behaviors fit into the leadership rubric, and how leaders can be developed and evaluated. It identifies key contributing factors to leadership, including relationships, communication, resilience, positivism and self-efficacy, and presents the connections between these variables as they affect the practice of leadership. It incorporates the dynamic nature of leadership into our understanding of the term, noting that leaders and leadership evolve and change frequently depending on the context of the situation. It also highlights the potential risks of applying quantitative methods to behavioral variables.

DLT is built upon the concepts of other major leadership theories, and provides opportunities for continued development and refining of these leadership principles.
# TABLE OF CONTENTS

List of Figures ........................................................................................................................................... x

List of Tables ................................................................................................................................................ xi

Acknowledgements ......................................................................................................................................... xii

Chapter 1 1.1 Introduction ................................................................................................................................... 1

1.1.1 Leadership research in health care ........................................................................................................ 4

Chapter 2 Establishing a need for the study of leadership principles ......................................................... 7

2.1 Problems with leadership research ........................................................................................................... 8

2.1.1 Lack of a standardized definition or theory of leadership ................................................................. 8

2.1.2 Leadership as a way of improving group performance ..................................................................... 11

2.1.3 Leadership as the infusion of meaning ................................................................................................. 13

2.1.4 Leadership and Healthcare: The shift in the purpose of healthcare organizations ......................... 16

2.2 Healthcare economics as a driver of healthcare leadership .................................................................. 17

2.2.1 Healthcare leadership as shaped by the current economic climate ..................................................... 21

2.3 Conclusion ............................................................................................................................................... 27

Chapter 3 A definition of leadership, and the context in which I will study it ............................................. 30

3.1 Leadership in the healthcare environment ............................................................................................... 30

3.1.1 Leadership hierarchies in not-for-profit hospitals ............................................................................. 31

3.1.2 Physicians ........................................................................................................................................... 32

3.1.3 Hospital staff: Nursing ....................................................................................................................... 33

3.1.4 Business leaders ................................................................................................................................ 34

3.1.5 Board of Directors ............................................................................................................................. 35

3.2 Definition of Terms ................................................................................................................................. 35

3.3 Definition of leadership ............................................................................................................................ 37

3.3.1 Leadership Ontology .......................................................................................................................... 42

3.3.2 Discovering a theory of leadership: use of the case study ................................................................. 49

3.3.3 Mixed methods approach to investigating leadership .......................................................................... 50

3.4 Summary ............................................................................................................................................... 50

Chapter 4 Qualitative study of leadership using Grounded Theory Methodology .................................... 52

4.1 Methods .................................................................................................................................................. 52

4.1.1 Study participants ................................................................................................................................. 53

4.1.2 Data Collection and Analysis ............................................................................................................... 55

4.1.3 Validation ........................................................................................................................................... 57

4.1.4 Ethical Issues ..................................................................................................................................... 57

4.1.5 Limitations ......................................................................................................................................... 59
8.2 Situating Dynamic Theory of Leadership in the Literature

8.1 Semi-structured interviews

8.2 Situating Dynamic Theory of Leadership in the Literature

Chapter 8: Implications and Applications

8.2 Situating Dynamic Theory of Leadership in the Literature
8.3 Testing Hypotheses of DLT ................................................................. 280
8.4 Implications of DLT ........................................................................... 282
  8.4.1 Implications for health care ......................................................... 282
  8.4.2 General leadership applications ................................................. 285
8.5 The process of theorizing ................................................................. 290
8.6 Conclusion ....................................................................................... 292

References ............................................................................................ 294

References for Chapter 1 ......................................................................... 294
References for Chapter 2 ......................................................................... 296
References for Chapter 3 ......................................................................... 307
References for Chapter 4 ......................................................................... 311
References for Chapter 5 ......................................................................... 313
References for Chapter 6 ......................................................................... 356

Appendix A  Sample Questions from the MLQ and ALQ Survey instruments .. 359
LIST OF FIGURES

Figure 4-1 Dynamic Leadership Theory ................................................................. 108
Figure 5-1 Dynamic Leadership Theory Hypotheses ................................................. 116
Figure 6-1 Power Curve for Paired t-Test ............................................................... 234
Figure 6-2 Revised Dynamic Leadership Theory Model ............................................. 241
Figure 6-3 Revised DLT Model .................................................................................. 248
Figure 6-4 Correlation matrix for the revised DLT Model ........................................... 249
Figure 7-1 Dynamic Leadership Theory ................................................................. 256
Figure 7-2 Contributions of DLT to the literature ...................................................... 264
Figure 7-3 Shortcomings of DLT .............................................................................. 270
LIST OF TABLES

Table 2-1 Major Leadership Theories (Bligh, 2011; Burke, Diaz Granados, & Salas, 2011; Caza & Jackson, 2011; Johnson, 2009; Uhl-Bien & Marion, 2008) ........................................ 10

Table 2-2 Economic changes in health care ........................................................................ 20

Table 6-1: Dynamic Leadership Theory Hypotheses ...................................................... 217

Table 6-2 Response rates of participant subgroups ....................................................... 224

Table 6-3 Participant rates from the institutions ............................................................. 224

Table 6-4 Demographic Comparisons ......................................................................... 227

Table 6-5 Coefficients for Variables for determination of moderator effect .................... 243

Table 6-6 Table of coefficients for SE as a moderator ................................................... 245

Table 6-7 Factor Loadings for DLT .............................................................................. 246

Table 6-8: Cronbach's Alpha ....................................................................................... 246

Table 6-9: Mean and Standard Deviation .................................................................... 246

Table 6-10 Covariance Matrix with p values ................................................................. 247

Table 7-1 Study hypothesis and the degree to which they are confirmed ...................... 263
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Chapter 1

1.1 Introduction

“When you shoot a physician,” the CEO explained to his top management team, teaching them how to lead employed physicians, “You have to shoot him in the head. If you shoot him in the foot, then he can still come back and give you more trouble.” A CEO instructed another group of healthcare leaders how to gain employees’ respect: “We need to learn from the Romans,” he explained. “When they crucified Jesus Christ, they did not do it in a secluded spot; they put him on a cross on a hill so that everyone could see him suffer. That teaches us how, by making an example of poor employees, the rest of the group will learn not to question us.”

In a leadership development seminar, several hundred leaders from a large health system gathered in a large auditorium, settling in for two days of leadership training. The CEO acknowledged how hard they had been working during the prior weeks providing care for patients suffering from the devastating effects of a major influenza epidemic in the community. “Why are we working so hard?” he asked the exhausted group. “I’ll tell you why. All of this volume has resulted in a huge increase in our bottom line, and we will all get a bonus this year. That is why.”

In a different setting, several dozen leaders from a healthcare system were toiling in the hot sun on a long Saturday morning washing cars for a local charity to raise money for cancer victims. The CEO of the system was amongst them, scrubbing dirt and grime from customers’ cars shoulder to shoulder with the other volunteers. He stopped only
long enough to drive his own car through the assembly, adding an extra hundred dollars to his donation to the group.

At a charity event, the hard-nosed CEO of a local health system astounded hundreds of community leaders when he bid thousands of dollars over the previous offering for an item at an auction sponsored by the local chapter of the American Heart Association. The assembled leaders’ suspicions that the CEO was grandstanding were quickly replaced by their even greater astonishment when the CEO, upon placing the winning bid, donated the item to another local charity so they could re-sell it to help raise funds. The charity re-auctioned the item for several thousand dollars.

A single mother of four young children in a different community was struggling to meet the financial and physical needs of her young daughter who was undergoing treatment for a severe form of cancer. Employed by the local health system as an aide, she was trying to cover the escalating costs of keeping her daughter alive and her other children fed and clothed with her meager salary. She broke down with emotion when her supervisor from the hospital arrived at her home one evening with dozens of items she desperately needed for her daughter, and thousands of dollars of donations from leaders at the hospital.

These different faces of leadership exemplify the tremendous confusion and escalating chaos emanating from the field in recent years. Does leadership mean swallowing one’s inhibitions against inflicting suffering (presumably emotional) on coworkers and doing whatever else it takes to maximize a firm’s profits, as the first set of anecdotes suggests? Or is it about creating meaning and purpose for employees as they sacrifice their time and energy in pursuit of making a difference in a world filled with
heartache and suffering, as the second group of anecdotes demonstrates? Should emerging leaders be taught, as one health system’s human resources executive proclaimed, that every employee is inherently lazy, and will only apply themselves if their fear of punishment for slacking is greater than their desire to defraud the system? Or should they develop an appreciation for the tremendous energy and commitment that employees exude when they emotionally engage and align with a compelling vision?

The leadership literature, particularly that consumed by most practicing leaders and executives, is ambiguous, contradictory, and filled with untested maxims derived from anecdotes about super-star CEO’s that presumably would help every level of leader, from housekeeping supervisor to corporate executive, reach economic Nirvana. The academic literature provides little help navigating these tempestuous waters, with leadership theories and innovations often measured for their ability to improve the “bottom line,” thus leading to the conclusion that effective leadership is ultimately doing whatever it takes to maximize profitability.

Despite the “anything goes as long as you do not end up in jail” approach to leadership entrenched in many corporate executive offices reflecting practitioners’, scholars’, and authors’ addiction to financial performance, other streams of leadership research and writing diverge from this culture, stressing alternate leadership objectives such as meaning, purpose, and personal fulfillment. This movement in the leadership world recognizes the importance of economic solvency to organizational success, but maintains it is a means to, not an end of, effective leadership.

Having lived and worked in this cauldron of opposing leadership beliefs and ideals for several decades as a physician, executive, and community leader, I have
become deeply troubled by its enervating effect on our culture and institutions. As a ‘pracademic,’ I perceived an opportunity to jump into these troubled waters to search for definitional clarity, a rock of understanding and theory upon which the effective practice and development of leadership could be firmly built. No single man or woman, no matter how gifted a researcher, orator, or practitioner can move this massive leadership mountain of books, articles, magazines and thesis to a new cultural location. However, perhaps one committed practitioner/researcher can at least find a place to begin forming a new leadership hill that will provide a foundation upon which organizational leadership ‘realtors’ might consider building their leadership culture.

1.1.1 Leadership research in health care

A compelling opportunity to study leadership emerges in the healthcare field. Not only is it the field with which I am most familiar, studying leadership in the setting of health care creates an opportunity for significant learning about both fields. Discovering more effective ways of understanding leadership, and thus of selecting, training, and utilizing leaders, will become a crucial competency for hospitals and health systems seeking to thrive in an increasingly resource-constrained environment. Developing and retaining effective leaders creates significant value for healthcare systems (Day, 2000; McAlearney & Sinioris, 2010) by improving patient and employee satisfaction and the quality and safety of care (McAlearney & Butler, 2008). Conversely, highly performing hospitals possess greater leadership capacity than low performing hospitals (McAlearney
& Garman, 2011). Given the intractable challenges facing health care, one cannot overstate the importance of creating effective leadership within a healthcare organization.

Prominent among the leadership challenges facing health care is gaining an understanding of the potential leadership roles that clinicians (physicians and nurses) can assume, and understanding how they might be best prepared and trained for these roles. For example, multiple authors (i.e., Cherry, Davis, & Thorndyke, 2010; McKenna & Pugno, 2006; Menaker & Bahn, 2008; Porter & Teisberg, 2007; Schwartz & Pogge, 2000) identify physician leadership as crucial to attempts to address such crisis as out-of-control costs, limited access, and poor quality. Clinicians intimately understand clinical care, carefully accept responsibility for their contributions to excessive costs of care, and occupy a unique position from which to implement the changes in care delivery called for by healthcare reform. Thus, it is natural to call for their inclusion in leadership roles; nevertheless, this intimacy does not equate to effective leadership nor does it predict the ways in which clinicians would be best trained and utilized as healthcare leaders.

The intent of this dissertation is to first present an understanding of the challenges, difficulties, and discontinuities of leadership theory and principles that leaders perceive in challenging circumstances by studying leadership in a hospital setting. I will then use those insights to construct a theory of leadership that bridges gaps in existing theory and practice. I will then situate the proposed theory in the current literature and then test it through the use of a quantitative survey-based case study. Using the outcomes of this evaluation, coupled with the proposed theory, I will make recommendations for improving the understanding, development, and use of leadership in
both the healthcare and general leadership settings, as well as for further study of the topic.

I will structure this dissertation as follows. Chapter 2 provides academic support for and underscores the importance of this study. It documents the ambiguity surrounding leadership, the crucial role of leadership for the effective functioning of an organization, and how the lack of definitional clarity regarding leaders and leadership negatively impacts both leadership research and practice. Chapter 3 will include a definition of some of the unique, healthcare-related terms used in the study, as well as a brief description of the hospital environment as a means of providing a context for the dissertation. It will also contain a proposed definition of the term ‘leadership,’ and an ontological and epistemological support for the definition. Chapter 4 presents a qualitative study of healthcare leadership using grounded theory methodology. I will use the data to identify an emergent theory of leadership (Dynamic Theory of Leadership – DLT) that provides insight into the theoretical gaps presented in Chapter 2. Chapter 5 will situate the theory in the existing literature and will also explore the theory’s position with regards to major leadership theories, and will conclude with the proposal of a quantitative case study to test five of the six hypotheses generated by the theory. Chapter 6 will present the results of a quantitative survey-based study that evaluates these hypotheses. Chapter 7 will discuss the results of the survey, and the contributions of this dissertation to the literature as well as some of the shortcomings of DLT. Chapter 8 will provide a summary of the dissertation, and a brief discussion of its implications for the effective practice of leadership.
Chapter 2

Establishing a need for the study of leadership principles

In this chapter, I present the rationale for a study of leadership principles in the healthcare setting. Chapter 5 provides an in-depth review of the literature by which the principles of the leadership theory emerging from the qualitative study can be evaluated. Nevertheless, I will use references to the literature in the current chapter to support the compelling need for a dissertation on leadership.

As stated, the purpose of this chapter is to convince the reader that a compelling need exists to conduct a study of leadership principles with the intent to propose and defend a leadership theory that advances existing theoretical approaches to leadership. In order to accomplish this, I will establish that the literature lacks a clear definition of leadership and its purpose(s), a deficit which contributes to the profusion of definitions and theories in the field.

For instance, in the healthcare setting, many studies have shown that leadership plays an important role in achieving organizational outcomes. However, it is not clear from this literature what it is about leadership that contributes to improved outcomes. These studies seldom distinguish leaders from bureaucratic managers, and it can be debated whether it is management or leadership that makes a difference in outcomes, or even whether there is a difference between these two organizational functions.
In this dissertation, I make the case that, given the importance attributed to the concept of leadership a compelling need exists to 1) better define leadership, 2) to distinguish it from similar roles and functions in an organization, and 3) to establish a foundation whereupon its relevance as a unique organizational entity can be clarified.

2.1 Problems with leadership research

2.1.1 Lack of a standardized definition or theory of leadership

Leadership is in a state of crisis, missing a cogent theoretical structure upon which the practice of leadership can be built and strengthened (Nohria & Khurana, 2010). This is a serious indictment, given both the sizable market for leadership insights, as evidenced by the burgeoning number of articles and books written by non-academic authors, coupled with the increased scrutiny business and other leaders receive for perceived leadership shortcomings (Manion, 2005; t'Hart, 2011).

Repercussions of leadership ambiguity contribute to this identity crisis. Indeed, the very existence of leadership as an organizational entity has been questioned for the past three decades (Grint, 2011; Wasserman, Anand, & Nohria, 2010). The leadership field’s persistent failure to establish a clear definition of the term ‘leadership’ may have caused this crisis, or resulted from it, or both. Countless pages of academic and consumer leadership literature sit on library and book store shelves around the world, the vast majority of which fails to articulate a clear definition, let alone a standard definition, of leadership. A search conducted in October, 2012 on Amazon.com for books with
either “leader” or “leadership” in the title returned over 32,000 selections. A similar search on Google Scholar returned 1.3 million articles whose titles included at least one of these terms. Nevertheless, despite this veritable mountain of physical and electronic print, several authors (Bass, 2008; Stodgill, 1974; G. Yukl, 2006, p. 5) conclude, upon reviewing the literature, that there are nearly as many definitions of leadership as there are authors discussing it. Glynn and DeJordy (2010, p. 121) agree, referring to leadership research as being in a “definitional quagmire.” Yukl and Van Fleet (1992) went so far as to suggest that attempts to define leadership only lead to controversy and confusion, and should be avoided when doing research in the field. Upon reflection, such a conclusion is troubling, allowing, as it does, for research to be based on differing assumptions of the meaning of the term, and thus to yield incompatible results analogous to different teams of medical researchers studying different formulations of a medical therapy, and then attempting to compare their results.

I am not the first, nor undoubtedly the last to bemoan the lack of definitional clarity surrounding the concept of leadership (W. G. Bennis, 1959; Podolny, Khurana, & Besharov, 2010). However, granting the existence of definitional chaos, perhaps a helpful question in our search for understanding leadership might be, “what is the purpose of leadership?” with the hope that once understanding purpose, one could find value in pursuing greater clarity of definition. I come to this idea by observing that many, if not most, leadership theories address mechanisms of leadership, or even more specifically, tactics used by leaders without clearly stating the focus or purpose of those mechanisms and tactics.
<table>
<thead>
<tr>
<th>Leadership Theory</th>
<th>Key Variable(s)</th>
<th>Point of the Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Man</td>
<td>Remarkable personal characteristics</td>
<td>Possession of characteristics “makes” a leader</td>
</tr>
<tr>
<td>Trait-based</td>
<td>Physical and mental prowess</td>
<td>Possession of characteristics “makes” a leader</td>
</tr>
<tr>
<td>Theory X/Theory Y (McGregor)</td>
<td>Approach to subordinates</td>
<td>Leaders’ effectiveness depends on approach</td>
</tr>
<tr>
<td>Ohio Leadership Studies</td>
<td>Leader’s attention to structure or relationships</td>
<td>Leaders’ effectiveness depends on approach</td>
</tr>
<tr>
<td>Michigan Leadership Studies</td>
<td>Leader’s attention to employees and production</td>
<td>Leaders’ effectiveness depends on approach</td>
</tr>
<tr>
<td>Fiedler’s Contingency Theory</td>
<td>Leadership approach of leader</td>
<td>Leaders’ approach depends on situation</td>
</tr>
<tr>
<td>Path-Goal Theory</td>
<td>Use of goals, rewards, environment, relationships</td>
<td>Leaders succeed by helping subordinates achieve goals</td>
</tr>
<tr>
<td>Leader-Member Exchange</td>
<td>Division between ‘in’ and ‘out’ groups</td>
<td>“In” groups more likely to succeed</td>
</tr>
<tr>
<td>Transformational Leadership</td>
<td>Charisma, stimulation, relationships</td>
<td>Leaders achieve through strength of relationships with followers</td>
</tr>
<tr>
<td>Authentic Leadership</td>
<td>Transparency, moral/ethical behavior, self-awareness, openness</td>
<td>Leaders are more effective when using these principles</td>
</tr>
<tr>
<td>Team Leadership (including shared leadership)</td>
<td>Team-based behaviors (coaching, monitoring, delegating, facilitating)</td>
<td>Team leaders are more effective using these behaviors</td>
</tr>
<tr>
<td>Followership-based approaches</td>
<td>Motivations, relations, values, perceptions of followers</td>
<td>Followers’ characteristics determine success of leaders</td>
</tr>
<tr>
<td>Complexity Leadership Theory</td>
<td>Emergence, adaptation, formal/informal settings, Complex Adaptive Systems</td>
<td>Leadership is exercised in unpredictable ways by formal and informal leaders</td>
</tr>
</tbody>
</table>

As can be seen from table 2-1, existing leadership theories might be more appropriately labeled, “Leader Theories” as they focus essentially on the various traits, characteristics, approaches, relationships, values, and actions of leaders, while none
specify what leadership does or is. The rather circuitous implication is that leadership is what a leader does or causes to happen. This begs the question of how one might know if one is or sees a leader versus an authority figure, a bureaucratic office-holder, a charismatic salesman, or any of a number of other potential imitations of leaders. For that matter, is it possible that individuals fitting the above descriptions are indeed leaders if they perform the activities or form the relationships described by one or more of these theories? Said differently, the difficulty I find with leadership theory is that it often identifies leaders based solely on their hierarchical position, but then attempts to describe how they should lead, based solely on what the leader does.

2.1.2 Leadership as a way of improving group performance

Jack Welch (Morris, 2006) famously originated the injunction that a leader’s purpose is to optimize shareholder value. As another author stated, “Creating value is still the game… For the leaders of publicly traded companies, the long-term market capitalization of the company is the indicator I use…” (Tichy, 2002, p. 5). Meeting this objective is dependent on the business’ ability to achieve optimal profitability; that is, its performance. A corollary then, of the basic business maxim regarding improved shareholder value is that a leader’s purpose (and the reason to have leadership) is to improve the associated organization’s performance (Nohria & Khurana, 2010). By primarily defining leadership in terms of organizational performance, however, it becomes vulnerable to irrelevance if, as has happened, organizational theorists identify more significant drivers of performance. This is not to dissociate leadership from
organizational performance. The point is that while performance may accompany effective leadership, it is not the primary purpose of leadership.

These challenges to leadership follow two main avenues (Podolny, et al., 2010). The first is that ‘leadership’ merely identifies the effects of a collection of organizational dynamics on organizational performance (Kerr & Jermier, 1978; Pfeffer, 1977), including such things as power and authority, culture, outside pressures, etc. The second line of attack is that it is difficult to show that individuals in an organization, leader or otherwise, have a significant impact on organizational outcomes, particularly when compared to other measurable factors such as environment, industry, and competitors. For instance, Lieberson and O’Connor (1972) found in a study of 167 large corporations that chief executives were responsible for little of the variation in organizational performance compared to other characteristics of the firms, such as the type of industry, business environment, and corporation-specific factors.

More recent studies provide a more nuanced understanding of these issues, but still produce results broadly in keeping with Lieberson and O’Connor. For instance, Weiner and Mahoney, using a sample of 193 companies, found an average CEO-associated profitability boost of 12.8%, just two percentage points lower than the Lieberson and O’Connor study conducted a decade earlier. Bertran and Schoar (2003), used the “carryover effect,” a term derived from CEOs who directed more than one firm, to calculate that the leadership influence on a firm’s performance is 5%. A recent study (Wasserman, et al., 2010) found the average CEO effect on firm performance was 13.5%, which was in line with the aforementioned Lieberson and O’Connor study; however, the study also found that CEO effects varied widely across different industries, from 2.4% in
meat products companies to over 30% in wholesale electrical goods firms. Meanwhile, other macro-economic factors (year of the study, industry, and various company factors) accounted for over 50% of the variance in firm performance.

These studies demonstrate with remarkable consistency over many decades a sense of the relatively low magnitude of the top executives’ impact on firms’ performance. The question then becomes how much of this effect can be attributed to leadership, versus how much can be explained by so-called micro factors such as power and authority (Gordon, 2011), cultural effects (Schein, 1985), etc. Such differentiated effects can be difficult to quantify. Nevertheless, defining leadership in terms of organizational performance clearly opens it to a challenge of irrelevance.

2.1.3 Leadership as the infusion of meaning

If performance measures fall short of supporting the leadership construct, is there an alternative approach by which significance might be attributed to leadership? Recent treatises on the topic (Bryman, 1996; Podolny, et al., 2010) hearken back to classical era authors’ assertions that the true function of leaders and of leadership is to impart meaning to the institution. Standing at the brink of the “modern” industrial world, these classical authors expressed grave misgivings about the potential ill effects of the changing corporate model on the ability of workers to find meaning in their lives as a focus on profitability and performance – Weber’s impersonal bureaucratic “iron cage” - replaced their sense of purpose and community (Weber, 1992).
The exact import of “meaning” differed amongst these authors. For Weber, it meant tying the organizations’ work to values around which the individual worker structured her/his life, a function with which he tasked charismatic leaders (Shils, 1982). The prototypical charismatic leader described by Weber in this regard was John Calvin who brought the exigencies of the work place into line with the purposes of Protestantism, proclaiming parishioner businessmen’s success through hard work reflected their election to salvation, thus infusing their work efforts with considerable purpose (Weber, 1992; Rothbard, 2010).

Durkheim proposed (1947) that professional organizations, functioning as a source of social interaction and shared work-related values, fulfilled the function of instilling meaning in workers. This may, in fact, be the case, but such benefits could fall short of providing a substitute for an individual’s traditional core personal values, such as when bureaucracy replaces religion and family as the workers’ center of social identity. Barnard (1938) in a departure from Weber, equates meaning and purpose, tasking the executive with finding a means whereby the organization’s purpose would become the worker’s purpose, thus replacing rather than supporting their traditional foundation of meaning (religion and family according to Weber).

This nuanced discussion around leader-instilled meaning for organizational members persists among more recent authors as well. For instance, Selznick postulated that leaders’ infusion of values and identity into an organization transformed it into an institution, a socially dynamic entity whose purpose is greater than pure economic production (Selznick, 1983). Bennis and others, in the tradition of Barnard, speak of self-mastery as the unit of meaning, a state resulting from work as a state of being replacing
work as an activity, accomplished by bringing personal, organizational, and societal goals into alignment with job demands, organizational environment, and individual competencies (Bennis, Parikh, & Lessem, 1994).

Morgan (2006) takes the discussion further in his adaptation of his Plato’s cave allegory to what he calls a “psychic prison” comprised of the mental models organizational actors employ to rationalize their bureaucratic existence. In this construct he explores the different types of meaning which imbue organizations (and tasks their leaders with promoting) by either the organizations’ members, or by outside stakeholders. He uses the example of Frederick Taylor’s “Scientific Management” (1911) which proposes that all organizational work should be based and rewarded on workers’ efficiency and productivity (which brings us in a full circle to the proposal that organizations’ purpose is to produce, and their leaders’ purpose is to increase their ability to produce). Thus, Taylor’s “meaning” for the individual worker became fused with the desire of the organization’s owner for maximum production. Morgan applies Freud’s model of psycho-sexual-social interplay to suggest Taylor’s approach was an example of organizations as tools of society (and leaders as tools of the organization) to suppress and/or control underlying physiologic/psychological urges (i.e., libido) in the interests of a harmonious organization able to achieve increased levels of production (2006, pp. 212 - 217). In a different take on this concept, Klein (1965), Bion (1959), Jaques (1955) and others posited that the role of the institution and its leaders was to protect the individual/group from anxiety.

These are but a few examples of the principles informing the discussion articulated by Weber. Is it the role of leaders to enhance the economic productivity of the
organization, a view of which the bureaucratic machine is emblematic? Or, conversely, is it the leader’s role to bridge the psychological gap between workers as sentient, values-driven human beings and the spirit-suppressing organizations in which they work? I hasten to clarify that as Barnard suggested, the two functions may be linked; that is, that performing the latter function is potentially a means of accomplishing the former. The two occupations, as discussed above, may be separate and independent, or they may be related. For instance, the positive organizational leadership literature establishes a strong connection between both organizational profitability and worker engagement as measures of meaningfulness (Cameron & Spreitzer, 2012).

2.1.4 Leadership and Healthcare: The shift in the purpose of healthcare organizations

The current healthcare environment provides an example of the dichotomy between meaning-focused and performance-focused leadership. The modern healthcare institution faces a wide array of economically-based challenges, pressures, and imperatives while fulfilling expectations to provide the deeply human and intensely personal product of health. The ongoing crisis in healthcare, for instance, can be framed in terms of a grand division between economic issues such as uncontrolled expenses, resource utilization, reimbursement mechanisms, and other similar concepts, and patient-based outcomes such as satisfaction and quality measures (Kellis & Rumberger, 2010). Recent healthcare legislation and payer agreements, which tie reimbursement for
hospitals and physicians to performance, (Congress, 2010) even further impel healthcare towards economic foci.

2.2 Healthcare economics as a driver of healthcare leadership

It has not always been thus; the shift to an economic focus in healthcare is relatively recent and represents rapid evolution from what had previously been a remarkably stable, professionally controlled model of care delivery in which economics were largely of secondary importance (Mick & Wyttenback, 2003). While it is not the intent of this dissertation to give an event-level recounting of this retrenchment in the healthcare delivery system, it may be worthwhile to describe the pre- and post-shift environments briefly to establish a better understanding of how they compare in order to set the stage for understanding the importance of the role of leadership in today’s healthcare environment. The inflection point in this narrative is the introduction of Medicare in 1965, the reverberations of which have directly or indirectly contributed to this marked shift in the healthcare market dynamics.

Prior to the introduction of Federal reimbursement for the provision of health care for elderly and indigent patients, independent primary care physicians (family practitioners, internists, obstetricians/gynecologists, and pediatricians) delivered the vast majority of health care (Scott, 2003). Physician autonomy often went unquestioned; either professionals (physicians) or businessmen/women who were beholden to the physician staff provided the majority of hospital leadership (Friedson, 1970; Starr, 1982). The focus of hospitals and physicians was quality patient care; in other words, quality
was the basis for physician authority and provided the justification for public support of hospitals as institutions (Mick & Wyttenback, 2003). For-profit healthcare was relatively uncommon, at least at the hospital level, and public law and the American Medical Association (AMA), serving as the exclusive, powerful voice of organized medicine (Scott, 2003), strongly discouraged and any hint of commercialism on the part of physicians or hospitals.

As shown in table 2-2, seismic changes in the economic environment of health care have enveloped the field over the past half-century. Over this period, while the American population increased 66%, healthcare expenditures increased 18-fold. Even though not all dollars attributable to physicians’ expenditures are salary dollars, as they also include overhead, supplies, and equipment expenses, these figures show that physicians and hospital directors have seen a remarkable rise in personal income relative to other segments of the economy. The average physician has gone from making roughly double the average salary of working adults to making nearly twelve times that salary today (Census, 2012) while the average hospital CEO has gone from making twice the average worker’s salary to making nine times as much.

This is not an argument that clinicians, such as physicians and nurses, and hospital CEO’s are making too much money (or too little). The point to be made is that the economic complexion of healthcare has changed dramatically from the first half of the twentieth century to the beginning of the twenty-first century, suggesting a shift in the relative balance between care that is patient and quality-focused to productivity-focused care during this period.
The competing interests of market and institutionally-based health care has been a topic of significant research in the organizational literature for a number of years (Scott, 2003; Scott, Ruef, Mendel, & Caronna, 2000) as the effects of greater specialization, increased technology, and greater access to reimbursement have driven healthcare expenditures higher.
Table 2-2 Economic changes in health care

<table>
<thead>
<tr>
<th>Measure</th>
<th>1960</th>
<th>2011</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>186 Million</td>
<td>311 Million</td>
<td>67%</td>
</tr>
<tr>
<td>National real GDP (2005 Dollars)</td>
<td>$2,831 Billion</td>
<td>$13,315 Billion</td>
<td>470%</td>
</tr>
<tr>
<td>National Health Expenditures</td>
<td>$147,132 Million</td>
<td>$2,700,739 Million</td>
<td>1836%</td>
</tr>
<tr>
<td>Health Expenditures as a % of GDP</td>
<td>1%</td>
<td>20.28%</td>
<td>202%</td>
</tr>
<tr>
<td>Hospital Expenditures</td>
<td>$47,855 Million</td>
<td>$850,522 Million</td>
<td>1777%</td>
</tr>
<tr>
<td>Physician Expenditures</td>
<td>$30,289 Million</td>
<td>$541,421 Million</td>
<td>1787%</td>
</tr>
<tr>
<td>Number of Physicians</td>
<td>262,000</td>
<td>661,000</td>
<td>252%</td>
</tr>
<tr>
<td>$’s per physician</td>
<td>$115,600</td>
<td>$819,094</td>
<td>709%</td>
</tr>
<tr>
<td>Number of Hospital Beds</td>
<td>669,600</td>
<td>808,600</td>
<td>21%</td>
</tr>
<tr>
<td>Occupancy Rate (beds)</td>
<td>75 (502,000)</td>
<td>66 (533,676)</td>
<td>-12% (6%)</td>
</tr>
<tr>
<td>Number of Hospitals</td>
<td>7200</td>
<td>5724</td>
<td>-20%</td>
</tr>
<tr>
<td>Number of Beds/Hospital</td>
<td>70</td>
<td>93</td>
<td>33%</td>
</tr>
<tr>
<td>Average $’s/Hospital</td>
<td>$6,647,000</td>
<td>$148,588,749</td>
<td>2235%</td>
</tr>
<tr>
<td>Average Hospital CEO Salary</td>
<td>$53,800</td>
<td>$320,500</td>
<td>596%</td>
</tr>
</tbody>
</table>

(Note: as discussed previously in this chapter, the use of a derivative of the term “institution” implies the involvement of an organization with values and identity that extend beyond a pure economic interest).

Increased expenditures attracted greater regulatory oversight which, coupled with the increased financial sophistication attending the growing number and size of revenue streams, created a greater degree of complexity in healthcare organizations such as hospitals (Scott, et al., 2000). Without training or experience in managing complex organizations, clinicians’ influence over hospital administration (either as hospital managers or as professional staff) rapidly declined (Scott, 2003), replaced by a
A professional class of managers who have succeeded in bringing market forces to bear in the hospital arena. The net result of this evolution is a heterogeneous healthcare environment with a tradition of strong but fragmented institutional forces focused on the human aspects of health care now competing with or possibly replaced by (in some instances) strong market forces (Alexander & D'Aunno, 2003; D'Aunno, Succi, & Alexander, 2000).

As illustrated by Alexander and D’Aunno (2003), the relationship between market and institutional forces in the healthcare environment is complex, reflecting a combination of institutional forces competing with, dominating, operating in parallel with, or integrating with market forces. For instance, the rapidly escalating employment of physicians by hospitals (Cassil, 2011; O'Malley, Bond, & Berenson, 2011) may be an example of market forces dominating institutional forces as physician autonomy and priorities give way to market-driven demands for efficiency and productivity. On the other hand, provisions of the Accountable Care Act of 2010 (Congress, 2010) calling for both economic and patient-based (quality and safety) reforms on the part of hospitals have introduced a parallelism between market and institutionally-based forces.

### 2.2.1 Healthcare leadership as shaped by the current economic climate

Despite the wide recognition of a potential organizational schism between institutional and market-based dynamics in health care, the implications of this dichotomy for the study of leadership have received far less attention. Significant treatises on health care organizational theory (for example, Johnson, 2009; Mick &
Wytenback, 2003) give short shrift to this dualism, either by ignoring the role of leaders (and leadership) as actors in the interplay between the two foci of organizational behavior, or by excluding the economic/values interplay in their discussion of organizational leaders and leadership.

The point is not the thoroughness of healthcare organization and leadership tomes, but rather that, as this discussion has shown, the identity and definitional crisis that has enveloped the leadership field in general has similarly afflicted health care. In the face of an avalanche of economic upheavals and changes, healthcare leadership theory is either implicitly regarded as irrelevant to the discussion (Mick & Wytenback, 2003) of economic performance vs. institutional values, or the discussion is irrelevant to a review of healthcare leadership (Johnson, 2009). This begs the question that if healthcare leadership is necessary to achieve the central enterprise of health care (accomplishing its mission – either economic or institutional), then why should important resources be devoted to attracting and retaining leaders?

As in the general leadership literature abundant evidence supports the contention that meaning-based leadership has an essential and significant impact on non-economic processes, particularly those encompassing patient care outcomes (Judge & Piccolo, 2004; Judge, Piccolo, & Ilies, 2004). For example, patient safety improvement initiatives depend on visible leadership for success (Frankel, Leonard, & Denham, 2006), and many current safety initiatives fail because of the lack of CEO leadership and support (Buerhaus, 2007). Senior leader modeling is a crucial ingredient in developing a climate of quality and safety (Tubbs, Husby, & Jensen, 2011). In fact, some authors (Clarke, Lerner, & Marcella, 2007, p. 312) define safety as a “demonstrated commitment by
leaders to create and maintain a system that provides adequate expertise, training and resources to accomplish the task successfully and simplifies the workplace.” Nursing leadership helps to create an environment that facilitates improved patient outcomes (Laschinger et al., 2008) through improved staff satisfaction which is predictive of patient satisfaction and decreased staff turnover (Capuano, Bokovoy, Higtchings, & Houser, 2005; Robbins, Davidhizar, C., & Faan, 2007).

In another study of nearly 18000 staff from 86 acute care hospitals in the UK, leadership effectiveness had a significant inverse association with patient complaints, and a significant positive association with quality ratings by the Healthcare Commission and Clinical Governance Review ratings of hospital performance (Shipton, Armstrong, West, & Dawson, 2008). Leaders’ creation of a “care quality climate” almost fully mediated these effects through organizational learning, giving priority to patients’ needs, and creating expectations for high standards of patient care.

Effective nursing leadership leads to improved nursing and patient outcomes. Houser (2003) found a significant inverse association between effective nursing leadership and patient mortality, finding that the nursing managers’ stability and expertise correlated strongly with improved outcomes. Other studies (Tourangeau, 2005; Tourangeau et al., 2007; Tourangeau, Giovannetti, Tu, & Wood, 2002) also found a positive association between effective organizational nursing leadership behaviors and patient outcomes. Patient mortality, medication errors, patient elopements, and staff emotional exhaustion decrease with effective nursing leadership (Squires, Tourangeau, Spence-Laschinger, & Doran, 2010).
Leadership also affects patient outcomes indirectly through structural and cultural mechanisms. A study of 52 hospitals in England found a significant association between high-performance human resource practices, such as sophisticated leadership-based appraisal and training programs, and patient outcomes including mortality (West et al., 2002; West, Guthrie, Dawson, Borrill, & Carter, 2006).

Leadership at least partially determines the success of organizational change (Dückers et al., 2009; Joshi, Lazarova, & Liao, 2009). It provides the ability to create a learning climate in which experiments are encouraged, for leaders to articulate a clear and consistent vision, and to enhance organizational and employee adaptability to change while individuals receive the support they need to meet high expectations (Legatt & Dwyer, 2003). Several authors have shown the importance of creating a learning culture as a means of improving quality and safety in hospitals. A study of over 300 clinical leaders in 89 Canadian hospitals (Ginsburg, 2003) found that certain leadership behaviors, such as familiarity with quality data and creation of a quality culture in which the organization learned from errors, had a significant association with performance. In a study of 20 hospitals undertaking quality improvement initiatives to learn from medication errors and thus improve rates of adverse drug effects, strong leadership was a significant predictive factor for successful change (Leape et al., 2000).

Conversely, anecdotes of calamitous outcomes from ineffective leadership also appear frequently in the healthcare literature, including failed mergers (OECD), fraud and corruption (Judge, Bono, Ilies, & Gerhardt, 2002; Vroom & Jago, 2007), and ineffective quality regimes (Hindle, Braithwaite, Travalgia, & Iedema, 2006). This disappoints but does not surprise given the rapidly evolving dynamics of the healthcare industry, the
tremendous pressures under which healthcare leaders labor, and the fantastic amounts of economic resources devoted to the provision of health care (shown in table 2.2).

Not a uniquely American phenomenon, ineffective healthcare leadership also plagues the UK health system. A former director for the NHS said,

In every service, I noticed underlying themes of poor leadership, professional isolation, ineffective systems and processes, disempowerment and poor communication. The underlying team issues included an ‘everyone knows’ culture, active covering-up, indecision, a disconnect between management and clinicians, and a culture of fear (Imison & Giordano, 2009)

These descriptors sound hauntingly familiar to those individuals immersed in the US healthcare system.

Ineffective healthcare leaders constitute an significant source of physicians’ dissatisfaction with hospitals and health systems in which they work, such as with cost-cutting decisions, utilization review, and dysfunctional hospital cultures (Bogue, Guarneri, Reed, Bradley, & Hughes, 2006). Matheny (2008) found from a survey of 104 senior physician leaders that nearly 100% felt physician satisfaction was important on an individual level, and 92% felt that it was important for organizational performance, but only 54% felt that their organization valued physician satisfaction. Not only does physician dissatisfaction lead to more physicians leaving the practice of medicine (Landon, Reschovsky, Pham, & Blumenthal, 2006) or changing jobs (Pathman, Konrad, & Williams, 2002), it also results in substandard patient care, patient dissatisfaction, increased medical errors, and higher healthcare costs (DiMatteo, Sherbourne, & Hays, 1993; Haas et al., 2000; Pathman, et al., 2002; Shanafelt, Bradley, Wipf, & Back, 2002).

Lack of clinical leadership and goal-misalignment between clinical and non-clinical leadership contributes to the lack of progress in improving the quality and safety
of hospitals (Pronovost, Marsteller, & Goeschel, 2011). Often, physicians’ resistance to reform in quality and other areas constitutes one of the greatest difficulties leaders face adapting to the changing regulatory and economic healthcare environment (Degeling & Carr, 2004; Degeling, Maxwell, Kennedy, & Coyle, 2003). This may stem in part from findings that an individual’s educational level inversely relates to his or her perception of leaders’ effectiveness (Morrison, Jones, & Fuller, 1997). As professionals with high levels of education, physicians resist authoritarian decisions and mandates, but may respond more effectively to relationship-based leadership styles (Snell, Briscoe, & Dickson, 2011). Tensions quickly develop between hierarchical managers in healthcare systems and physician leaders when reform proposals undermine physicians’ autonomy and professionalism (Doolin, 2002; Kitchner, 2000).

Crucial benefits of effective clinical leadership such as better patient outcomes, improved retention of valuable clinical personnel, and improved staff morale may diminish, however, as newer generations of workers and consumers give less deference to authority figures, and exhibit less willingness to accept their directives on faith alone (Svensson, 2006). Similarly, the professional-leadership divide may also undermine the benefits of healthcare leadership. As professional autonomy wanes in the face of ever more prescriptive regulatory and reimbursement-related administrative dictums, clinical professionals face the challenge of acquiescing to administrative and managerial demands while exercising appropriate professional and clinical expertise to form a “hybrid professionalism” (Doolin, 2002). The evolution of hospital and health system leadership from centralized control to more adaptive, decentralized leadership creates opportunities
for clinical leaders to achieve organizational success through cultural adaptation to these challenges (Zismer & Person, 2008).

The common thread of these reports, both negative and positive, is the association between perceived leadership and organizational outcomes. They provide a hint that the infusion (or lack thereof) of meaning into the various organizations in the form of a focus on patient safety, patient outcomes, professionalism, etc. significantly mediates this association if we are willing to accept non-economic ends as representative of the term “meaning.” This connection is not explicit, however, as it may have been a connection with economic rewards (individual or organizational) that led to the reported effects.

2.3 Conclusion

In this chapter, I set out to establish the importance of conducting a study on the purpose of leadership by looking specifically at the context of hospital-based health care. I first cited evidence from the leadership literature showing the lack of a clear leadership definition, which in turn may be related to the lack of an understanding of leadership’s purpose. I discussed the multiplicity of leadership theories which dwell predominantly on how leaders lead, but fail first to define leadership.

Based on this lack of definitional clarity regarding leaders and leadership, I proposed a dichotomy as a means of informing this discussion on the purpose of leadership. The first prong of this dichotomy is the possibility that leadership’s perceived primary purpose is to enhance the economic productivity of organizations, based on the view that organizations’ purpose is to enhance the economic status of their beneficiaries
(shareholders, for instance). The second arm of the dichotomy, as proposed by classical leadership theorists, is that leadership’s primary purpose is to bridge the emotional and psychological gap between personal values and priorities and organizational cum bureaucratic depersonalization through the infusion of meaning into the organization.

I used the health care setting as an example of this dichotomy, showing that a great divide exists in healthcare organizations between institutional and market-based forces and that the role of leadership is missing from the discussion of this contest. It seems to be the case that leadership is crucial to achieving optimal, or at least improved, patient outcomes. Nevertheless, when market-based priorities replace or supersede this institutional function of leadership, it forces us to answer the “so what” leadership question. That is, if, as shown in other industries, leadership is responsible for a relatively small effect on the economic performance of an organization, and that effect might be attributed to other organizational dynamics (like power, management, position, etc.) which are often confused or conflated with leadership, then is the topic truly worthy of the time and attention it receives?

Therefore, I assert a compelling need exists to understand better the purposes of leadership in these organizations in order to capture its benefits while conserving scarce resources. This is the core question for this dissertation; namely, to discover the purpose of leadership, whether it is to improve economic performance, infuse meaning beyond economic performance, or to achieve some other organizational dynamic. The hope is that an understanding the purpose(s) of leadership will assist in the creation of a workable definition of the term, lead to a cogent theory of leadership, and assist organizations in understanding their needs for developing and strengthening their leadership capabilities.
The next chapter will describe the hospital environment as the context in which I conducted a study of leadership. Included in this discussion will be a definition of key terms used in this dissertation. I acknowledge the limitations of confining this investigation to a single segment of a single industry, and will discuss these limitations at greater length in Chapter 6. Nevertheless, as a preliminary justification for this limited study population, I point to a number of key factors. The first is that healthcare in general, and the hospital and physician industry in particular, represent a large swath of the American economy (20% and 10%, respectively; see table 2-2), and are thus of adequate significance to use as a substrate for a study of leadership. The second justification is that, as discussed by several authors (Eisenhardt, 1989; Pratt, Rockmann, & Kaugmann, 2006), a topic studied in extreme (for that topic) contexts may produce greater insights than when one studies it in less remarkable situations, as the extreme circumstances may enhance the visibility or significance of the processes under study. I propose that health care is an extreme leadership environment because of its complex structure (with multiple competing empowered hierarchies), its rapid pace of change, the regulatory and financial scrutiny applied to it, the nature of its ‘product’ (often life and death, or life and health situations), and its size. Finally, leadership may function differently in different industries (Wasserman, et al., 2010), and by limiting the study to a single industry, there is a greater chance of identifying important leadership principles that can then be researched in other industries as well. In the following chapter, I will present the background for a qualitative study of a representative leadership sample of the healthcare segment (a case study), and will then discuss its importance for an overall understanding of leadership.
Chapter 3

A definition of leadership, and the context in which I will study it

The purpose of this chapter is two-fold. The first is to present a rationale for studying leadership in a healthcare environment, as well as to describe and define that environment. The second is to present a working definition of leadership that I will use in conducting the study.

3.1 Leadership in the healthcare environment

As discussed in the previous chapter, I have chosen to study leadership in the healthcare environment because it represents both an extreme leadership context as well as an ideal setting in which to observe the forces buffeting the practice and theory of leadership. Specifically, I have chosen to study leadership in the non-profit hospital industry. Hospitals provide an excellent substrate for such an investigation for a number of reasons. First, health care in general, and hospitals in particular, are in a period of crisis. They confront multiple interrelated dynamics forcing them to adapt quickly to their rapidly changing environment in order to survive. Second, several overlapping authority structures, such as physicians, nursing, and business leaders possess decision-making authority in a hospital, which creates an opportunity to compare and contrast their differing approaches and beliefs towards leadership. Third, hospital-based leaders (physicians, nurses, and business leaders) function in markedly different contexts within the same institutions, which provides an opportunity to investigate the influence of
context on leadership beliefs and perceptions, which in turn will provide a crucial perspective to the ontological, epistemological, and theoretical analysis of leadership.

This study aggregates and compares the ideas and perceptions regarding leadership of hospital-based leaders (physicians, nurses, and business leaders) as a means of gaining conceptual insights into leadership. In order to accomplish this, I will first perform a qualitative study to investigate the functions, purposes, and determinants of leadership in a prototypical healthcare setting. Using grounded theory methodology, I will analyze data from the study to help identify an emergent theory that helps define leadership and its purpose(s). After performing a review of the literature as it relates to the theoretical principles emerging from the qualitative study, I will perform a quantitative study to test hypothesis based on the emergent theory. I will conclude this dissertation with a discussion of the significance of the theory, its contributions to the existing leadership literature, and opportunities for further investigation of the theory and its implications.

3.1.1 Leadership hierarchies in not-for-profit hospitals

I will briefly describe here the leadership structure found in not-for-profit hospitals in order to enhance the clarity of the terminology used in this dissertation. Hospitals are complex organizations, and there is little that is intuitive about their leadership structure. An understanding of hospitals and their organizational structures will be helpful in de-coding references to leadership in the healthcare context.
Not-for profit hospitals have multiple parallel leadership structures with varying degrees of interaction amongst them. These leadership systems include 1) physicians, 2) hospital staff (nurses and other clinical personnel (techs, assistants, etc.)), 3) business leaders, and 4) boards of directors. These four divisions function as a “four-legged” stool, with each leadership structure assisting the others to support the seat of the stool; that is, the hospital institution.

3.1.2 Physicians

Physicians may either be employed by the hospital or they may be independent practitioners; nevertheless, regardless of their employment relationships with the healthcare institution, they often function in a semi-autonomous fashion in relation to the institution’s business leadership structure, exercising a considerable degree of authority over hospital staff (nurses and others), and having little interaction with the board of directors. Hospitals often employ physicians as “Chief Medical Officer” or “Chief Clinical Officer” who have the responsibility to secure the medical staff’s engagement in and accountability for various guidelines and institutional policies. The Chief Medical Officer works closely with the Medical Staff President, an elected spokesperson for the medical staff and a ‘go-to’ person for physician-related issues. These roles are included in the membership of the Medical Executive Committee, a legislative and review body that creates and enforces institutional guidelines, sets expectations for physician behavior, and reviews and approves requests by physicians for membership in the hospital’s medical staff. Other physician leaders include department chairpersons who oversee
segments of the medical staff with similar specialties or functions; medical directors, who exercise clinical oversight of various hospital functions (such as respiratory care, intensive care, etc.); and section leaders who assist department chairmen in their responsibilities by overseeing smaller groups of specialist physicians. This dissertation defines ‘executive’ physicians as those spending eight or more hours per week dedicated to leadership roles. Physician ‘leaders’ are those in leadership roles who spend less than 8 hours per week in leadership roles. I chose this level of leadership commitment as the cutoff between these two categories of physician leaders because it represents a full day of dedicated leadership activity each week, and conversely, at least a full day away from clinical practice each week. The net effect of this level of commitment is that the physician must have sufficient executive skill to both make up for the lost clinical activity, as well as to justify his or her involvement in leadership activities for a significant portion of each week.

3.1.3 Hospital staff: Nursing

Nurses and other non-physician clinical staff are employees of the hospital who provide support for the clinical care of hospitalized patients under the aegis of one or more physicians acting as “attending” physicians for each case. I chose the nursing staff as a prototypical hospital staff group because they are the largest group of clinicians, have a well-developed leadership structure, comprise the preeminent non-physician staff in a hospital, have responsibility for the institution’s direction and management of patient care, and are “clinical professionals” by virtue of their education and training.
The Chief Nursing Officer administers the nursing function in a hospital, and has overall accountability for all nursing activity within the institution. A group of nursing directors helps to oversee broad areas of nursing function, such as discrete geographical areas, or education and training. A nurse manager, responsible for the performance of twenty to over one-hundred staff nurses, supervises each hospital floor and/or clinical entity (such as the ICU or Maternity Ward), and answers to the Chief Nursing Officer, while other nurse leaders are responsible for smaller areas of patient care or more discreet functions. Nurses may fill other executive functions within a hospital, such as acting as managers of various departments or functions (such as surgery, quality, case management, and social work). This study defines executive nurses as those at vice-president and director levels within the organization, as well as nurse managers of large and high-profile departments such as the ICU and maternity wards.

3.1.4 Business leaders

Hospital business leaders function as managers of the various non-clinical hospital departments, including finance, legal affairs, supply-chain, facilities, etc. Executive business leaders, including the Chief Executive Officer, other non-clinical members of the top management team (Chief Operating Officer, Chief Legal Counsel, Chief Financial Officer, etc.), and managers of large functional areas (typically at the vice-president level) such as strategy, construction and maintenance, compliance, etc. assume accountability for the overall direction of the hospital. Managers of smaller or
more limited areas of hospital operations are non-executive managers for the purposes of this study.

3.1.5 Board of Directors

The members of the board of directors of a non-profit community hospital are fiduciaries for the community’s interests in the institution. In this role, they have ultimate accountability for the financial and clinical performance of the hospital, including the quality and safety of the care provided to patients. In order to meet this accountability, the board of directors appoints and supervises the hospital director (the Chief Executive Officer), oversees the quality, safety, and financial programs of the hospital, gives final approval for significant changes to the hospital’s programs, policies, or facilities, and accepts or rejects recommendations from the medical staff for appointment of new physicians and the selection of new medical staff leaders. Executive members of the board of directors choose new members from among community business and civic leaders, subject to the approval of the entire board.

3.2 Definition of Terms

I use the following terms throughout this dissertation and a standard definition is crucial to provide a basis for understanding the various contextual references. I provide here functional, as opposed to library definitions in order to enhance the reader’s conceptual understanding of the study context.
Hospital: for the purposes of this study, the term refers to a not-for-profit acute in-patient facility. It includes both academic medical center in-patient hospitals as well as community-based hospitals. The term “not for profit” is somewhat misleading, as it certainly does not imply that the hospital has a negative bottom line. Hospitals, including not-for-profit hospitals, strive diligently to produce a positive bottom line. The not-for-profit designation simply means that any ‘excess’ income generated by the hospital’s operations or investment activities must be retained by the organization, and cannot be paid out as dividends to owners. The term ‘acute’ refers to the type of patient accepted by the hospital. Acute patients remain in the hospital for a relatively short duration of time – 1 to 10 days, with an average of 4 – 5 days. This is as opposed to a chronic-care hospital where patients may remain for months or years.

Executives: Executives are those individuals occupying key positions in the organizational hierarchy as Executives, Vice-Presidents, or Directors. In addition, I include physicians with significant medical staff responsibilities in the rubric ‘executives.’

Non-executive leaders: These are individuals with a position of manager or director in the organizational hierarchy.

Medical Staff: The medical staff comprises physicians, both employed and independent, with formal privileges (i.e., permission) to see and treat patients at a given hospital. Medical staffs are hospital-specific, but physicians are able to be a member of more than one hospital’s medical staff if they choose. The medical staff has its own hierarchy, with a president, vice-president and one or two other ‘executive’ leaders, and several department chairpersons (depending on the number of departments). In addition,
the executive title also includes chairpersons of key medical staff committees (quality, bylaws, credentials, etc.) whose decisions carry considerable weight within the medical staff.

Nursing structure: Nurses participating in this study were all employed by their respective hospital. Executive nurses occupy three positions within the organization. The first are nurses serving at the Vice-president or executive level for nursing or other programs within the hospital. The second are hospital-wide directors of different nursing functions, such as education and staffing. The third are directors of a geographic area or nursing department (as opposed to hospital-wide functions), but who qualify as executives because of the strategic nature of their area of influence, its size, and/or its complexity. For example, the pool of nursing executives includes the nursing director of the ICU. Non-executive nurse leaders are those who direct smaller or less complex departments, and nurse managers.

There are many healthcare terms that may have a bearing on the study of leadership a clinical environment, but the foregoing discussion will hopefully provide an adequate context for the purposes of this dissertation without additional definitions. I next establish a definition of leadership as a basis for the qualitative research presented in Chapter 4.

### 3.3 Definition of leadership

As I have already discussed, one of the principle weaknesses of the leadership literature is the profusion of ad-hoc definitions of the term, filling the vacuum, so to
speak, created by the lack of a standard definition. Despite feelings of trepidation in contributing to the definitional chaos surrounding ‘leadership,’ to conduct a study of leadership without first defining the term violates the standard which I have just established, and leaves the reader to construct his or her own conclusions as to the significance of the findings. Definition intimately supports theory, which in turn reinforces definition. By presenting a definition of leadership, I am laying the foundation for a theory of leadership, which will in turn further clarify its definition.

As predicted by Weber, Barnard, and other classical authors, institutional actors’ engagement in their institution’s mission is dependent on the presence of the psychological condition of meaningfulness (Kahn, 1990; May, Gilson, & Harter, 2004), defined as measuring the value of work or effort based on an individual’s ideals, values and standards (Renn & Vandenberg, 1995). Engagement encompasses the “harnessing of organizational members’ selves to their work roles; in engagement, people employ and express themselves physically, cognitively, and emotionally” (Kahn, 1990, p. 694). It is “A positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption” (Schaufeli, Salanova, González-Romá, & Bakker, 2002, p. 74). Organizational outcomes and performance depend to a significant extent on employees’ engagement in organizational work (Schaufeli & Bakker, 2004; Simpson, 2009).

Alternatively, the lack of congruence between an individual’s ideals and their work environment; that is, the lack of meaning leads to the disengagement of the individual from their work role (Morris & Feldman, 1996). Disengagement, in turn, leads to lack of commitment, lack of motivation, depression, loss of energy, apathy, and
even physical symptomatology (Aktour, 1992; Laschinger & Finegan, 2005; Thomas & Velthouse, 1990).

Recent extensive research into the means and value of infusing meaning into an institution falls under the rubric of “positive organization scholarship (POS).”

focuses on the generative (that is, life building, capability-enhancing, capacity-creating) dynamics in organizations that contribute to human strengths and virtues, resilience and healing, vitality and thriving, and the cultivation of extraordinary states in individuals, groups, and organizations (Dutton, Glynn, & Spreitzer, 2006, p. 3).

POS derives from the positive psychology field which holds that in contradistinction to psychopathology, which deals with psychological illnesses, there exists a deep reserve of human psychological strengths that facilitate achievement and progress, and that should be understood and incorporated into individuals’ interactions with institutional environments (Dutton, et al., 2006).

Martin Seligman, a leading proponent of the positive psychology movement (Seligman & Csikszentmihalyi, 2000), defined the positive organizational behavior movement as existing at three levels, namely the subjective level, the individual level, and the organizational level. It calls for

an increased focus on the building of human strength (as opposed to shoring up human weakness), a focus on creating good lives for healthy people (as opposed to healing people who are psychologically distressed), and building the best in people (as opposed to repairing the worst) (Dutton, et al., 2006, p. 3)

It is the application of these principles to the institutional environment that creates the field of positive organizational scholarship (also referred to as “positive organizational behavior” (POB)).
POB is a derivative of positive psychology, and is defined as the “study and application of positively-oriented human resource strengths and psychological capacities that can be measured, developed and effectively managed for performance improvement in today’s workplace” (Luthans, 2002, p. 698). The positive approach to leadership, or PAL, was proposed in 2001 (Luthans, Luthans, Hodgetts, & Luthans, 2001) by building upon the foundation of positive psychology and positive organizational behavior.

Luthans and his colleagues (Luthans, et al., 2001) then, using positive psychology and positive organizational behavior as a springboard for studying leadership, defined positive leadership as comprised of Realistic optimism, emotional Intelligence, Confidence (self-efficacy), and Hope (as reflected in the acronym “RICH”).

Avolio and Gardner (2005) incorporated an expanded concept of positive leadership in Authentic Leadership Theory. According to this theory authentic leaders possess positive psychological capital as defined by the RICH characteristics of hope, realistic optimism, confidence, and intelligence (defined by Avolio and Gardner as resilience). They also have a positive moral perspective, using agency to make “right” and “ethical” decisions as specified by the mores and codes of the culture in which the leader and organization exist (Hannah, Lester, & Vogelgesang, 2005).

My proposed leadership definition aligns closely with much of the positive leadership literature, following as it does the concept that leadership occurs through the infusion of positive meaning into the institution. Nevertheless, I disagree with the positive leadership literature’s use of performance as the primary justification of this type of leadership. This is a puzzling if not a counterintuitive association, as it devalues the significance of individual meaningfulness from a core human concept to that of a
strategic asset useful for creating a market advantage. It is difficult to conceptualize the authenticity of personal positive attributes of hope, optimism, altruism, and resilience built on the foundation of market dominance. As outlined in the previous chapter, leadership, regardless of the methods employed by leaders, may be of a trifling level of significance in determining organizational performance, particularly when other organizational dynamics such as power and bureaucratic influences also impact actor’s decisions and actions.

In contradistinction to the positive leadership literature, therefore, I define leadership as changing the cognitive processes of a group or individual. Effective leaders embrace their core purpose of changing a group’s cognitive processes through the infusion of meaning in order to achieve increased meaning, purpose, energy and enthusiasm directed toward the accomplishment of its mission.

This definition of leadership also allows for changing the cognitive processes of the group or its members in less positive ways as well. Changing cognitive processes can also occur through the imposition of behaviors or values by the use of power or fear. Instilling fear for one’s physical, mental, or intellectual well-being to accomplish institutional objectives represents a different category of leadership than the infusion of positive meaning; an armed robber should not be considered an effective leader!

An individual’s attempt to utilize institutional actors to accomplish negative outcomes, such as criminal behavior, the personal aggrandizement of one or more of the executive team, or withdrawal of freedom from another individual or group are manifestations of this different form of leadership. Leadership as thus defined becomes a spectrum, ranging from the positive infusion of meaning to the forced changing of
cognitive processes. It would seem likely that individuals could migrate along this spectrum depending on their skills, abilities, and the contexts in which they function as leaders.

When leaders focus on policies and procedures rather than on the group’s meaning and vision, leadership becomes ineffective. Although one might reasonably question how this point meets the definition of leadership, it aptly demonstrates the continuous nature of the leadership spectrum.

Thus, we conclude that leadership is a process by which a leader changes the cognitive processes of a group or individual, either through the infusion of meaning into an institution, or through negative interactions in which leaders change cognitive processes by force, fear, or other such dynamics.

3.3.1 Leadership Ontology

The following discussion places my definition of leadership, and the emergent leadership theory proposed in this dissertation, in an ontological and epistemological context. The significance of this discussion stems from the choice of approaches by which I will present this study of leadership, as well as providing a foundation for the definition of leadership that provides the mechanism for pursuing this research. I will first discuss the philosophical basis for defining leadership as the infusion of meaning by presenting an ontology which defines reality as a cognitive process. This will be supported by an epistemological foundation of virtue and ethics, providing a basis for the discussion of meaning. Ontology concerns the existence or state of being of an entity
(Merriam-Webster), while epistemology deals with the way in which a thing can be known.

Leadership has a long, complex, and dynamic history. Ancient texts, such as the Bible, Plato’s Republic (380 BC) and Sun Tzu’s Art of War (320 BC) give multiple accounts and impart various points of wisdom regarding leadership. Other texts from the Classical and Renaissance periods build upon and add to these earlier works with lessons in leadership that focus largely on political, military, and business applications of leadership. A review of the philosophical fluctuations of “modern” leadership writings in the 20th and 21st Centuries, beginning with the ‘Great Man’ theories in the 1900’s, progressing to Taylorism in 1911, Human Relations Theory in the 1920’s, Contingency and Early Systems Theory in the 1950’s through 1970’s, Transformational Leadership Theory in the 1980’s and 1990’s, and distributed leadership theories in 2000 and beyond, to name only a few, provides a glimpse into the fragmented development of leadership science, and the frustrations the field has experienced in arriving at a commonly accepted definition of leadership (Grint, 2011).

Partially resulting from this ambiguity, a number of authors over the past three decades have begun to question either the existence of leadership as a distinct organizational phenomenon, or its significance to the functioning of organizations. Nohria and Khurana (2010, p. 9) summarized several articles questioning the role of leadership in modern institutions by stating, “The dominant organizational scholarship of the past thirty years does not see a substantive role for leadership.” Several authors argue that the environmental constraints of the modern corporation make it difficult to detect leaders’ impact on organizational performance. Factors such as the organizational culture,
its position in industry, its assets (Hannan & Freeman, 1989), organizational decision-making complexity (Cyert & March, 1963), and its personal limitations (DiMaggio & Powell, 1994) each has the potential to compete with and overshadow the effect of leadership in the organization.

Conversely, other authors support leadership as an entity essential for organizational performance. For example, leaders’ impact may depend on organizational context, including the industry in which the organization operates (Wasserman, Anand, & Nohria, 2010). Another example is that of Bertrand and Schoar (2003) who found a small but significant impact of CEOs on firm performance by looking at inter-company differences between different CEO’s leadership of the same firm.

In order to understand better the significance of leadership to the modern organization, one must understand its ontological foundations as a means of establishing a coherent definition of the term. This in turn will provide the basis upon which a study of leadership can be undertaken.

Ontology concerns the existence or state of being of an entity (Merriam-Webster). Leadership has been the subject of considerable debate amongst various philosophers and authors as to its meaning and importance (Hofweber, 2013), a full discussion of which is beyond the scope of this dissertation. Nevertheless, applying the ten categories of Aristotelian ontology framework (Aristotle, 1995) helps to establish the ontological underpinnings of leadership. Following this framework, characteristics of leadership leading to its ontological definition are as follows: 1) Leadership has no detectable substance; a person cannot feel, touch, or physically interact with it. 2) Leadership is not physically quantifiable. One cannot specify the weight, color, speed, or size of it. 3)
Leadership possesses certain qualities that can be described and that distinguish it from other organizational processes. 4) Leadership relates, as shown in this dissertation, to other organizational processes, both by influencing those processes and being influenced by them. 5) Leadership does not occupy a place in the environment. One cannot specify where leadership is at any given time. 6) Leadership does not assume a posture or shape. 7) It is not clear that it can assume different states of being. Individuals exercise different forms of leadership, and these have different outcomes or impacts on other processes and entities; nevertheless, this may not be a case of different forms of being as much as different ways in which the being of leadership applies to a situation. 8) Its use or application can change another object, although the only direct change is likely to be the thought processes of another individual or group of individuals. 9) Leadership does not change as the result of its interaction with another entity, even though an individual’s use, understanding, or exercise of leadership might change dramatically as the result of this interaction.

From these characteristics of leadership, we turn to Aristotle’s *Metaphysics* to dissect the import of this classification with regard to its ontological nature. From his study of *being qua being*, we learn that leadership can achieve reality only through its association with another entity of substance (Cohen, 2012), which in the case of leadership is its association with humanity. I will not take the time to explore the ways in which humanity 1) qualifies as a substantial reality, and 2) that leadership gains reality based on its association with this substance other than to point out that the crucial connection between humanness and leadership establishes it as a real entity. Further, I point out the corollary of this deduction is that leadership outside of humanness ceases to
be real; that is, that leadership is and can only exist as it is present in the perceptions, actions, and beliefs of one or more individuals. This also elucidates the point that a discussion or theory of leadership as a non-human entity has no meaning in this ontological structure. As soon as leadership separates from a human host, it ceases to exist (I will leave the ontological question of whether non-human animals can exercise leadership to another discussion).

The dependence of leadership’s reality on its association with humanity brings us squarely to the Platonic question of whether it is the representation of leadership that is real, or leadership itself that exists. Is leadership simply a representation, without existence, or is it a reality expressed through the substance of humanness; that is, a simulacrum? The question is a crucial one to the study of leadership, and perhaps underlies the identity crisis through which leadership as a concept is currently passing. In other words, if leadership as a representation of human thought exists only as perceived by individuals, but has no real identity otherwise, then we should relegate it to the realm of neuropsychiatric investigation; an interesting psychological phenomenon, but without greater meaning. On the other hand, if leadership as a simulacrum is a reality, founded upon humanness, but nevertheless an entity which exerts influence, causes and results from events and relationships, and which can be created, reproduced, and manipulated, then its study springs to the forefront of business, political, administrative, and religious understanding. This framework transcends Leuccipus’ (Berryman, 2011) materialist atomism approach by extending reality to non-physical objects and opens the door to “non-realist” ontological concepts (Miller, 2010) that may include interpersonal processes such as leadership. In other words, this discussion around the existence and
nature of leadership extends beyond its physical properties by embracing an approach to understanding interactions between individuals and/or processes. This places the discussion in a subjectivist realm.

For this distinction, I turn to Deleuze and Krauss (1983) who join Nietzsche to counter Platonism by using the concept of a simulacrum to contravene Plato’s arguments that reality is comprised solely of representations. By abolishing the distinction between representation and realism, between essence and reality, we tie the existence of leadership to humanity without removing its identity (Lacan, 2009). It is true that the moral basis of ‘being,’ the ‘being’ associated with “ought to” or “should” is jettisoned in by a turn away from Plato (Deleuze & Krauss, 1983); nevertheless, having established the non-representational reality of leadership, I return to Aristotle to reconsider the role of values in establishing the nature of leadership.

Aristotle proposed three approaches to gaining an understanding of the real world. *Episteme* is scientific knowledge, based on the assumption of the existence of context-independent universal rules and theories which can be discovered through analytic rationalizing. *Techne* is the “art of knowledge”; knowledge as a craft; context-dependent knowledge that one practices, but does not necessarily prove or analyze. *Phronesis* is value-based, context-dependent knowledge; it is knowledge that describes the interaction of individuals and their ideals and beliefs (Flyvbjerg, 2002).

Weber (1978) and others decry the gradual descent from values rationality, as described by Aristotle’s phronesis, to instrumental rationality which embraces episteme in modern Western Society, to the point that many believe science is synonymous with this rationality, and consider a values-based approach to “scientific research” as
“unscientific” (Flyvbjerg, 2002). While this values-independent approach to knowledge discovery may be wholly appropriate for elucidating reproducible physical phenomenon (such as establishing the boiling point of water at a standard pressure), its application to the social sciences and to the interaction of poorly defined and immeasurable entities such as sensibilities, values, desires, intuition and wisdom create significant problems. Perhaps the most notable of these is the lack, despite centuries of research by great researchers and scientists, of universal truths, predictable phenomenon, and reproducible reactions to standard stimuli.

This is not to suggest that leadership as a social phenomenon is purely relativistic, nor even more importantly that we should adopt a nihilism regarding leadership research. The phronesis – episteme tension, though, does call for a balance between the two approaches. The dependence of leadership research on the experience, knowledge, intuition and practice of leaders (spoken of broadly); that is, on leadership phronesis must be recognized and embraced if the research is to have relevance to the real social world. This does not, however, preclude an epistemic approach to leadership research based upon the principles of rationality and “scientific” investigation. As Ferrara described the task, it is the development of a theory (episteme) of judgment (phronesis) (Ferrara, 1989). In walking this tightrope between the two approaches to investigation, however, we must not succumb to the temptation of giving episteme greater weight than phronesis as we work to discover operating principles - admittedly an epistemic approach, but unintended to be so. The task is to discover not just the “how” and the “what” principles of leadership (episteme), but also the “should” and the “why” principles of leadership as well (the phronesis)) of leadership. To make a mark in this intellectual forest discernible
from the many other marks hidden in the trees (of praxis), a theory must be built on a value-rationality foundation, where it can be beneficially supported by both instrumental-rationality and value-rationality investigations.

3.3.2 Discovering a theory of leadership: use of the case study

I conclude my discussion of the philosophical underpinnings of leadership with a treatment of the most appropriate context in which it can be studied based upon the *phronesis* concept. Along with Socrates and Plato, as elucidated by Flyvbjerg (2002) I adopt the case study as the approach most consistent with leadership research. Beveridge’s (1950, p. 101) statement, “more discoveries have arisen from intense observation of very limited material than from statistics applied to large groups” encapsulates the benefits of the case study in social-science research. A case study of leadership allows the observation of the entity as practiced by professionals with many years of experience. It provides a rich context in which the practice of leadership can be understood in a non-reductionist environment. It allows the level of investigation to be elevated from the first stage of human learning (rules-based) to the advanced stages (expert) as described by Dreyfus and Dreyfus (2000).

Different types of cases provide support for different investigational approaches. Randomly selected cases help avoid bias in selection; extreme cases or those with maximum variation help identify important characteristics exerting significant influence on leadership. Paradigmatic cases are most useful in developing a metaphor (theory) for the environment in which the entity is applied (Flyvbjerg, 2002)
3.3.3 Mixed methods approach to investigating leadership

Mixed-methods research ideally suits the study of leadership. Interview-based, qualitative phronesis research utilizes the wisdom, values, knowledge, and experience of proven leaders. It reflects the ontology of leadership as dependent upon, but separate from the perceptions of practitioners and observers. By constructing the interviews in a case-study format (single institution), I take advantage of the benefits of this approach in a phronesis study. By centering the definition of leadership on a values-based determination, the infusion of positive meaning, I acknowledge and embrace values-rationality as the foundation of this dissertation.

In combination with a qualitative study, I also use an instrumental-rationality approach by employing a survey instrument with statistical analysis to test the hypotheses derived from the emergent leadership theory structured using the qualitative study. The use of this method does not imply an epistemic prioritization for the study outcome. Rather, it supports a phronesis approach with an instrumental rationality that corroborates and enhances but does not replace qualitative findings. The theory emerges, not from an instrumental approach, but from a values-based qualitative approach, which instrumental rationality, in the form of a quantitative survey, supports.

3.4 Summary

In summary, I walk the fine line of combining phronesis with episteme, and Aristotle with Plato in this dissertation. I present a cognitively-based definition of leadership, and a values-centric theory of how it can be effectively (and destructively)
practiced. I propose a method of exploring this concept of leadership that is consistent with Aristotelian phronesis research. I acknowledge the difficulties this approach may entail when it comes to generalizing the theory to diverse cultures and environments. Nevertheless, I also argue that the benefits a solid values-based foundation upon which to build a theory of leadership quickly eclipses these difficulties. A “coming from nowhere, and going nowhere” instrumental foundation ultimately creates leadership that is devoid of meaning.

In the next chapter, I will present a qualitative study based on semi-structured interviews. Using data from this study, I will then construct an emergent theory which will provide theoretical and definitional clarity of leadership.
Chapter 4

Qualitative study of leadership using Grounded Theory Methodology

In Chapter 2, I established the existence of a significant degree of chaos and confusion regarding the role and importance of leadership in general, and in healthcare in particular, and outlined some of the adverse consequences of this confusion. In Chapter 3, I proposed a definition of leadership based upon the ontologic construct of cognition as the basis for reality, and suggested an epistemological basis for studying leadership; i.e., the in-depth interrogation of practitioners’ perceptions, insights and reflections on leadership. In this chapter, I describe a study based upon this ontological and epistemological foundation using Grounded Theory Methodology to analyze interviews with healthcare leaders.

Qualitative methods are especially useful to uncover the meaning individuals attribute to their experiences (Creswell, 2007), and I believe this approach is well-suited to investigate the leadership experiences and perceptions of leaders within the healthcare field. The study consisted of first developing codes, categories, and themes derived from the content of the interviews, and then, using this information, identifying an emergent theory of leadership which I will present and discuss.

4.1 Methods

This study consisted of interviews with 40 executives associated with (either employed by or on the medical staff of) a hospital system in Central Pennsylvania. I chose a bounded system (a case study) for participant selection in order to gather rich,
detailed information about a leadership system that will allow for identification of theoretical principles which will then be amenable to quantitative analysis (Creswell, 2007). Case studies facilitate rich descriptive analysis by allowing in-depth observations of a system. “It is pointless to seek to explain what we have not described with a reasonable degree of precision (King, Keohane, & Verba, 1994, p. 44).” Case studies are also most consistent with *phronesis* research as described by Flyvbjerg (2002) and as discussed in the previous chapter. They allow the social science researcher to observe experts practicing in their “natural” environments and thus discover the underlying principles of expert practice (Dreyfus & Dreyfus, 2000). By using a case study approach, I also hope to avoid confounding factors such as different cultures of leadership, different definitions of “executive” and different physical environments that may affect the data collection. By choosing a prototypical case to study, that is, a health system that is representative of other health systems across the country, the principles of leadership I uncover in this study can then be applied to other similar settings.

4.1.1 Study participants

I invited the 20 most senior (that is, highest in the organizational hierarchy) nurses in the organization, and the 20 most senior physicians in the organization to participate in the study. The nurse interviewees consisted of 18 females and 2 males; the physician interviewees consisted of 19 males and 1 female. The nurses were 95% Caucasian and 5% African American. The physicians were 75% Caucasian, 10% Asian, 10% Hispanic, and 5% African American. 100% of the nurses had a master’s degree; none had a
100% of the physicians had a doctorate in medicine; none had a master’s degree in management. All of the interviewees had leadership tenure of at least five years in leadership positions in the health system (or other health systems); some had much more, with several of the nurses having leadership tenure of over 30 years. The leadership experience of nurses included vice president, director, and department head positions. For physicians, it included positions such as vice president, medical staff officer, department chairman, and program director.

Invitations to the participants included a description of the study, its purpose, an estimate of the amount of time that would be required to participate, an indication of free will (that the invitee could refuse participation without fear of repercussion), clarification that there was no compensation for participation in the study, and a statement that the invitee was free to withdraw from the study at any point. I advised them that the interviews would be recorded, and transcribed, and subjected to analysis as part of the study, and that the participants’ interviews would be kept strictly confidential (that is, that while the study may quote statements made by individuals, it would not divulge the source of the statement nor the participant’s role). Of individuals invited to participate in the study, 100% accepted the invitation. Of the 40 individuals participating in the study, one declined to have the discussion recorded, but agreed to have detailed notes made of the interview.

Interviews of the study participants were semi-structured (Lowi, 1979), using the following five questions for each interview with an ensuing discussion of the participants’ answers:

1. How do you define leadership?
2. Why do nurses (physicians) become leaders?

3. Why do leaders succeed?

4. Why do leaders fail?

5. How would you describe your leadership?

### 4.1.2 Data Collection and Analysis

I recorded and transcribed the interviews, which lasted approximately one hour each. I will maintain backup copies of the transcriptions in a secure location for five years following the completion of the study. I thoroughly reviewed and then coded interview transcripts using the software program MaxQDa. I also wrote memos as I reviewed the data and entered them into the text and codes where appropriate (Huberman & Miles, 1994). I used early interviews to develop and refine analytic questions (Lowi, 1979). Memos consisted of insights, reflections, and observations about the participants’ thoughts and how they presented them. I included these memos in the data analysis along with the transcribed interviews and codes. The computer program allowed for the arranging and rearranging of the codes and memos using comparisons of participants’ responses. I also applied the “flip flop” technique (Lowi, 1979), which consists of “turning a concept inside out” or of looking at the concept from different perspectives, to develop inquiries that yielded further analytic insights from the interviews (Strauss & Corbin, 1990).

Axial coding followed open coding of the interviews (Lowi, 1979), which “puts the data back together again in new ways by making a connection between a category and
its subcategories” (Strauss & Corbin, 1990, p. 97). This resulted in consolidating the open codes into coding categories as described in the literature (Creswell, 2007). I did not designate the codes a priori in order to avoid biasing the reporting of the data or introducing unnecessary limitations on its analysis (Marshall & Rossman, 2006). The code names were descriptive and extracted from the transcribed material (Creswell, 2007). Selective coding followed, which involved “selecting the core category, systematically relating it to other categories, validating those relationships (by searching for confirming and disconfirming examples), and filling in categories that need further refinement and development” (Strauss & Corbin, 1990, p. 116).

I compared and analyzed codes and categories until they were saturated; that is, until additional analysis yielded no further categories or codes, and the coding system accounted for all of the data. The criteria for labeling a code as ‘core’ included a) the code being central to the other codes and categories, b) frequency of the code’s occurrence in the interview transcripts, c) the ease with which it relates to the other codes and categories, d) the clarity with which it suggests a general theory, e) its theoretical power, f) its ability to explain a maximum variation in terms of dimensions, properties, conditions, consequences, and strategies (Creswell, 2007, p. 290).

I searched for opportunities to deconstruct the data by looking for contradictions, areas not discussed, and false dichotomies (Czarniawska, 2004). I constructed an emergent theory of leadership using this process of analyzing the codes (Creswell, 2007) which I will present at the conclusion of the chapter. Figure 4-1 graphically illustrates the findings of the study (Lowi, 1979).
4.1.3 Validation

Although some question the usefulness of validating qualitative studies (Wolcott, 1990), I substantiated the findings of the qualitative portion of this study by member checking (Terry, 2003) and prolonged engagement (Price, 1962). Member checking consists of sharing the results of the interview coding with study participants for their verification and reflections on its credibility (Lowi, 1979). Validation through prolonged engagement occurred by applying the experience I have accumulated during the 30 years I have spent in the field and my understanding of the culture, as well as my relationships with the participants.

I validated the coding of the interviews through blinded (to the original coding) coding of 10% of the interview transcripts by a third party reviewer. The third party reviewer used the same coding system as the author after receiving instruction as to the meanings of the codes. Inter-coder agreement was 75% for the presence of codes, and 65% for the correlation of coded segments. I conclude this level of agreement is adequate given the subjective nature of the coding, the nuanced differences between the different codes, and the difference in experience between the reviewer and the author.

4.1.4 Ethical Issues

I did not identify any ethical issues in the performance of this study. The Penn State University Internal Review Board (IRB) reviewed the study and designated it as exempt from further IRB, reflecting their conclusion that it had a low risk of ethical concerns.
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<td>15</td>
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<tr>
<td></td>
<td>Confidence</td>
<td>4</td>
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<td></td>
<td>Savvy</td>
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<td></td>
<td>Experience</td>
<td>0</td>
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<td></td>
<td>Respect</td>
<td>9</td>
<td>21</td>
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<td></td>
<td>Professionalism</td>
<td>1</td>
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<td></td>
<td>Courage</td>
<td>3</td>
<td>9</td>
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<tr>
<td><strong>Ineffective Leadership</strong></td>
<td><strong>Total</strong></td>
<td>31</td>
<td>53</td>
</tr>
<tr>
<td><strong>Destructive Leadership</strong></td>
<td>Authoritarian</td>
<td>42</td>
<td>46</td>
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<td></td>
<td>Finance-focus</td>
<td>13</td>
<td>2</td>
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<td></td>
<td>Self-focused</td>
<td>24</td>
<td>9</td>
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<tr>
<td><strong>Dynamic Leadership</strong></td>
<td>Emergent Ldrship</td>
<td>11</td>
<td>3</td>
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<tr>
<td></td>
<td>Network Ldrship</td>
<td>17</td>
<td>15</td>
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<tr>
<td></td>
<td>Variable Ldrship</td>
<td>5</td>
<td>13</td>
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I carefully safeguarded the anonymity and confidentiality of the interview results by blinding participants’ identities in the reports of the surveys, using password protected files for computerized storage of data, and locking paper files in file cabinets. Resources in the health system, including leadership trainers, consultants, and the author were available for participants with further questions regarding the results of his or her leadership interview.

I obtained informed consent from participants in a free and non-coercive manner prior to conducting the interviews. I explained the purposes of the interviews, as well as the confidential nature of the information obtained, and the safeguards that would be taken to prevent its unauthorized use. I also told participants that they were free to withdraw from the interview at any time they wished. Participants gave their verbal consent to the interview, as well as their implied consent through their participation in the study. There was no attempt to mislead or deceive study participants (Singleton & Straits, 2010).

4.1.5 Limitations

This study uses case study methodology, in which participants are within a bounded system (a single institution). While the value of this design lies in its ability to perform an in-depth study of a system of leadership, and to control for a multitude of institutional-specific externalities that could potentially affect leadership behavior, it also potentially limits the generalizability of the results.
The use of a prototypical healthcare system that is representative of other healthcare systems around the country mitigates this limitation. It is a community-based acute care hospital system, as are 87% of US hospitals (AHA, 2013). It operates as a not-for-profit corporation as do 60% of hospitals (NonprofitHealthcare.org, 2013). The average number of beds of hospitals in this system is 165, compared to the national average number of beds in community non-profit hospitals of 160 (AHA, 2013). Its hierarchical leadership structure is representative of not-for-profit hospitals, as are the roles of the different categories of leaders (physicians and nurses) that were included in the interviews.

A second limitation is the role of the researcher as an executive in the health system from which participants were selected during the period of the interviews, leading to a potential bias in the study results and thus a lack of generalizability to other healthcare systems. I minimized this limitation by paying strict attention to confidentiality of the results, emphasizing the voluntary nature of the study, and reassuring participants that there would be no repercussions resulting from the study. The ability of the researcher to gain a deeper and fuller understanding of the individuals’ perceptions and experiences by having some knowledge of, and experience in, the organizational context in which they serve as leaders and a relationship of trust with many of the participants. Furthermore, the researcher’s extensive experience in healthcare in general and his tenure in the hospital system under study allows for a greater depth of understanding and insight into the discussion of leadership by the study participants.
Another limitation of this study is its use of a relatively small sample size and a relatively short time frame. The small sample size is the result of budgetary and logistical constraints. If the results of this study identify significant opportunities for additional research, larger samples could be used for future studies. The short time frame is also a function of logistical constraints, but is offset by the value of keeping time-based externalities (shifting environment, potential for loss of participants, significant unanticipated clinical or organizational events, etc.) to a minimum.

4.2 Results

The frequency of the codes from the transcribed interviews is shown in table 4-1 above. Codes reflect unique ideas and observations expressed by an interviewee. Although the statements which were assigned a code ranged from a single word to over 100 words in length, each code represented a separate idea or thought from the interview. Multiple codes were occasionally assigned to a single sentence or thought when its meaning was shared between two or more coding categories. For instance, one interviewee related the story of a leader who was unsuccessful as a leader as the result of her use of an authoritarian leadership style, which led to her failure to establish adequate relationships with her followers. This story was coded under the “relationship – group” category and sub-category, as well as the “destructive leadership – authoritarian” category and sub-category.

The frequency table is not meant to demonstrate statistical significance of individual codes nor statistical correlations or differences between the different groups of
interviewees (physicians and nurses). Not only would such determinations be inconsistent with the qualitative approach used for this part of the dissertation, they would not be supported by the study methods which were directed towards gathering in-depth descriptive rather than quantitative information. The purpose of this study was to detect an emergent theory of leadership from these practitioners, a process which requires obtaining a detailed understanding of the practitioners’ leadership experiences, as opposed to a quantitative analysis of their discourse.

Despite this caution, there is still significant information reflected in the frequency table. The frequencies of the categories of leadership topics provide an clear indication of their significance to the interviewees’ overall leadership perceptions. The frequencies of the subcategories provide similar information regarding the relative emphasis these leaders placed on the components of major leadership dynamics. The table provides a global picture as to how the interviewees perceived leadership and the dynamics of which it is composed. I hasten to remind the reader, however, of the potential perils of over-interpreting the numbers. They are far more useful and reliable as qualitative characteristics of the interviews than as quantitative measurements of the information from which they were derived.

4.2.1 Leadership as the infusion of meaning

The interviewees described leadership in terms of meaning 136 times, or an average of 3.4 times in each interview. A significant minority (20% of the instances of discussing meaning as an important aspect of leadership, or an average of 0.7 times in
each interview) of these instances were comprised of a discussion of the importance of vision to the leadership process.

The interviewees emphasized the importance of meaning to leadership. One said, “There’s an underlying caring for humanity that drives their leadership style or how they develop their leadership skills” and another,

Clinicians should have a bigger role only because they’ve had the experience and expertise usually of caring for patients or taking care of patients. So they have the bigger picture perspective of what that is and how to lead that.

Representative statements by other interviewees describing the nature of leadership include

It’s the ability to guide people who follow you in the proper direction. In our line of work hopefully it’s to lead people to approve patient care/outcomes, make sure it’s factually based, evidence based, and not just deal with hunches, but sometimes someone has to make a decision and you can’t flounder and say I don’t know, you have to make a decision to lead the people who are behind you.

and

They look for the good and welfare of the system. I think that’s what I’ve learned over the years too, it’s more than you are representing not just the physicians in the department but you have the responsibility to the system too. To make sure that things are done for the good of the system and kind of mesh the two together and see if you can’t get a happy medium there.

These comments demonstrate the importance the clinicians placed on leaders having a focus on the mission of the healthcare system (providing excellent care to patients in this case), and instilling in their colleagues a desire to bring that mission to fruition. These comments also give a good example of how a single comment can be coded in several different categories, as these mention communication, self-efficacy, resilience, and other relevant characteristics of effective leadership.
The interviewees also described leaders helping a group arrive at a common understanding of which actions need to be taken, and then getting the group and its members on board with the initiative. It was important to nurses in particular that the project to which the group was committing be characterized as a positive effort, or in other words, that it be aligned with what was perceived as the goal of the institution as a whole; that is, the improvement of patient care.

Nursing interviewees clarified that leadership is not just about taking care of the organizational “nuts and bolts;” in other words, it is about more than just staffing, reporting, organizing, etc. For these nurses, the leader’s function was to instill a sense of duty, devotion, commitment, and enthusiasm for the project into the group. They pointed out that individuals come to the work place with personal and family-related priorities uppermost in their minds, and that the effective leader was someone who would be able to align the institutional mission with the individual’s value system as a means of obtaining his or her buy-in and loyalty to the group and its purposes. The leader also has accountability to ensure that the group’s actions have meaning that is consonant with the underlying value system of the individual nurses.

Nursing leaders were judged based on their ability to infuse the importance and primacy of the principles of patient care into the group. Initiatives which enhanced the provision of patient care provided a substrate for leadership, while those that detracted from this mission were seen as either irrelevant or detracting from the purpose of the institution and the role of leadership. Again, in emphasizing the importance of patient care as the focus of leadership, nursing managers were clear that providing a technical or scientific basis for the provision of care was necessary but not sufficient for leadership.
In order to qualify as true leadership, the leader’s task was to change or enhance the group’s will, the individual’s dedication to the effort, and/or the desire of the group to achieve the objectives that enhance patients’ care.

Similarly to nurses, physicians expected their leaders to infuse positive meaning into the institution (group) in order to qualify as leaders. Physicians also characterized this meaning as being centered on patient care, and they had little use for leadership that focused on non-patient-care issues such as economic goals or personal priorities. Specifically, physicians often described leadership as the engagement of individuals through the alignment of their goals, value systems, and culture with those of the institution.

Physicians used the term “vision” to describe ‘meaning.’ They rejected the idea that operational effectiveness in such areas as staffing, organizing, and reporting constituted leadership. They advocated for the idea that leadership involves the engagement of group members, and ensuring that the underlying meaning of the initiative – its positive impact on patient care, its ability to improve the institution’s ability to provide better care, etc. – is effectively communicated to the group in a way in which the group is energized and committed.

Physicians described leadership as the infusion of meaning leading to a change in the people being led, not just the institution or process that they led. For example, one physician described this process as follows,

I think that the best leaders are ones who are able to get others to work at their peak. I think the really good leaders develop the people around them to be operating better than they were able to operate before. They just sort of naturally do that and it’s really hard, but they do that naturally. Those are the best ones.
because one person can only do so much but if you can develop 20 people to operate, or 50 people to operate at a much higher level.

This physician recognized that leaders energize groups or individuals through the infusion of meaning, which they accomplish in part by discovering and developing individuals’ latent capacities.

4.3 Factors influencing the exercise of leadership

Given the strong consensus participants demonstrated in identifying leadership as processes built upon the infusion of meaning, I will next identify those group and institutional dynamics which the interviewees felt were most influential in allowing the process of infusing meaning to proceed. I will discuss the major categories of factors identified by the participants, and touch on the ways in which they felt these factors influenced the effective functioning of leadership.

4.3.1 Relationships

The participants overwhelmingly identified relationships as the most influential characteristic of effective leadership. The concept of relationships being important to the practice of effective leadership, or the absence of relationships being an significant contributor to leadership failure, was coded 253 times during the interviews, or an average of 6.3 times in each interview. Nurses were more likely to mention the importance of relationships to effective leadership than physicians. Nurses mentioned
this relationship an average of eight times per interview, while physicians averaged around five times per interview.

The interviewees’ described relationships between leaders and group members as determinative of effective leadership. For instance, after recognizing ‘group focus’ as the most crucial attribute of relationships, physicians’ next described forging relationships by demonstrating appropriate behavior, while nurses felt that the next most significant attribute of healthy relationships was the ability of leaders to mold their leadership approach to the needs and strengths of group members. Interviewees also acknowledged the significance of other leadership characteristics in establishing and maintaining robust relationships. A shared adherence to an ethical code plays an essential role in developing healthy relationships. Leaders also identified coaching in which leaders establish relationships by developing group members, and recognition, in which leaders strengthen relationships by recognizing the contributions of group members as crucial leadership behaviors.

Interviewees’ statements underscoring the significance of leader-group member relationships to effective leadership include, “that someone does it out of the goodness of their heart and kind of takes someone under their wing is so much more influential than any sort of formal program in my opinion” and, referring to effective leadership styles, “Relationship is probably most effective” and, “Generally I think you can lead a group as long as you have that trust and that relationship.” These statements indicated the central role relationships play in clinical leaders’ perceptions of effective leadership. They exemplify the group’s belief that relationships form the basis for effective leadership, creating a foundation upon which leaders are able to carry out their leadership enterprise.
A physician described competently practicing clinical medicine as an effective method of creating strong relationships:

You have to be a higher standard to be able to bring people to your point of view and that in my mind is passive in that you are just being who you are. But it has to be very active in that you have to go out and engage people and discuss with them and form relationships with them and understand what their needs and wants are and go from there.

This statement suggests that effective leaders engage group members in affirmative, positive relationships by demonstrating the standard of behavior and care that they advocate.

Examples of statements illustrating the significance of flexibility in creating and strengthening relationships include,

the ability to see that they are capable of making mistakes, that they’re not infallible, that they can listen to other’s opinions and take them into consideration and maybe change the way they are thinking because of the input they receive.

and

but then listening and finding out what people think won’t work and then being strong enough of a leader to admit that ok maybe I was wrong we need to back up and re-look at it. It’s just basic communication; simple stuff.

These statements illustrate the effectiveness of leaders using their relationships with group members to help steer the group towards the leaders’ vision. Effective leaders also find a way to incorporate relationships and the good of the organization into their decision-making processes.

The participants also related stories of leaders failing to acknowledge group members’ input and ultimately resulting in leadership failure. For example one nurse stated,
You can get stalemated with your level of experience and sometimes it keeps you very narrow-minded so having stimulation from outside sources to help stimulate your thinking and your growth is very beneficial.

and another, speaking of failed relationships, stated, “I think a lot of them, when they get into a leader type position they want to go directly by the books, it gets them into trouble and I think that’s a lot of it.”

Some introspective nurses also recognized the potential danger of focusing on relationships, realizing the potential of sacrificing group achievements to the maintenance of relationships. Nevertheless, the interviewees’ experience and wisdom dictated that effective leadership requires strong relationships. The group did not refer to relationships in the trivial sense. Leadership-enhancing relationships are not simply friendships or acquaintanceships. As used in these interviews, the term carries a weightier import, referring to professional, robust relationships that facilitated support, communication, and shared knowledge. In other words, the term ‘relationships’ refers to a shared meaningfulness of the group’s vision, a level of trust in the mutual motivation of leaders’ words and actions. Leaders use relationships to create a shared desire to ensure optimal patient care despite the challenges of the healthcare environment. They assure group members that personal strengths, weaknesses, and pertinent non-work issues (child care, spouse’s work schedule, etc.) are factored into group’s expectations of individuals.

According to these clinical leaders, relationships form the foundation for providing effective leadership. Strong relationships based on mutual trust and confidence enable the leader to infuse meaning into the group that is consistent with the group’s system of values and ethics. Leaders infuse meaning that focuses on the group’s core
reason for existence, which, in the case of these healthcare leaders, is optimal patient care.

4.3.1.1 Relationship Building

The group of clinicians identified several characteristics of leaders that serve to enhance the strength and effectiveness of their relationships, and are thus crucial to the performance of leadership. These dynamics inform the capacity of leaders to establish robust relationships. When they reflect these personal beliefs and characteristics in their actions and words, they enhance group members’ willingness to establish meaningful relationships. On the other hand, clinicians related compelling anecdotes of leaders’ lack these characteristics undermining their relationships.

Each of these organizational dynamics enhances the infusion of meaning through the development of effective positive relationships. They comprise four main categories, including 1) communication, 2) self-efficacy, 3) positivism, and 4) resilience. Communication encompasses listening, understanding, and expressing concepts clearly and convincingly. Self-efficacy consists of confidence, courage, competence, accountability, savvy, experience, respect, and professionalism. Positivism includes charisma, compassion, humility, integrity, motivation, passion, and trust. Resiliency includes achievement, commitment, goals, knowledge, ownership, and perspective. Taken together, these positive characteristics enhance the abilities of leaders and their colleagues to achieve institutional objectives. They do not define leadership, but strengthen it by enhancing leaders’ ability to infuse meaning into the group, thus enabling
stronger, more effective relationships. I next describe each of these the significance of these attributes of leadership, and relate how clinical leaders associated them with leadership-enhancing relationships.

4.3.2 Communication

Communication was coded 55 times during the interviews, or an average of 1.4 times per interview. Leaders clearly and powerfully express their vision and ideas, a characteristic of leadership which accounted for 66% of the coded segments for communication. Leaders also listen effectively, a crucial leadership characteristic identified by interviewees in 25% of the coded segments for communication. The interviewees described the ability to demonstrate understanding as an effective communication technique in 7.3% of the coded segments for communication.

Examples of coded segments describing the importance of communication include the following. One nurse exclaimed, “If you can’t communicate, you’re never going to be a good leader,” a statement which summarized the feelings of the group regarding the central role of communication in leadership. Another participant described the link between communication and relationships from a leadership perspective:

I find that people that don’t communicate very well are probably unsure with what it is that they’re doing so they either back up and they don’t communicate or else they come off as being domineering and aggressive because they are not sure of themselves.

In discussing the importance of careful listening, one of the participants said, “I’ve seen leaders fail. The people I have seen fail are the people that really don’t listen
Another of the interviewees explained how listening is central to establishing and maintaining strong relationships,

I think listening is a big part of it. If you’re going to tell someone this is the way we’re going to do something, if they’re doing it all the time they may actually have a better way of doing it because they do it. If leadership is not taking that into consideration, that’s a big reason for failure.

As this physician explained, when the leader listens carefully to group members’ feedback, in addition to benefitting from their insights and experience, he or she also strengthens crucial relationships, thus further enhancing their leadership effectiveness.

The participants in the study described communication as a crucial capability of leaders, enabling them to infuse meaning through their relationships with group members. They observed that the skill with which leaders are able to communicate often defines the degree of success of their leadership. They emphasized the significance of bi-directional communication, which allows leaders to incorporate followers’ perspectives, ideas, opinions, and values into their decision-making processes. Effective communication also facilitates other determinants of effective leadership, such as trust, commitment, passion, compassion, and many others. In contrast, the group identified inadequate or poor communication as a frequent cause of leadership failure.

4.3.3 Self-efficacy

Self-efficacy describes a leader’s ability to demonstrate confidence in their ability to lead as well as in the group’s ability to achieve their vision. It reflects the courage necessary to make the decisions and to take the actions needed to move the group forward. It includes the willingness to be held accountable for one’s actions and words,
to demonstrate respect for the group and its mission, and to manifest the competence and professionalism worthy of a leader.

The analysis of the transcribed interviews yielded 97 codes related to self-efficacy, or just fewer than 10% of the total codes. Interviewees mentioned self-efficacy an average of 2.4 times in their interviews. They described competence (24% of the codes related to self-efficacy) and respect (30% of the codes related to self-efficacy) as the most common characteristics of self-efficacy. Nurses described the association between self-efficacy and leadership 65 times, or an average of 3.2 times per interview, discussing it twice as frequently as physicians’, who spoke of it 34 times, or an average of 1.6 times per interview.

An example of how self-efficacy enhances leadership is this statement from a nurse who describes the qualities of a highly effective leader, “the strength of being able to handle anything or the strength in knowledge or having that knowledge base to say ‘Oh, I’ve dealt with that before, I know how to deal with this situation.’” This statement describes how a leader’s self-efficacy allows him or her to strengthen leadership relationships by demonstrating the confidence and relating the experience that confers greater credibility in leadership situations.

Another nurse stated,

Women are very different, men versus women culturally, and the way you were brought and the way you were taught to think about yourself and your role in life, whether you just become a mother who stays at home, that subservient role versus one that’s not better than men, but at least equal. I think so many nurses do not feel like they are as good as other health care roles. I’ll hear people say I’m just a nurse.
This statement attributes some of the leadership differences between nurses and physicians to a gender-based gap in self-efficacy. The interviewee recognized the importance of narrowing that gap in order to achieve a stronger leadership presence for nurses. The nurse also recognized the role that the lack of self-efficacy plays in defining the leadership relationship with other healthcare workers (including other nurses).

Both physicians and nurses identified self-efficacy as crucial for effective leadership. Group members expect the leader to possess confidence in their own abilities, and to be able to instill confidence in those with whom the leader interacts. Interviewees related experiences of leaders reverting to ineffective and destructive leadership styles upon discovering that they lacked the necessary confidence and conviction to exercise more effective leadership. For instance, one interviewee, relating the reasons why clinical leaders fail, stated,

But I think some people are afraid to say, ‘I don’t know’ or say, ‘that’s a little bit too much for me to handle’ or, ‘I don’t even want to go there.’ They want a title but they really shouldn’t be in that type of position because they don’t know or have the experience or the education or the knowledge. And also maybe not having a good mentor to say OK we know you don’t know this but we’re willing to give you the opportunity to learn, and I think that if they don’t recognize that, that could possibly be a failure.

As this nurse pointed out, when a leader lacks the courage, confidence, and competence to confidently identify the group’s mission and provide the energy and motivation necessary to accomplish it, the leader cannot be successful.

Physicians attributed significant power to knowledge’s association with self-efficacy. Several concluded that physicians automatically assumed leadership roles in patient-care situations based on their superior knowledge (thus mistaking knowledge for
leadership by conflating its effect on the infusion of meaning with leadership). For instance, one physician stated,

I think physicians are leaders because they have a specific set of knowledge that they’re put in the situation of being the one who has to deliver that knowledge. Like my earlier analogy of the only person who knows how to fix the engine becomes the leader in that situation, I think a physician is put into a medical situation and naturally becomes the leader as the person with the most knowledge, the long term understanding of what has to be done and goes into many of those leadership roles by the knowledge factor but there still is a wide range of personalities and how that is delivered.

This physician not only describes the importance of knowledge as a source of meaning for the team of care providers, but also emphasizes the significance of leaders’ self-efficacy (courage, competence, respect) allowing them to utilize his or her knowledge.

While this emphasis on knowledge may seem to undermine the connection between the infusion of meaning and the exercise of leadership, a deeper analysis reveals that this is not the case. For physicians, meaning derives from knowledge. As scientists, they depend on knowledge as a significant source of meaning. As used here, ‘knowledge’ embraces the accumulated wisdom of research and expert analysis of clinical situations. Physicians depend less on formal leaders as a source of meaning because they acknowledge leadership in a greater variety of knowledge-based associations.

In order to have adequate self-efficacy, leaders must have the courage, the knowledge and learning, and the trustworthiness associated with it. Both physicians and nurses perceived that courage enables leaders to overcome obstacles to his or her quest to impart a vision and energize the group to adopt and fulfill it. One participant related the story of leaders appointed to a new program without adequate knowledge or experience. He concluded, “A lot of lead hospitalists or directors of hospitalist programs that knew
nothing, and were appointed, and there was a huge failure rate in the leadership from those people”

Another person, describing the role of courage in defining great leadership, related the story of a group of executives meeting with the board of directors to express their lack of confidence in the CEO, an action that could have resulted in the group losing their positions. She related,

But, not knowing what the outcome of that would have been, I mean we could have all been told, ‘goodbye, too bad so sad.’ So I think that was a real example of leadership, because I was acting and I think everybody in the room was acting on what was best for this organization and not necessarily what was best in our own interests. So I think that’s a great example.

As a result of this group’s courage to risk termination in order to further the interests of the organization, the organization benefitted both from a resolution of the CEO issue and from a significant enhancement its leadership culture.

The interviewees also described leaders strengthening their relationships by effectively imparting knowledge to group members. Many commented on the difficulty clinical leaders who lack self-efficacy have in establishing relationships with others, acknowledging that strong leader-based relationships require the courage and competence sufficient to impart knowledge through example and instruction.

Clinicians expressed the expectation that their leaders maintain competence in both clinical and management roles. They look to their leaders for an example not just of good leadership but of the competent practice of medicine as well.

In discussing the importance of leaders setting an example, physicians also related their expectations that their leaders not hover over them, believing such micromanagement leads to dysfunction and inefficiency. Instead, physicians’ expect
leaders to infuse meaning by demonstrating and teaching appropriate behavior, and then allowing clinician–follower to incorporate the meaning into their practice as they see fit. Physicians’ training inculcates this model early in their training and places a high value on independence, self-directed learning, and autonomy as opposed to more collaborative approaches to leadership. Thus the importance of a high level of self-efficacy in physician leaders becomes even more apparent, given their distant leader-physician relationships. The strength of leader self-efficacy expressed in terms of competence, courage, and confidence must not only overcome the increased distance of their relationships, but also provide a conduit for the infusion of meaning.

Lack of self-efficacy was identified by the group as a risk for ineffective or even destructive leadership. A leader with inadequate self-efficacy experiences difficulty creating strong relationships with followers, leaving them unable to infuse meaning into a group. This can also result in the use of destructive leadership styles as a compensatory mechanism.

Several of the participants observed that leaders lacking self-efficacy often resorted to authoritarian leadership because of their inability to form strong relationships. For instance, one nurse stated, referring to leadership failure, “I don’t think people are comfortable enough with themselves to not be authoritarian as leaders.” She is saying that without self-efficacy, leaders have a greater difficulty establishing strong, flexible relationships that incorporate feedback from group members. As a protective mechanism, in order to avoid feedback that might expose their lack of competence and courage, these leaders employ authoritarian leadership behaviors.
Self-efficacy can facilitate ineffective or destructive leadership via other mechanisms as well. For example, physicians are trained to have a high level of self-efficacy, which is understandable given the importance of making decisions regarding their patients’ needs and acting on those decisions. Nevertheless, this characteristic can become problematic in leadership situations in which a leader is overly confident of his or her skills and abilities. Physicians are not quick to yield to opposing (or different) points of view, preferring instead to maintain the practices and thought patterns which they find effective. Physician and nurse interviewees identified this tendency to shun feedback as problematic for physician leaders who lack the necessary flexibility to establish relationships of trust. One interviewee said,

What are more prevalent I think is the authoritarian again going back to these are the rules and this is the book and we’re going to live by the book. ... You have to be prepared to change and you have to be prepared to change and accept new concepts. If you don’t, you’re not going to survive.

This person felt that the lack of flexibility that can result from over-confidence may precipitate a leader’s failure.

4.3.4 Positivism

Both groups of clinicians were vocal regarding the significance of leaders’ positivism to leadership effectiveness. Positivism was used by these participants to refer to characteristics of leaders such as charisma, compassion, passion, humility, integrity, motivation, and trust. It is a state of optimism and sanguinity, and the opposite of insouciance, pessimism, and lassitude. Without a positive orientation, the groups did not feel that a leader would effectively advocate for his or her vision. As will be discussed
later in this dissertation, many of these positive attributes fall under the rubric of charisma. In fact, charisma has been used frequently to describe effective leaders both in this study and in the leadership literature in general.

I coded Positivism 69 times in the analysis of the transcribed interviews, or 6.6% of the total codes, for an average of 1.7 times in each interview. Nurses and physicians mentioned positive characteristics of leadership with about the same frequency: nurses had 33 codes, or an average 1.65 codes per interview, while physicians had 36 codes, or an average of 1.8 codes per interview. The most frequent subcategories of positivism were trust, which accounted for nearly a third of the codes for positivism, and compassion, which accounted for one fifth of the codes.

One person’s description of the importance of positive attributes of leadership stated,

It has to do with having a passion and having a desire … there’s a drive and a passion and a calling or a goal… so just because you can manage things well and organize things well- I look at organization and prioritization and everything- great skills for a manager, but I think leadership rises above that.

This statement reiterates the idea that a leader with these positive characteristics rises above the ineffectual approaches to leadership demonstrated by many managers, and is able to build relationships based on the energy associated with their positivism.

Another leader said,

And he’s compassionate and he feels for my feelings too and I think he will fight for me and when you fight for somebody below, he will fight for you. And I think those are the few qualities that I really would define very clearly in a leader.

This again emphasizes the tremendous impact of positive attributes on a leader’s ability to establish powerful relationships that facilitate the infusion of meaning.
Trust was identified by both groups of clinical leaders as an important facet of positivism. For instance, one said, “usually you can be a manager you know everything in the business world of how to do that but if you don’t have the trust and respect and those personal skills you are going to fail.” This clinical leader articulated the permissive effect of trust on the exercise of leadership, and relates it indirectly to the relationships between the leader and group members, pointing out that these relationships falter in its absence. Another interviewee linked these two variables, stating, “Generally I think you can lead a group as long as you have that trust and that relationship,” reflecting their observation that relationships enable leadership, and trust enables relationships.

Another connection between positivism and relationships was explained by an interviewee discussing compassion, who stated,

that you have to think of the entire team, what they are capable of, and think from their perspective and once you’ve done that, and showed that compassion and then you made a plan based on the whole thing, I think you will succeed.

It is worth noting that this participant uses ‘compassion’ in a manner that is very similar to the way the previous participant used ‘trust,’ suggesting that leaders perceive these characteristics – trust, compassion, passion, etc. – as closely related manifestations of positivism.

Another positive trait identified by the leaders, passion also relates closely to trust and compassion. As one participant observed, “you must be passionate as a leader,” reflecting the importance of this manifestation of positivism in establishing relationships sufficiently strong enough to support and enable leadership. Another person said,

It’s wanting to, whether it be a department or system or whatever, to make that system not just OK, but great. Strive to want to be better than they are. But again, it has to be deep down that you’re not ok with the status quo.
This statement also defines passion leading to effective leadership as being focused on the common mission of the group, energizing the leader and the group to strive for greatness.

Both nurses and physicians identified strong values, reflected by a strong moral and ethical foundation, as an essential determinant of leadership. Leaders known to have integrity, manifested by honesty and by ethical behavior, had greater credibility when trying to change a group’s cognitive processes. The interviewees also identified the lack of an adequate moral or ethical foundation as a significant contributor to leadership failure, observing that an ethical void undermines a leader’s relationships with her followers, and removes meaning from the leaders’ actions. The nurses specifically mentioned the importance of honesty, transparency, fairness, and integrity as important moral underpinnings of effective leadership.

Finally, humility, identified by a number of clinicians as a crucial characteristic of leadership, is another attribute of positivism. Leaders demonstrate positivism when they don’t take themselves too seriously, and when they don’t give in to temptations of self-aggrandizement and excess. When leaders exercise humility, placing the welfare and needs of the group above their own, thus ensuring that groups members are supported and nurtured, even at the expense of their own interests and desires, the group perceives them as possessing positivism. For example, one leader stated,

I think that certainly someone who does have the knowledge and experience and also the humility to say gosh I made a mistake or I don’t know and not be afraid to make that mistake or I’ll try but I’m not sure I’m going to succeed but give every effort to that.
This statement describes leader’s humility as enabling effective relationship-building through flexibility and experience, which in turn confers credibility and likeability on the leader. Where these priorities become inverted, and humility gives way to pride leading to leader-centric decision-making and behavior, a leader may lose the ability to recover from the resulting self-induced damage to relationships and group meaning.

4.3.5 Resilience

Resilience constitutes the fourth category of variables contributing to leadership-based relationships. Resilience reflects the ability of a leader to recover from setbacks without sacrificing their effectiveness or enthusiasm, to reliably and consistently demonstrate leadership in the midst of trying circumstances, not succumbing to negativity, anger, or reprisals when experiencing interference or destructive influences from others.

Participants described resilience 145 times in the interviews, or an average of 3.6 times in each interview, accounting for 14% of all codes. Nurses and doctors described resilience as a core characteristic of leadership with identical frequencies. They mentioned knowledge most frequently as a manifestation of resilience, addressing it 60 times during the interviews, for an average of 1.5 times per interview. Having a proper perspective, and being committed to achieving specific goals, both strong contributors to resilience, received the next highest number of codes, with 26 codes each, for an average of 0.7 codes per interview.
Some of the ways in which interviewees described the relationship of resilience with leadership include, “The sustain thing is how I really define a leader. You see sustained performance over a period of time.” This statement describes a leader’s perseverance, a component of resilience, as being definitional of leadership. Elaborating further, this leader stated, “Once I’ve made a decision, I support it all the way through, and the people around me.” This idea ties resilience, manifested here as perseverance, to leadership through its effect on the relationships between leaders and group members.

Similarly, another participant stated,

I think good leaders to me are people who are really good listeners, who are thoughtful, who can see the overall picture, who don’t get excitable, but yet show a firm commitment to sticking with the organizations principles and things.

This comment demonstrates this leader’s perception of the connection between commitment (an attribute of resilience) and other characteristics that strengthen leadership-based relationships, such as communication (listening), perspective (also an attribute of resilience), and positivism (thoughtfulness and equanimity).

‘Resilience’ includes goals and commitment because the resilient leader must have a central driving core purpose to which he or she commits, a meaning that defines his or her leadership. These attributes enable a leader to weather the storms that constantly batter healthcare organizations. A nurse commented, “Events and things that are going on are also going to define what happens for that leader, because you may want to go after one goal, but something might change outside of your control forcing you to go after another goal.” In other words, the resilient leader does not allow a missed goal to derail the group’s progress, but forges on, adopting other goals that may allow the group to arrive at the same ultimate destination. Another clinician describes the
significance of goal-directed, resilient behavior, “I think a great leader knows how to involve their staff in goals, and to get them to work toward goals that are good for business.” As this person stated, the leader relates to the group through the medium of goals, which in turn provide the energy and direction that help the group press forward.

Physicians also observed that their colleagues in leadership positions often fail as a result of inadequate determination and commitment to the group’s vision. They attribute this deficiency to the training environment in which young physicians confront leadership situations with little preparation or training, resulting in negative perceptions of leaders and leadership. For instance, during a surgical procedure, a surgeon in training must provide leadership for the operating room team of nurses and technicians, even though he or she likely has little in the way of established relationships with them. In the exigency of the moment, he or she (the surgeon) may feel compelled to resort to autocratic leadership to accomplish their objective (completing the surgical procedure). The trainee recognizes the inadequacy of their leadership approach and comes away with a negative perception of leadership (and of physicians as leaders). As a result these situations, physicians develop an aversion to leadership, preferring instead to focus on interactions with their own patients.

Having a broad perspective, another attribute of resilient leaders, also contributes to leadership effectiveness. Several of the clinicians related stories of leadership failures related to leaders’ failure to see the “big picture.” Resilient leaders must see above the fray, provide a consistent message of hope and optimism that perspective brings, and not fall prey to the daily setbacks and difficulties inherent in a dynamic, challenging environment such as health care.
4.4 Ineffective Leadership: Failure to infuse meaning

An ineffective leader neither infuses nor destroys meaning in a group. He or she accomplishes objectives by ensuring group members’ compliance with policies. They commit to doing a job, performing a task, and obeying regulations. They do not promote trust, enhance engagement or build the group’s unity around their mission and purpose. Participants in the study applied this description of leadership to their prototypical concept of managers.

Interviewees made this comparison of leaders with managers 84 times during the interviews, or an average of 2.1 codes per interview, accounting for 8.4% of all codes from the interviews. Nurses discussed the difference between managers and leaders twice as frequently as physicians, accounting for 63% of the codes in this category, or an average of 2.7 ineffective leadership codes per interview, compared to physicians’ comments accounting for 37% of these codes, for an average of 1.6 ineffective leadership codes per interview.

Neither physicians nor nurses equated leadership with a bureaucratic position or responsibility. While they recognized that as part of a strong bureaucratic organization, leaders must pay allegiance to the institutional officers and hierarchical figures appointed by the bureaucracy, they repeatedly described a clear distinction between bureaucratically designated officials and leaders. The term most often used for bureaucratic roles was “manager.”

Managers differ from leaders in significant ways, the understanding of which serves to reinforce the concepts of leadership which the participants attempted to convey.
They described managers as task and numbers-focused, not meaning-focused. As opposed to forming relationships and seeking to empower the group, managers based decisions on established policies and procedures, focusing on tasks instead of meaning-based goals, and using policy rather than vision to process information and arrive at a decision. One person said, speaking of a manager, “she was black and white, no grey and I saw no leadership qualities in her whatsoever,” illustrating the strongly-held perception that leaders differ distinctly from prototypical managers. Another said, “Vision is about leadership versus task for management,” showing the importance of vision (meaning) in the exercise of leadership and how the interviewees perceived lack of vision (lack of meaning) as synonymous with management.

The interviewees perceived that managers focus on financial objectives rather than on optimizing the provision of patient care, bolstering their view of managers as non-leaders. One such interviewee stated, “an MBA, coming in and taking an administrator job, I think they are focused on finances and maybe not so much the process down in the dirt, in the weeds basically,” referring to the lack of patient-focused meaning in the approaches of many managers.

The participants described managers in dismissive and negative terms, almost to the point of making failed leadership synonymous with “managers.” One person said, “usually you can be a manager you know everything in the business world of how to do that but if you don’t have the trust and respect and those personal skills you are going to fail,” illustrating the association between a manager’s lack of leadership-based relationships, and their propensity to fail.
Interviewees often attributed poor outcomes of leadership/management efforts to a managerial approach to direction. They perceived managers as a separate category of institutional actors, one whose importance to the overall functioning of the institution may be significant, but clearly does not include leadership. Describing this dynamic, one person said,

“So a manager can be one who makes a schedule, who tells people what to do, who tells people if they’re doing things correctly or incorrectly, or somebody who molds slowly; but a manager can be somewhat of a glorified housekeeper, whereas a leader is somebody that people follow, hopefully in addition to the management role.

This statement clarifies that managers serve essential functions in an organization, but that these functions are different than leadership. It introduces the concept that while managers and leaders may perform two separate roles, the same person may fulfill both. Such a ‘leader-manager’ successfully manages the operational details of an institution in addition to creating and maintaining leadership-based relationships and using them for the infusion of meaning into a group.

The interviewees also perceived the gradual ascendance of managers in health care as institutions increasingly focus on financial performance, subordinating the role of leaders’ use of knowledge, skill and training to infuse patient-centric meaning into the organization. They perceive “leadership training” as often focusing on “manager training,” highlighting business-related managerial skills, while avoiding leadership skills that involve individual cognition, group cohesion, and meaning making. Illustrating this idea, one person said, “the curriculum may make a manager out of you but a curriculum cannot make a leader out of you.”
Interviewees observed that those outside of the healthcare environment, including boards of directors and other community representatives, easily confuse managers with leaders because of their (managers’) ability to achieve financial performance (which is easily measurable) while ignoring or undermining the creation of group meaning by aligning individual goals and desires with the institution’s core purpose of providing optimal care (which is less amenable to measurement). An example of this opinion was expressed by one leader, “I think those differences come in the leadership part. So you can manage things; you can manage a budget, you can manage different things but leadership is making a change in behavior and having a view of where you want to go.”

It is important to point out that managers do not necessarily exclusively practice ineffective leadership. Regardless of their position, whether in housekeeping or cardiac surgery, a manager may choose to accomplish his or her objectives through the exercise of constructive leadership (by identifying a vision, developing the necessary relationships, engaging in communication and infusing the meaning upon which the vision is based), or conversely, through ineffective leadership by adopting behaviors that are policy and rule-based, that do not engender relationship-building, and that do not infuse meaning. For instance, one leader said,

To be a good manager, obviously you have to be ingrained in the day to day process, more so than if you’re leading the team or you’re leading to a common goal, then it’s bigger than that, than the managing of the day to day. But I do think that managers have to have leadership skills.

This comment expresses the view that managers may face situations in which they are called upon to lead, and need to have developed leadership skills for these situations. Another interviewee explained, “Some people begin to excel in leadership
roles very early as more mechanical managers as well. And some people remain excellent managers but terrible leaders all of their lives.” This statement again illustrates the continuum of leadership and management, and clarifies that at least some individuals are able to progress from management to leadership independent of their organizational position or title. As another person said, “Management is a title; leadership is a quality,” inferring that leaders do not depend on being officially anointed by an organization to exercise leadership, while managers are more dependent on organizational authority to carry out their role.

4.5 Destructive Leadership: the loss of meaning

Destructive leadership causes the loss of meaning through the destruction, replacement or extraction of meaning from a group. Destruction of meaning may result from negative, fear-based relationships that cause group members to place their own safety and interests above the core purposes of the group. Destruction of the group’s core meaning may also occur when a leader replaces its vision or purpose with some other goal such as the leader’s own interests or the financial performance of the group.

Group members related multiple anecdotes of leaders exercising “destructive leadership.” They referenced destructive leadership 136 times in the transcribed interviews, for an average of 3.4 times per interview, which accounted for 13.1% of all codes. Physicians referred to destructive leadership 79 times or nearly four times per interview, while nurses mentioned it 57 times, or 2.8 times per interview. The interviewees discussed authoritarian leadership most frequently when discussing
destructive leadership, which resulted in nearly two-thirds of all of the destructive leadership codes. The other significant forms of destructive leadership discussed included self or leader-focused leadership, responsible for a quarter of the destructive leadership codes, and financially-focused leadership, accounting for 10% of the codes for destructive leadership.

4.5.1 Authoritarianism

Interviewees frequently referred to authoritarian leadership and its destructive effects on the organization (88 total codes for authoritarianism, or an average of 2.2 codes/interview). The interviewees clearly felt that this type of leadership causes destruction of purpose and meaning for both leaders and their organizations. For example, in discussing leaders who fail, one person said, “I’ve also seen failure over their style of leadership, like someone that has an authoritarian style. I just don’t think it has a place in healthcare and I’ve seen people fail.” Another individual said, “You can’t be authoritarian in that role or you won’t get anything done because you shut everybody down.” These two representative statements emphasize the leaders’ perception that authoritarian leadership leads to failure of the leader as a result of both its negative impact on leader-based relationships, as well as its incompatibility with the mission and purpose of healthcare. As another person observed, “Authoritarian leadership probably does not work in healthcare because it can potentially hurt the patients we are trying to help if we are too authoritative.” He points out that the destruction of meaning caused by
authoritarian leaders results in less effective patient care as the group of caregivers changes their focus from excellent care to self-preservation.

The interviewees perceived that authoritarian leadership undermines patient care by destroying meaning in the group. This destruction results from the lack of leader-based relationships between the leader and the follower, which the clinician interviewees (nurses and doctors) believe to be an indispensable component of safe patient care. The implicit message of authoritarian leadership is not only the lack of a desire to establish a connection with the follower in order to inculcate meaning, but also a clear message that optimal patient care occupies a lower priority than bureaucratic process. Authoritarian leadership also removes motivation from staff members subjected to this leadership style, thus further destroying meaning from the group.

In spite of its destructive effects and incompatibility, participants perceived authoritarian leadership to be relatively common in healthcare. For instance, one leader observed, “But I would say probably authoritarian is the most prevalent, unfortunately,” indicating he felt that healthcare leaders use authoritarian leadership most commonly. Another person agreed with this assessment, stating, “I still think the authoritarian is the predominant.”

The predominance of authoritarian leadership in healthcare settings defeats logic, given the extensively trained, highly intelligent professionals comprising the employee based in health care. One physician felt that his training had cultivated an authoritarian approach to leadership, stating, “I think the authoritarian leadership just fell into place because it was easy and then it fell into my training.” Other leaders felt that a tradition of
authoritarian leadership in healthcare facilitates its continued and prevalent use today.

She stated,

Part of the difference is the authoritarian approach, and I think that’s an old approach but that’s still part of our culture right now, is the authoritarian approach of physicians and the submissive yet very strong approach of nursing knowing what needs to be done regardless of what I may say.

This person also agreed that many patients and healthcare workers perceive both nurses and physicians as being authoritarian as a result of their training and culture.

Another person’s insight on the prevalence of authoritarian leadership focused on the strict regulatory environment in healthcare, stating,

I think what healthcare wrestles with is, I suspect, is why we defaulted to authoritative we have to do this you have to do this now is because now we are being dictated to and oh well, we can’t not do that. I’m sorry I have to say you have to do that. But it’s not my fault; you’ve got to change the government.

In other words, when faced with a specific requirement, leaders perceive that it may be easier to issue a mandate and then require compliance as an authoritarian leader rather than to involve the group in identifying ways in which the requirement conforms with their mission and vision, and then engaging the group in achieving compliance.

Several of the interviewees commented that authoritarian leadership is counterproductive particularly when leading professionals. For instance, one person said, speaking of authoritarian leadership, “You are not going to get buy-in that way especially if you are working with people who are highly able,” and another,

I think if you were a leader say and you were working with piecework where people really didn’t care and they were only there to be productive and get a check at the end of the day that might be different. But I think in healthcare where it’s a more global thing that you’re trying to accomplish I don’t think it works because you’ve got smart people who have ideas and you need to listen to those and just don’t say do it because I said so. You’re not going to get anything done.
In other words, one cannot expect professionals to function independently in the complex patient care environment, depending on their own cognitive processes, and then mindlessly follow mandates from non-clinicians in the business environment. This type of leadership undermines the crucial role of cognition in leading knowledge-based workers in any leadership process. Given that effective leadership results from infusing meaning into a group or institution, it requires that “followers” engage cognitively in the leadership process. Authoritarian leadership lacks the core constructive leadership characteristic of leader-follower interactions, thus precluding the exercise of constructive leadership.

This is not to suggest that only non-clinical business leaders exercise authoritarian leadership (i.e., those without a patient care related background). Most of the nurses and physicians in the panel readily admitted engaging in authoritarian leadership on a regular basis. For instance, one nurse said “There’re days when you have to have the authoritative one.” Another said, “A lot of it is authoritarian for whatever reason, sometimes, it’s regulatory, sometimes it’s because of finance and sometimes it’s just this is the way we’re going to do it.” These leaders identified circumstances, whether driven by business exigencies or patient care demands or other factors, in which the leader feels they have no choice, even understanding the potential repercussions, other than to utilize authoritarian leadership.

When clinicians engage in authoritarian leadership approaches, they often have sufficient knowledge and understanding of healthcare and adequate relationships to provide constructive leadership, but due to contextual restraints (lack of time, patience,
and resources for instance) forego the opportunity to seek out and incorporate opinions and feedback from followers in their decision-making processes. One leader commented, speaking of these situations, “There are days when I can become very, I’m told, autocratic, and I don’t want their input. Sometimes it’s like, no, it’s not going to be that way.” In other words, this person assumed an authoritarian leadership approach when she didn’t have the time or energy to be a constructive leader. The interviewees believed that constructive leadership requires greater time and effort than destructive leadership approaches such as authoritarian, making it more likely that in exigent circumstances leaders will revert to destructive styles even though they universally acknowledged that doing demonstrates a suboptimal approach to leadership and engenders risk to patients and their care.

4.5.2 Self-focused destructive leadership

Both groups of leaders gave personal anecdotes and expressed strong opinions regarding the deleterious effects of self- or leader-focused leadership, including such behaviors as self-absorption, unwillingness to accept input or feedback, and anger when challenged as indicators of self-focused leadership behavior. Although the study wasn’t designed to produce quantitative results, the participants’ stories showed a significant incidence of self-focused behavior by leaders, a finding bolstered by the 33 total codes relating to it.

A comment exemplifies this perception, describing a leader seeking to fulfill their own needs rather than those of the organization: “Also I’ve seen people fail, the chairman
before me, I think he put his personal interests first, and vendettas, you can’t do that.”

Another person felt that physicians commonly manifest this leadership approach, stating,

I think doctors are more selfish. I think that leadership to physicians significantly develops as a ‘what can this do for me’ scenario. And I think that the level of leadership training that we get as residents really promotes a very limited scope of leadership where the growth of the persons being led is not necessarily an important factor.

As in the previous comment, this person perceived that certain leaders pursue their own personal agenda of self-interests as the focus of their leadership instead of the group’s vision and purpose. Significantly, this person believes that physicians develop self-focused tendencies during their residency training, a time during which they manifest greater susceptibility to their mentors’ example and precepts.

Self-focused leadership destroys meaning in a group in at least three ways. First, it causes group members to replace their core meaning and values with leader-centric meaning as they strive to adapt to his or her needs for self-adulation and control. Secondly, when group members fear the consequences of failure to meet a self-focused leader’s expectations, they may put their own organizational survival and safety above the core values of the group. Finally, as the group takes on the self-focused characteristics of the leader, the loss of meaning becomes institutionalized, leading to an even greater destruction of the group’s core values and culture.

4.5.3 Financially-focused destructive leadership

Leaders also decrease meaning in a group by replacing it with different foci (visions or directives) that do not align with the group’s core purpose. The participants in
the study identified the most common of these as a primary focus on financial performance. For instance one person stated,

I am afraid that it is increasingly becoming a corporate model in medicine and when that happens then I’m afraid that it is the bottom line that matters because in the corporate circles they are a business and they do need to meet the bottom line of whatever stated goals are.

This statement reflects the perception that the focus of health care organizations continues to shift from patient care to financial performance. Commenting on the destructive nature of this focus, another leader stated,

But I really believe that you have an unusual situation because you cannot just dictate with money what’s going to happen because you will have discontented physicians and other practitioners who may not stay in the job long enough or may not provide you with the type of customer service that you want.

This statement illustrates that changing the focus of the group of practitioners away from their core purpose of patient care to a financially driven model creates a dissonance that may lead to loss of morale, and even to loss of key personnel.

The participants understood the crucial nature of financial performance as an enabling tool in achieving their mission of patient care, as demonstrated by the comment, “No, I think they are helpful. I think it’s helpful for us to know how administration makes financial decisions, but I don’t think that qualifies us to make those decisions.” Nevertheless, as this leader was careful to point out, financial performance must remain a secondary, supporting focus of the institution and its mission in order for the group to retain its vision. Individuals leading the group must have the vision and tools necessary to enhance the group’s primary purpose through the infusion of purposeful meaning.
Thus a financial focus as a dichotomous variable serves either to support constructive leadership or to engender destructive leadership. Clearly, unless an organization is financially viable, it cannot secure the resources necessary to fulfill its core mission. A leader seeking to accomplish his or her group’s mission and purpose must bear financial accountability for its operations. Both groups of interviewees (nurses and physicians) readily acknowledged this reality, and placed great importance on leaders accepting this stewardship as part of their leadership calling.

Nevertheless, both groups also described a boundary beyond which financial focus becomes a serious obstacle to effective leadership. This boundary is the point at which finances evolve from being a means to an end to being the end themselves. Both nurses and physicians expressed concern that either health care has already reached this point, or is approaching it rapidly. Regardless of health care’s progress towards this boundary, the clinicians expressed grave concerns that as healthcare leaders lose sight of their core purpose, turning their institutions into economically-oriented businesses as opposed to patient-centric organizations, they risk losing their vision and meaning.

Some of the interviewees observed occasional leaders who perceived leadership as an opportunity to enhance their financial rewards. For instance, one person said, “the historical perspective on medical leadership has been that it is reward based; you make more money, you have a bigger position, that kind of thing.” Another commented,

So you see everybody and his brother right now who wants to go into admin. Many of those people have basically looked and said ‘look, I don’t want to be a primary care doc and make 150,000 dollars a year, be here weekends and have to take night call. If I go into administration, I can make more money.
These statements support the perception that at least some leaders pursue financial results as their primary focus.

The reasons for this shift in the focus of healthcare leaders vary from a venal pursuit of personal benefit to a capitulation to the wave of business-centered healthcare previously described. Regardless of the reason, the interviewees perceived a financial focus as an inadequate basis on which to create sufficient motivation to achieve the group’s vision. They did not fail to recognize the importance of financial health to accomplishing the core mission of the institution (as well as their own ability to function as physicians). Nevertheless, while the distinction may be blurred at times, the clinicians identified a focus on financial performance as a precursor to leadership failure.

An economically oriented institution risks losing meaning as its core values are replaced by a financial focus. Financially-mediated loss of meaning occurs insidiously undermines group members’ values and core meaning. As group members become more intent on financial rewards, they too risk substituting economic pursuits for their core value (patient care in this case). A financially-oriented organization likely attracts financially-oriented individuals, thus further diluting the group’s core meaning in favor of financial rewards. As mentioned above, the interviewees recounted their observation of this evolution, and lamented the associated loss of meaning from their respective institutions.
4.6 Dynamic leadership

In addition to discussing the nature of leadership, both groups in the study (physicians and nurses) provided additional insights into the dynamic nature of leadership; that is, that leadership can be created and performed in a variety of ways. This is not a re-hash of the different approaches to leadership, but instead speaks to the dynamic nature of these approaches.

Analysis of statements by the group of interviewees yielded 64 codes dealing with the dynamic nature of leadership, or an average of 1.6 codes per interview. Both physicians and nurses addressed this topic with equal frequency, with nurses generating 31 codes (1.55 codes per interview), and physicians generating 33 codes (1.65 codes per interview) on the topic. These codes accounted for 6.2% of all codes. The interviewees discussed three general subcategories of dynamic leadership codes, including networked leadership (32 codes), emergent leadership (14 codes), and variable leadership (18 codes).

4.6.1 Networked leadership

Both groups recognized and commented on the inability of a single leader to provide exclusive leadership for an enterprise as complex as a healthcare system. Many recommended partnering a clinical leader such as a nurse or a physician with a business leader in order to provide the necessary expertise to run a complex organization like a hospital while maintaining the core meaning of the group. For instance one physician commented, “I really think that the model in healthcare management should be
collaboration between a business person and a medical person unless you can embody those in one human being.” Another said,

I do think they need to be paired with a business partner because I think that model works the best, I’ve seen it, I’ve read about enough of it, I’ve seen it in operation, I do like that dyad model where you actually pair a physician with sort of an executive who’s non-clinical. And the two work very tightly together because I think that they each can learn a lot from each other and in healthcare that’s probably the model that will initiate change.

These leaders explained their beliefs that shared leadership between a clinician and a business or financially-oriented individual may provide the full spectrum of support needed by the healthcare team.

The clinicians (nurse and doctor interviewees) did not capitulate to the idea that health care should be managed as a business, but rather recognized that financial performance provides the resources necessary for a successful healthcare operation.

### 4.6.2 Emergent leadership

The interviewees described leaders outside of the organizational hierarchy emerging in certain exigent circumstances. For instance, one person observed, “Certainly in an emergency type situation, a leader is going to rise to the top; is going to take charge, is going to take the initiative, is going to take responsibility,” reflecting the feeling that emergent leadership is expected in the healthcare setting. As another person said, “I would say that a title is one thing and a leader is not necessarily related to the title,” pointing out that formal appointment to a leadership position may or may not reflect their ability to lead.
Emergent leadership occurs in many situations, particularly when clinicians with leadership experience perceive a need to provide direction. Opportunities for emergent leadership occur frequently in the hospital environment, and the interviewees expressed familiarity with the concept.

For example, a code arrest, in which a patient’s heart stops beating, requires a clinician to engage immediately in the situation as an emergent leader. Every second lost restoring blood flow to the patient’s organs makes a crucial difference in the outcome of the arrest, and multiple tasks must be completed simultaneously in order to create the greatest likelihood of success. The emergent leader must coordinate the efforts of the other team members (who also emerge as followers) in the effort in order to achieve success.

The clinicians admitted that emergent leaders may also resort to less effective leadership styles in these situations. For instance, a residency program director stated,

The ones that I’ve seen evolve as leaders, and there are people who are leaders within the program, we like those to be formal leaders as chief residents, but there have also been negative leaders. You try to pick the natural leaders as chief residents, but for example, someone who is obviously unhappy can be a natural leader and be working against you.

This person describes situations in which emergent leaders practice destructive rather than constructive leadership, removing meaning from the group as they work to replace the group’s focus and mission with other agendas. These behaviors may place patients in jeopardy. For example, their destructive leadership behavior may serve to block important information from inclusion in the leader’s decision-making process as staff members avoid consequences of reporting unfavorable information.
This program director also described the importance of identifying emergent leaders, and placing them in positions of authority in order to formalize their leadership (as opposed to trying to suppress or control them).

4.6.3 Variable leadership approaches

In a related vein, nurses and physicians almost universally commented on their use of different leadership styles depending on the situation. One person’s comment, “leadership is more or less defined by the situation,” was typical of the perceptions of the group. Another leader gave a more detailed description of this phenomenon, stating,

On any given day I might feel that a more aggressive style may be better and another day I might feel doing nothing may be the best thing to do. So I think that has not only changed over time, it has become more humble over time; it has become less autocratic over time. And yet, on any given day, it can vary from being very aggressive to very passive. So it’s almost like a contradiction. Every day it may be three different situations where actions may be different and at the end of the day I try to figure out if there is some commonality to that, and I find that it’s not. So more and more I’m finding that there is probably a style that other people notice but when I’m making the decisions I don’t quite notice a style because I find that the style is so variable on a given day and given hour that I almost don’t see a pattern.

This person’s statement provides an understanding of the dynamic environment in which healthcare leaders apply their leadership skills, and the constantly changing needs of the group for different inputs and types of support. Another person commented,

I think as with everyone, you change some of what your leadership style is based on who you’re talking to. For example, in the high performers, somebody like____, you really, to a great extent, want to just leave them alone. They’re going to do well; they need a little bit of direction, but you really for the most part, want to leave them alone.
Clinicians did not modify their ideas of what constitutes effective leadership, but rather acknowledged the many difficulties involved in practicing optimal leadership. Situational characteristics that influence one’s leadership approach include the urgency and the intensity of the situation (for example, an emergent, life-threatening situation such as a patient with a gun-shot wound to the chest), the background and experience of the group members (that is, untrained interns versus highly competent and experienced physicians), and the leadership skills and capabilities of the leaders themselves (charismatic individuals with a ready ability to forge new relationships versus more introverted styles that require a longer time and greater effort to build the necessary relationships).

Leadership style is not a static personal trait, but a dynamic one in the vast majority of individuals. Individuals migrate to a preferred leadership style that becomes their “fallback” position when uncertainty, emergent circumstances, or loss of control of a situation occurs.

4.7 Summary and Emergence of a theory

In summary, clinicians described a spectrum of leadership from constructive leadership to ineffective leadership to destructive leadership. The ways in which a leader chooses to infuse meaning into the group differentiates points on this spectrum. Constructive leadership occurs when leaders infuse aligned, purposeful meaning into the group. Ineffective leadership results from leadership relationships lacking positive,
group-focused meaning. When leaders diminish or destroy the group’s meaning, they practice destructive leadership.

The clinicians defined constructive leadership as the infusion of aligned, purposeful meaning into the group, leading the group to increase its positive energy, vision, commitment, and purpose. The infusion of positive (aligned, purposeful) meaning into a group occurs primarily through leader-based relationships which serve as a conduit enabling this to occur. The clinicians also identified a number of organizational dynamics which influence or even determine the effectiveness of leadership, principally through their effects on the relationships between group members and leaders. These dynamics are categorized into communication, self-efficacy, positivism, and resilience.

The communication category consists of listening, understanding, and expression. Effective communication enables leaders to use their relationships with group members to infuse meaning into the group. It also demonstrates the significance of “two-way” relationships through “two-way” communication; in other words, of the leader enhancing the strength and vitality of relationships by not only delivering important messages, but also by clearly receiving information back from group members and acknowledging an understanding of its meaning and importance.

Self-efficacy is the ability of a leader to create, communicate, and achieve a meaning-based vision that reflects the group’s purpose and mission. In order to possess self-efficacy, a leader must have confidence, courage, competence, respect, experience, and professionalism. Self-efficacy facilitates the ability of leaders to strengthen their relationships with group members by giving them greater credibility and increasing the energy and power with which they interact with group members.
Positivism reflects a leader’s optimism and enthusiasm; their ability to inspire, engage, and enthuse group members towards achieving their goals. It includes characteristics mentioned by the interviewees such as passion, compassion, trust, integrity, motivation, humility and charisma. It enhances a leader’s effectiveness by strengthening and elevating his or her relationships with group members as they are attracted to and energized by these characteristics.

Resilience encompasses a leader’s ability to rebound from setbacks, to persevere in times of hardship and trial, and to be unswerving in their commitment to the mission and purpose of the group. It includes characteristics such as commitment and ownership, being knowledgeable, being achievement and goal-oriented, and having a healthy perspective on the environment in which the group functions. It strengthens a leader’s ability to inculcate meaning into the group by creating stronger and more effective relationships with group members as they come to learn that they can rely on the leader as a source of meaning despite the difficulties or challenges which they face.

When leadership lacks meaning, the interviewees described it as ineffective, and often ascribed this non-meaning leadership to managers. This is not to say that non-meaningful leadership is unimportant. The interviewees recognized that in order for the organization to function effectively, someone must attend to “managerial” functions such as staffing, organizing, reporting, and budgeting. However, they were clear that this organizational role was a much different one than leadership. A leader was able to infuse meaning into the group as demonstrated by their vision, the strength of their relationships with group members, their attention to the core mission and purposes of the group, and the energy and enthusiasm with which they pursued the goals and commitments on behalf
of the group. A manager focused on accomplishing specific tasks, did not espouse a vision or higher meaning for the group or their work, was rule and policy-focused as opposed to group and vision-focused, and failed to establish, maintain, and strengthen their relationships with members of the group.

Destructive leadership is a term used to describe leaders who destroy or remove meaning from the group. This occurs through authoritarian, leader-focused, and financially-oriented approaches to leadership. In authoritarian-based leadership, the leader damages his or her relationships with group members are damaged through several mechanisms. Group members risk their own organizational safety and survival when dealing with destructive leaders, thus changing the focus of the relationships to the leader’s needs as opposed to the group’s mission and purpose. Authoritarian leaders were described as being unwilling to accept group members’ input or feedback, thus placing the group’s mission in jeopardy as key information is not considered in the leader’s decision-making process.

Leader-focused leadership occurs when the leader’s primary objectives are their own interests and needs, and they use the group’s resources and energies to pursue these rather than the mission and purpose of the group. Financially-oriented leadership occurs when the purpose of the group becomes optimizing their financial performance rather than accomplishing their mission and purpose. This does not diminish the importance of financial importance as a means of accomplishing the group’s mission; it refers only to the situation in which it becomes the primary focus rather than a means to a greater end.

The group also described leadership in dynamic terms, meaning that it did not remain a monolithic, unchanging, dualistic relationship between a leader and a follower.
The ways in which leadership changes includes networking leadership, emergent leadership, and variable leadership approaches. The interviewees described the importance of leaders in a complex setting like healthcare being able to share their leadership with other individuals who possess skills, knowledge, experience and influence which they may be lacking. For instance, several of the participants recommended that clinical leaders and business leaders work closely together to ensure that they optimally address all of the interests of the group. The group of leaders also described examples of emergent leadership in which a person outside of the formal leadership hierarchy provides direction for the group. Finally, several of the leaders recounted frequently changing their leadership approach, sometimes in order to adapt to the situation and the environment in which they were functioning, and other times as the result of unplanned influences of personality, group composition, or other uncontrollable factors.

4.8 Dynamic Leadership Theory

A theory of leadership emerged from this study which I entitled Dynamic Leadership Theory. This theory arose from the previous discussion and analysis of the coded segments of the transcribed interviews. The graphic on the following page illustrates the theory, and which I then summarize with five hypotheses and a proposition as indicated in the graphic. The proposition reflects the dynamic nature of leadership, and is not shown on the figure because of the difficulty in illustrating it graphically.
**Hypothesis 1:** a) Leader-based relationships are positively associated with Constructive Leadership, b) negatively associated with Destructive Leadership, and c) are not associated with ineffective leadership.

**Hypothesis 2:** Positivism has a positive association with leader-based relationships.

**Hypothesis 3:** Communication has a positive association with leader-based relationships.

**Hypothesis 4:** Self-efficacy has a positive association with leader-based relationships.

**Hypothesis 5:** Resiliency has a positive association with leader-based relationships.

**Proposition:** Leadership is a dynamic entity, varying with respect to time, context, group composition, and the leader’s abilities.
As illustrated in the above figure, Dynamic Leadership Theory (DLT) hypothesizes that leadership occurs as leaders develop leader-based relationships with group members as a means of infusing meaning into the group. When this process is effective and leaders infuse positive meaning (mission and purpose-focused meaning which increases group member’s engagement in the group’s efforts) into the group, constructive leadership results. When leaders interact with group members without infusing positive meaning, ineffective leadership results. Destructive leadership results when leaders’ actions result in the loss of meaning from the group, or replacement of the group’s purpose and mission with foci unaligned with the group’s core mission and purpose.

Four leader characteristics or dynamics enhance leader-based relationships, including communication, self-efficacy, positivism and resilience, while the lack of these dynamics undermines attempts at creating constructive leadership. When these dynamics are missing or misused, leadership efforts become ineffective or destructive.

The theory is encapsulated in five hypotheses as indicated in the above figure; I also include a proposition in the theory.

**4.8.1 Hypothesis 1**

Hypothesis 1: Leader-based relationships are a) positively associated with constructive leadership, b) negatively associated with destructive leadership, and c) not associated with ineffective leadership.
This hypothesis arises from the strong association recounted in the interviews between leader-based relationships and constructive leadership. Interviewees described constructive leadership as the ability of leaders to infuse positive, aligned meaning into the group. In order to accomplish this, they deemed it imperative for leaders to have robust relationships, known as “leader-based relationships,” with group members based on meaning, purpose, mutual goals, and a mutual desire to accomplish the group’s mission.

Throughout the interviews, the interviewees described the critical importance of relationships to effective, constructive leadership. They also described the association of poor, untended, or negative relationships between leaders and group members with leadership failure. Leaders’ ability to develop leader-based relationships with group members often determined their success. I hypothesize that leader-based relationships relates positively to constructive leadership, meaning that the stronger the relationship, the more effective the leadership.

The participants clearly stated that ineffective leadership, often ascribed to managers, results from relationships that lack positive, aligned meaning. It occurs when ineffective leaders focus on tasks, policies, and operational details (staffing, budgeting, etc.) rather than striving to infuse meaning through leader-based relationships. Ineffective leaders do not develop, maintain, nor strengthen leader-based relationships with group members, as they consider this outside of their role and focus. Leader-based relationships enable leaders to infuse into the group. Absent leaders’ desire and ability to infuse meaning, leader-based relationships wither and dissolve. Therefore, I hypothesize that no relationship exists between ineffective leadership and leader-based relationships.
Destructive leadership results when meaning is destroyed or removed from a group. Destructive leaders may develop relationships with group members, but I hypothesize that these relationships are negative; that is, relationships allowing for the extraction of meaning from group members. For instance, an authoritarian leader may develop threatening relationships with group members, in which the group members feel compelled to follow the leaders’ missives because of threats of disciplinary action or job loss. Fear-based relationships such as these replace group member’s focus on the group’s mission and goals with a focus on protecting themselves from the leader, or on maintaining their employment. Self-focused leaders divert the group’s energies from its mission and goals, redirecting them to meet the needs and satisfy the expectations of the leader. Destructive leaders build relationships with group members based on their own needs; diminishing or destroying the group’s meaning. Therefore, I hypothesize that destructive leadership has a negative association with leader-based relationships.

4.8.2 Hypothesis 2

Hypothesis 2: Positivism has a positive association with leader-based relationships.

Positivism is manifested by optimism, compassion, motivation, and trust. Positivism describes the morale and engagement of the leader and its effect on the group. The interviewees felt that positivism played a significant role in developing and strengthening leader-based relationships, as it facilitates the ability of leaders to make
their message attractive and desirable for group members. I hypothesize that positivism has a positive association with leader-based relationships.

4.8.3 Hypothesis 3

Hypothesis 3: Communication has a positive association with leader-based relationships

Leaders described communication as a crucial ability to infuse meaning into group members by strengthening relationships. Positive expression, in which the leader delivers a message in a sensitive and meaningful way, provides an effective conduit for the infusion of meaning through leader-based relationships. Listening, on the other hand, enhances both the leader’s ability to shape effectively his or her message by considering the additional information obtained, as well as to strengthen his or her relationships with group members by demonstrating concern and respect for the group’s ideas and opinions. I hypothesize that communication has a positive association with leader-based relationships.

4.8.4 Hypothesis 4

Hypothesis 4: Self-efficacy has a positive association with leader-based relationships.

Self-efficacy refers to the confidence, courage, competence, and professionalism which a leader demonstrates in his or her relationships with group members. The
interviewees noted that leaders must possess self-efficacy in order to develop strong, effective leader-based relationships, as they inspired these same attributes in group members, enabling them to internalize the meaning delivered by the leader, and engage in the group’s mission. A leader lacking these characteristics cannot establish relationships with group members sufficiently robust so as to allow the infusion of meaning. Self-efficacy is hypothesized to have a positive association with leader-based relationships.

4.8.5 Hypothesis 5

Hypothesis 5: Resilience has a positive association with leader-based relationships

Resilience refers to the ability of leaders to persevere in the face of adversity, to stay “on message” in hostile or trying circumstances, and to “bounce back” or regain their momentum after a setback. The group of clinical leaders described resilience as a key attribute of constructive leaders. They described its positive effect on leader-based relationships as a result of the increased credibility and faith group members accorded leaders who demonstrated resilience. Resilient leaders develop and communicate effective meaning-based messages more effectively because of their commitment to the group and its mission, and their perspective of the environment and its potential effect on the group’s mission and purpose. I hypothesize that resilience has a positive association with leader-based relationships.
4.8.6 Proposition

Proposition: Leadership is a dynamic entity, varying with respect to time, situation, group membership, and the needs of the group.

The interviewees gave many examples of how leadership, far from being a stable fixed dualistic entity, is dynamic, frequently changing, often networked, and at times, unpredictable. They described emergent leadership, in which individuals assume leadership roles based on the group’s needs and dynamics. In complex environments, such as healthcare organizations, interviewees proposed leadership dyads in which two or more individuals with different skills, experience, and knowledge share leadership responsibilities. They also described leaders as frequently changing their leadership approach based on the needs of the group, the demands of the situation, and the abilities of the group members with whom they were interacting. I propose that leadership is a dynamic entity.

4.9 Conclusion

Leadership is a dynamic entity that is constantly changing as a function of the context, group membership, leader capabilities, leader and group resources and needs and depends on the establishment of strong leader-based relationships. The strength of these relationships is at least partially determined by the exercise of leader-specific characteristics including self-efficacy, positivism, communication, and resiliency. When relationships are not developed or used to infuse positive meaning into the group or
individual, ineffective leadership results. When meaning is destroyed or weakened by leaders, destructive leadership results.

I used grounded-theory methodology to analyze interviews with healthcare leaders in a Central Pennsylvania health system. As a case study of a bounded system, it provides an in-depth and rich description of leadership as perceived by these experienced practitioners in a complex and dynamic environment. Analysis of the qualitative data resulted in the construction an emergent theory of leadership. In order to establish its credibility and identify its relationship with the current leadership thought and practice, I will next situate it in the current literature, and then propose a quantitative study to test the theory’s hypotheses.
Chapter 5

Situating Dynamic Leadership Theory in the Literature

5.1 Introduction

Dynamic leadership theory (DLT) emerged from a qualitative study of leadership in a healthcare setting. By analyzing the perceptions and ideas of professional healthcare leaders concerning leadership through the use of grounded theory methodology, I identified theoretical principles and joined them into a theoretical construct consisting of five hypotheses and a proposition as enumerated in figure 5-1.

In the first section of this review, I will evaluate these hypotheses using recent literature as a means of obtaining a greater understanding of their significance to the effective practice of leadership. Given DLT’s new emergence from the qualitative study described in Chapter 4, it lacks support in the literature as a comprehensive theory. Nevertheless, the individual building blocks contributing to the theory, specifically

Figure 5-1 Dynamic Leadership Theory Hypotheses

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Description</th>
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<tr>
<td><strong>Hypothesis 1</strong>: Leader-based relationships are a) positively associated with Constructive Leadership, b) negatively associated with destructive leadership, and c) are not associated with ineffective leadership.</td>
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<tr>
<td><strong>Hypothesis 2</strong>: Positivism has a positive association with leader-based relationships.</td>
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<td><strong>Hypothesis 3</strong>: Communication has a positive association with leader-based relationships.</td>
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<tr>
<td><strong>Hypothesis 4</strong>: Self-Efficacy has a positive association with leader-based relationships.</td>
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<td><strong>Hypothesis 5</strong>: Resiliency has a positive association with leader-based relationships.</td>
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<tr>
<td><strong>Proposition</strong>: Leadership is a dynamic entity, varying with respect to time, situation, group membership, and the needs of the group.</td>
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leadership as the infusion of meaning, leader-based relationships, communication, resilience, positivism, self-efficacy, and the dynamic nature of leadership each has a significant presence in the organizational (but not necessarily leadership) literature as a topic of ongoing investigation.

Situating DLT and its building blocks in the literature provides a current understanding of their nature and attributes, and helps connect them to the concept of leadership. This review will not present an exhaustive recounting of their academic history, nor will it fully explore each of the subcategories that comprise these core leadership dynamics. Instead, it focuses on the association of each characteristic with constructive leadership.

I will compare and contrast DLT with major leadership theories in the second section of the chapter, with the goals of 1) gaining a greater understanding of the intricacies of DLT as seen through the lens of these theoretical constructs, and 2) elucidating the differences between DLT and these theories in order to show the unique contributions of DLT to the leadership literature. DLT builds upon the leadership foundation established by these theories, not supplanting them, but providing additional insights into the mechanisms of leadership.

I will first review the infusion of meaning as the defining process of constructive leadership, followed by a review of leader-based relationships as the main conduit through which the infusion of meaning occurs. I will then review communication, resilience, positivism and resilience as dynamic entities that support and enhance the infusion of meaning through leader-based relationships.
5.2 Leadership as the infusion of meaning

The clinical leaders in the qualitative portion of this dissertation defined constructive leadership as the infusion of positive meaning into an individual, group, or organization. Leadership as the infusion of meaning is a centuries-old concept, referenced by several classical leadership theorists. Even so a term such as “the infusion of meaning” is an ambiguous one, and requires further elucidation. What is meaning, and how does a leader “infuse meaning into a group?”

Infusing meaning encompasses a number of terms, including sense-making, sense-giving, and meaning making. The infusion of meaning consists of interpreting situations, adjusting self or group mental models of the environment, and then devising solutions to address the challenge or problem the individual or group is facing. Leaders’ core function is to accomplish this task, which distinguishes ineffective leaders, who do not engage in sense-making (as per my definition of ineffective leaders) from constructive leaders, who do (Holmberg & Tyrstrup, 2010).

Sense-making encompasses the “adaptive, dynamic, tactical and strategic, and timely synthesis and translation of knowledge as a process of enhancing decision-making abilities, leadership effectiveness, and group cohesion (C. M. Martin, 2010, p. 992).” Sense-making facilitates leaders’ construction of a repertoire of solutions and possible actions by allowing them to make sense of their environments, their capabilities, and their team resources (Springborg, 2010).

The infusion of meaning is a marker for the concept of serving an internal or external customer and of focusing on the effective functioning of the group. Leaders use
meaning to give purpose to production and performance measures, although followers may perceive it as a tool of dominion and control unless the meaning is constructed and presented in a transparent and trustworthy manner (Kerfoot & Knights, 1995).

As leaders infuse meaning into a group, they help group members come to terms with their own work-identities, and to discover purpose in their work-lives. “Group sense-making refers, in fact, to processes of interpretation and meaning production whereby individuals concerned with their identity in the social context of others seek to collectively accomplish a set task” (Patriotta & Spedale, 2009, p. 1227). Leaders play a critical role in creating group sense-making by directing the “meaning construction of others toward a preferred redefinition of reality” (Gioia & Chittipeddi, 1991; Maitlis & Lawrence, 2007, p. 441)

As mentioned, the infusion of positive, aligned meaning defines constructive leaders and leadership.

Leadership is realized in the process whereby one or more individuals succeed in the attempt to define and/or frame the reality for others. Indeed, leadership situations may be conceived as those in which there is an obligation or a perceived right on the part of certain individuals to define the reality of others. (Smircich & Morgan, 1982, p. 259).

Sense-giving helps orient leaders and group members to the group’s culture and mission, inculcating expectations about behaviors into the group (Patriotta & Spedale, 2009).

As proposed by DLT, leaders also infuse meaning as a way of destroying the core vision of a group. For instance, Alvesson and Willmott suggest leaders mold worker’s self-images and work orientation (sense-making) to align with managerially-defined objectives as a means of establishing power over an organization (2002). Leaders want employees to develop initiative, which they try to conform to management’s expectations
and desires by shaping employees’ meaning (Alvesson & Willmott, 2012). “The management of meaning is an expression of power, and the meanings so managed are a crucial aspect of political relations” (Alvesson & Willmott, 2012, p. 20).

Entitative, exchange-based approaches to leadership conflate infusion of meaning with worker productivity.

Employees are considered to be motivated as long as they are productive, regardless of whether their work is meaningful. The idea of motivation is considered to be a surrogate for meaning in a world where experts dominate decisions about how work should be structured and work frequently lacks any deeply valued purpose or significance. (Alvesson & Willmott, 2012, p. 94)

Sense making is something leaders do achieving organizational change, or when trying to convey a point of view or message (Dutton, Ashford, Lawrence, & Miner-Rubino, 2002; McNulty & Pettigrew, 1999)

Constructive leaders may also attempt to shape group members’ individual and work Identities as a means of infusing meaning. The line between manipulative or self-serving leaders abusing their power and/or abilities to influence workers’ identities as a means of achieving self-centered ends, and the constructive engagement towards an aligned vision of group members by shaping of their work-identities is a narrow one. For instance, healthcare workers bring compassion to work, but this may be displaced by the operational and economic pressures forcing the modern hospital to prioritize economic performance over patient care. In these environments, leaders exemplifying a core value of compassion can restore meaning and compassion to workers, thus facilitating more compassionate patient care (Kearsley & Youngson, 2012). DLT proposes that the purpose underlying meaning-making determines the constructive or destructive nature of its outcomes. As the group’s purpose aligns with its core ideals and beliefs, meaning-
meaning facilitates constructive leadership. When the purpose undermines, weakens, or contravenes the group’s core ideals, the meaning-making becomes destructive.

Ironically, leaders who focus on productivity as a substitute for meaning sacrifice tremendous stores of worker engagement and energy that they might otherwise use to achieve the group’s vision. Group members who find a powerful meaning in life experience emotional well-being and greater satisfaction with their environment (Ho, Cheung, & Cheung, 2010). Meaning in life facilitates eudemonia in group members (having a positive sense of well-being) (McMahan & Renken, 2011). A robust meaning of life correlates strongly with positive acculturation and positive emotions (Pan, Wong, Chan, & Joubert, 2008). The presence of meaning in life, and a search for meaning in life strongly relates to self-ratings of emotional wellness. Meaning in life accounted for 34% of the variance in workers’ perception of their well-being (Doğan, Sapmaz, Tel, Sapmaz, & Temizel, 2012). Commitment to multiple, diverse, self-transcendent sources of meaning such as those found in the work environment enhances the probability of living a meaningful life (Schnell, 2011). Positive emotions and well-being strongly correlate with group members’ productivity and success (K. Cameron & Spreitzer, 2012).

One group of leaders demonstrated this connection by successfully accomplishing organizational change by developing opportunities that appealed to workers’ values (Bartunek, Krim, Necochea, & Humphries, 1999). Other studies found that individuals who experience aligned meaning find greater success in meeting job demands. They have a decreased incidence of long-term sickness and experience lower levels of turnover. The inculcation of meaning at work creates a crucial organizational resource (Clausen & Borg, 2011).
A study exploring the differences between supervisors devoted to the sustainability of an organization and those who lacked devotion found that meaning derived from expertise, empowerment, values, inspiration, strategic thinking, and social contribution correlated closely with the presence of devoted group members (Tang, Robinson, & Harvey, 2011). This finding provides a roadmap for the development of group members who demonstrate a willingness to focus on the sustainability and success of the group. Leadership provides a crucial impetus to the meaning-making process and its success. For instance, one study found that successful leadership-enhanced meaning infusion predicted organizational commitment better than other variables studied (Asag-Gau & Dierendonck, 2011).

Leaders infuse meaning into a group in many different ways, including discursive methods, story-telling, and symbols. “Through evocative language and the construction of narrative, symbols and other sense-giving devices, leaders help shape the sense-making processes of organizational members toward some intended definition of reality” (Maitlis & Lawrence, 2007, p. 58). For example, a new university president infused meaning into the university by articulating his vision and illustrating how he wanted to change the organization (Gioia & Chittipeddi, 1991). In another study, leaders infused meaning into a company spin-off by creating new labels and meaning for the company’s identity (Corley & Gioia, 2004). Another group used graphs as a vehicle for infusing meaning into a group (Roth, 2004), illustrating the use of symbols as a sense-making device.

Leaders also infuse meaning through story-telling (Dunford & Jones, 2000). Stories and experiences are powerful tools when used to create meaning about relevant
situations and organizations (Nirenberg, 2012). For example, a leader transformed his company into a learning organization by relating stories about process improvement and Total Quality Management (TQM)-related successes (Snell, 2002).

One significant stream of research examined the differences between the expressed and intended meaning of leaders’ communications (and the meaning of the words which the leaders use) which may differ significantly. “Speaker meaning,” which the speaker intends to convey with his or her body language, tone of voice, etc., may differ from “expression meaning,” or the meaning of the words used by the speaker (Bezuidenhout, 2006).

Despite this difference, individuals construct the meaning of situations based on the literal and figurative interpretations they derive from clues in their environments (Coulson & Oakley, 2005). Digital technology’s lack of added information from body language, and tone of voice causes divergence of its actual, intended, and perceived meanings. Nevertheless, speakers (communicators) have accountability for their intended meaning. Unspoken or implied messages may carry a much more powerful meaning than spoken - or typed - messages (Haugh, 2013).

Other contextual factors magnify the complexity of infusing meaning into a group. For instance, the gender of a meaning-giver may impact the meaning attached to organizational symbols, messages and practices, making the consideration of gender crucial when constructing meaning-giving initiatives (Kyriakidou, 2012).

The emotional distance between leaders and group members also affects the infusion of meaning. Leaders perceived as more distant influence workers’ definition of themselves and their perceptions of meaning at work (Popper, 2013) more than leaders
perceived as “close.” Nevertheless, increased distance may also undermine the ability of leaders to monitor and adjust the meaning group members attach to his or her message.

Meaning infusion depends heavily upon the stimuli present in the leadership context. For instance, a complex environment often provides important opportunities for sense making (K. E. Weick, 1995). In a study of 27 orchestras and their directors, Maitlis and Lawrence found that,

All sense-giving is in response to troubling, uncertain, or confusing issues, but our study suggests that if an organization’s leaders have a limited appreciation of the threatened area, and if the threat is affecting an already poorly performing aspect of the organization, they will find it difficult to engage in significant sense-giving. (2007, p. 79)

Leaders’ most effective infusion of meaning occurs in response to ambiguity, involvement of large numbers of stakeholders (Maitlis & Lawrence, 2007), and the so-called sense-making gap, in which group members understand a situation differently than their leader. Executives effective in infusing meaning at the individual level may also prove best at sense-making at the organizational level as well, ultimately propelling their organization to higher performance (Akrivou & Bradbury-Huang, 2011).

5.2.1 Summary of leadership as the infusion of meaning

Constructive leadership, defined as the infusion of positive, aligned meaning, forms the basis of DLT. The infusion of this form of meaning, which encompasses terms such as sense-making, sense-giving, and meaning-making, has engendered considerable research effort. The infusion of meaning has been found to have a remarkable
importance in facilitating the effective exercise of leadership as well as in the enhancement of group functioning and performance.

Leaders infuse meaning by interpreting situations, beliefs, and goals based on the purpose and vision of the group, and using these interpretations to promote relationships, actions, and initiatives that enable the group to achieve its objectives. Adversity makes the infusion of meaning particularly essential, making it incumbent upon the leader to help place challenges and trials into perspective for group members, apply the group’s vision and purpose to the situation and help the group develop a repertoire of possible solutions that reflects their purposes and ideals.

As discussed in the review, the infusion of meaning distinguishes constructive leaders, who see this as their ultimate purpose, from ineffective leaders, who do not. Ineffective leaders focus on the instrumental aspects of the group and its objectives, ensuring that the group follows policies, completes budgets, attends to staffing and submits reports. Constructive leaders create meaning from these activities that supports the group’s purpose, and make sure it remains visible in the daily chaos and turmoil of organizational life.

The infusion of meaning also leads to negative outcomes when leaders choose purposes inconsistent with the core ideals and purposes of the group. This process results in destructive leadership, as it undermines the group’s vision, and undervalues, ignores, or even contravenes its core mission and purpose. A leader has a moral obligation to remain true to the group’s purpose, infusing meaning through the use of his or her skills and abilities to achieve the goals and initiatives that reflect the group’s core ideals.
This literature review provides a clear definition and understanding of the infusion of meaning, and gives substantial support for the concept of constructive leadership as the infusion of meaning. I will now explore each of the key hypotheses of DLT in the literature, situating them in the leadership and OB fields.

5.3 Leader-based relationships

The clinical leaders interviewed for the qualitative study portion of this dissertation identified robust, interactive, positive relationships as the foundation for constructive leadership. They shared insights into the crucial nature of leaders establishing, maintaining and enriching these relationships for leadership effectiveness. They recounted many anecdotes of leaders whose ability to lead declined or even failed as the result of inadequate relationships.

In this literature review, I will first define relationships, and then explore the different types of relationships that engender effective leadership, and discuss how leaders establish and maintain effective relationships. I will also present evidence from the literature regarding the impact of relationships on leaders and leadership, and ways in which faulty relationships can lead to leadership failure.

5.3.1 Definition of relationships

Relationships refer to an association between two people which that endures over time and circumstances (J. Reis, 2001). In order for a relationship to exist, the parties
involved must communicate effectively with one another. Three attributes of relationships – shared goals, knowledge, and mutual respect - determine their effectiveness (Gittell, 2013).

A myth of separate spheres of work and home permeates our culture, with work comprised of the political, instrumental, rational world of economic production, while home provides privacy for nonpolitical, natural, irrational, and emotional aspects of individuals, including relationships (Kanter, 1977; Perlow, 1998). Post-industrial revolution corporations adopted bureaucratic models of organization designed to enhance efficiency through hierarchy, division of labor, and impersonal, unemotional, and de-individualized rules, all of which strongly discourages close relationships (J. Martin, Knopoff, & Beckman, 1998). Overcoming this impersonal bureaucracy constitutes one of the greatest challenges modern leaders face as they seek to identify and infuse positive, purposeful, aligned meaning into an organization.

In order to achieve this crucial objective, leaders must use a variety of tools. For instance, one author proposed building relationships on a dialogical foundation, or the discourse (whether written, digital, spoken, etc.) used in the relationship (Sampson, 1993). Leaders’ relationships based upon a dialogic foundation share power with rather than exert hierarchical power over the group. They take advantage of the group’s combined resources rather than depending on the knowledge and understanding of a single individual. They encourage multiple diverse relationships within the group rather than a single set of hierarchical relationships, and they invite and encourage many lines of action rather than requiring or imposing consensus with the leader (Hosking, 2011).
Theories of leadership founded upon hierarchically-defined leaders and that propose leaders’ effectiveness depends on their individual characteristics are termed “entititative” theories. These theories treat leadership and the group being led as separate from or outside of the leader (an outside ‘entity’). They distinguish between the leader’s self and others, and propose creating relationships as a means of gathering information and gaining power over others (Hosking, 2011). Entitative leadership constructions consider leadership to be separated from the leader’s self and thus available for observation by an independent observer (Hosking, 2011). In contrast, the relational leadership epistemology embraced by DLT considers entities, knowledge, and power as internal constructions developed through ongoing relational cognitive processes.

Relationships create a foundation from which an individual can function. Humans possess an intrinsic need for sociality and group membership (Baumeister & Leary, 1995; Mitchell, 2000). Human behavior emerges from networks of interpersonal relationships (Uzzi, 1996). Freud believed that relationships determine human behavior and are central to humanness. He theorized that as infants are separated from their mothers, a separation anxiety develops which leads to disappointment and rage, requiring civilization to institute rules to tame man’s explosive potential, thus influencing their relationships (Freud, 1930).

Miller agreed with Freud that relationships provide a foundation for human functioning and behavior (Mitchell, 2000), but she disagrees with his proposition that they result from a pathologic base (1976). She asserts that Freud viewed human development from a male perspective, and suggested a more functional model highlights
women’s ability to develop their self-identity through connections with others, as opposed to males, who often grow their identities through separation from others.

Positive relationships can exert potent beneficial effects on individuals and organizations.

In positive relations, people are likely to become more self-aware of strengths and limitations, to feel affirmed and to become more open to continued growth and development. Mutual understanding, influence, benefits, and expectations create the possibility for greater self-discovery and a heightened sense of self-efficacy. (Roberts, 2007, p. 31)

Positive relationships contribute to individuals’ well-being and ability to function in their work lives as well. Referred to as “work connections,” relationships between and among group reflect interactions that form “the living tissue of the relationships” (Berscheid & Lopes, 1997, p. 136). Far from being stable, these connections reflect dynamic characteristics that facilitate changes in the way people think, feel, and behave (Gable & La Guardia, 2007), thus creating an ongoing challenge and opportunity for leaders as they attempt to form, maintain, and manage relationships within the group.

5.3.2 Relationships at work

Helping to explain the way in which group members perceive their relationships at work, cognitive network theory proposes that people develop relationships with others in order to align their expectations with those of the group regarding the nature of their work relationships, and how they should best be structured (Kilduff & Tsai, 2003). As these relationships become aligned, group members form high-quality connections (HQC’s). A subset of employment-based connections, HQC’s are short term, dyadic,
positive interactions that function through cognitive, emotional, and behavioral mechanisms (Stephens, Heaphy, & Dutton, 2013). The positivity of these connections is determined by how the persons involved feel as a result of their interaction (Stephens, et al., 2013).

5.3.3 Intimate relationships

As individuals become further aligned with group meaning and purpose, they begin to form intimate relationships. In this context, workplace intimacy is defined as an interaction in the workplace that reflects transparency and trust between individuals, allowing them to share their thoughts and ideas with other group members, trusting that this will be received with empathy and understanding (A. P. Aron, Mashek, & Aron, 2004).

Intimate relationships occur when group members share meaning with one another (Firestone & Firestone, 2004). While intimacy constitutes one aspect of love, which consists of intimacy, passion and decision/commitment (Sternberg, 1986), workplace intimacy in this context differs from romantic love associated with physical passion, and should not be confused with more pedestrian concepts of intimacy which are conflated with physical interactions. Individuals engaged in workplace intimate relationships attempt to support and enhance the happiness and self-worth of other group members as their primary objective, as opposed to developing power over others and prestige for themselves. Intimate relationships provide validation of self-worth and lead to collaboration (Sullivan, 1953). Group members engage in intimate relationships as a
means of establishing a base of mutual interdependence, empathy, understanding, and joint support as they perform key activities, and develop and sustain the group (Kark, 2013).

Intimate relationships help to buffer workers from stress-related pathology and result in decreased recovery time from illnesses and a decreased risk of relapse (Prager, 1997). They improve knowledge transfer and learning process by facilitating the passage of knowledge from one person to another, and enhance knowledge absorption by group members (Dutton & Heaphy, 2003). When leaders improve individuals’ psychological safety intimate relationships (Kark, 2013), they enable them to learn from group and personal mistakes, thus creating group knowledge (Stephens, et al., 2013).

Leaders engaging in intimate relationships help to enhance the efficacy of group members, and their ability to carry out the group’s mission. “Leadership from the network perspective involves developing social relationships within and across boundaries, and putting these relationships to use for the benefit of the organization” (Kilduff & Balkundi, 2011, p. 119). In intimate relationships, each person includes some of the other’s resources and identities in their own self-identity. Followers perceive themselves as 1) having access to a leader’s resources and 2) as being including the leader’s group identity, which leads to an enhanced sense of work self-efficacy and organizational self-esteem. This in turn allows the leader to realize satisfaction from the success and happiness of group members (A. Aron & Aron, 1986). Leader-based intimate relationships result in stronger attachments of followers to both the leader and to the group (Kark & Van Dijk, 2007), thus propagating intimate relationships within the group as group members emulate the leader (Kozlowski & Klein, 2000).
Intimate work relationships empower workers, and increase their energy and enthusiasm. Their sense of identity, self-worth, and self-efficacy increase (Kark & Shamir, 2002). Workplace intimacy influences individuals’ cognitive processes (Agnew, Van Lange, Rusbult, & Langston, 1998). It improves their cognitive performance by improving their information processing and the performance of their working memory (Ybarra et al., 2008). It improves physiological functioning such as the cardiovascular, immune, and neuroendocrine systems (Heaphy & Dutton, 2008). Intimate relationships facilitate employees’ recovery from loss (Lilius et al., 2008), and transitions at work (Ibarra, 2003). They also facilitate the development and growth of individuals (Ragins & Verbos, 2007). They enhance the attachment of individuals to the work organization and to the community (Blatt & Camden, 2007), and facilitate organizational change (Meyerson, 2001).

Social network theory proposes that the cognitive aspects of leaders’ relationships have significant effects on group function (Kilduff & Krackhardt, 1994). When a leader uses social network ties to lead, he or she must appreciate connections amongst group members outside of their relationships with the leader (Kilduff & Balkundi, 2011, p. 122).

5.3.4 Ego networks

The ego network is the circle of relationships surrounding the leader, and is comprised of a density and range. Density is the degree to which individuals in the network also have relationships with one another. Members of a dense network share
their perceptions and attitudes toward the leader (Krackhardt & Kilduff, 1999), which in turn can influence (positively or negatively) a leader’s ability to accomplish his or her objectives.

The range of the leader’s relationship network refers to its diversity; that is, the number of individuals who are dissimilar to the leader in some important aspect (gender, race, etc.). A diverse network confers the potential advantage of access to more extensive information and greater involvement in decision-making. “Homophilous networks,” in which group members lack diversity, restrict information available to the leader (Popielarz, 1999).

The leader’s density and range of intimate relationships may have significant consequences for his or her effectiveness. The net effect of the density of intimate relationships depends upon the positivity and negativity of group members’ perceptions. If group members perceive the leader in a positive light, a higher density of relationships enhances the leader’s effectiveness, while a dense network of group members with negative perceptions undermines the leader’s effectiveness (Kilduff & Balkundi, 2011).

### 5.3.5 Mastery relationships

Intimate relationships can exert powerful beneficial effects on human well-being and optimal functioning (H. T. Reis, Collins, & Berscheid, 2000), while mastery relationships may have the opposite effect. These relationships reflect a management approach characterized by leaders’ efforts to control and manage others (Kark, 2013), and by intolerance to individuals’ needs and weaknesses. Leaders who perceive relationships
as an opportunity to exercise mastery maintain a distance between themselves and group members in interpersonal interactions. The anxiety engendered by this form of relationships results in tension and stress as group members and leaders constantly mull over the power and control present in their relationships (Kark, 2013). Mastery-oriented leaders often pursue competitive leisure activities as an extension of their search for power (Kark, 2013). On the other hand, leaders engaged in intimate relations connect with others by focusing on feelings and needs, and seeking collaboration and interdependence (Kofodimos, 1993), shunning power-based interactions.

5.3.6 The dark side of intimate relationships

Exchange relationships, based on expectations of a return for investments into the relationship, differ significantly from communal relationships, in which one partner focuses on meeting the needs of the other (Clark & Mills, 1993). In exchange relationships, the parties keep track of what they contributed to the relationships, while in communal relationships, they keep track of what the other party needs, since the benefit of the relationship is in meeting the other person’s needs (Clark & Mills, 1993). In intimate work relationships, both communal and exchange relationships emerge from the demands of the work environment (Ingram & Zou, 2008). ‘Exchange intimacy’ has the trappings of true intimacy, but its purpose is to establish greater control over the other person, while emotional intimacy centers on the other person’s needs and opportunities (Kerfoot, 1999). Emotional intimacy is authentic and transparent while exchange intimacy has a potential for abuse (Kark, 2013).
Exchange intimacy exemplifies the dark side of leader-based intimate relationships, in which leaders abuse the trust and dependence which they create in the group. For instance, a minister recently took advantage of his close relationships with his parishioners by engaging in sexual improprieties and involving them in a gambling enterprise. Parishioners manifested their continued support for the minister by challenging and demonizing victims who accused him of abuse (Hunter, 2013). Establishing clear boundaries of propriety and professionalism constitutes a crucial aspect of intimate relationships, and groups must understand the processes for dealing with inappropriate behaviors within such relationships.

5.3.7 Relationship-based leadership theories

The significance of intimate relationships to leaders’ effectiveness has only recently gained wide appreciation. Traditional leadership research focuses on discovering and identifying attributes of leaders, such as their traits (R. House, 1977), behavioral styles (Lewin, 1946), the context of leadership situations (Fiedler, 1971) and the nature of leader-member exchanges as in LMX theory (Graen & Uhl-Bien, 1995). These approaches, however, ignore the critical nature of leaders’ relationships with group members.

Leaders, group members, and organizations derive tremendous benefit from intimate work relationships. “Leadership can be understood as social capital that collects around certain individuals – whether formally designated as leaders or not – based on the
acuity of their social perceptions and the structure of their social ties” (Kilduff & Balkundi, 2011, p. 120; Pastor, Meindl, & Mayo, 2002).

More recent leadership theories recognize relationships as essential for successful leadership. Relations-oriented behavior forms a fundamental part of Path-Goal Theory, Situational Leadership Theory, Leadership Substitutes Theory, and Least Preferred Coworker Contingency Model (Yukl, 2011). “Modern concepts of leadership identify the relational content of the interaction between people as the key aspect involved in the structuring of situations and the altering of perceptions and expectations” (Kilduff & Balkundi, 2011, p. 121; Uhl-Bien, 2006). In today’s knowledge-based organizational environments, relationship-based post-heroic models of leadership replace earlier leader-centric theories (Carmeli, Ben-Hador, Waldman, & Rupp, 2009; Fletcher, 2004; Uhl-Bien, 2006). Researchers appreciate knowledge-based work’s requirement for a more collaborative and relational style of leadership, and a less individualistic work environment (Pearce & Conger, 2003). Leaders willing to form intimate relationships garner greater engagement and effectiveness from group members (Burt, 2005).

“Relationship” theories of leadership focus on equality and collaboration, and shun hierarchy-based power. They recognize that relationships foster individual health and well-being, and enhance positive outcomes (Fletcher, 2007). Relational theories propose three attributes of leadership: 1) it is shared and distributed amongst the group, and not enacted by a single individual; 2) it is a social process in which interactions are the key, and 3) it results in learning, growth, and well-being for the organization.

Relationships not only enhance the well-being of individual group members and leaders, but facilitate the group’s effectiveness as well. Organizational work performed
through social processes and connections underscores the relational foundation of organizations (Stephens, et al., 2013). Network connections (relationships) provide both economic and operational value to individuals and communities (Burt, 2000). Enhanced relationships such as intimate work relationships increase the value of the group to the rest of the organization and to the community as a whole (Gnyawali & Madhavan, 2001).

### 5.3.8 Summary of leader-based relationships

Relationships constitute a core attribute of humanity. Humans are “wired” to exist in relationships with others. Relationships exist in many different forms and at many different levels of an organization, and contribute significantly to effective group functioning and structure. They provide the substrate upon which leaders exercise constructive leadership.

Leader-based relationships refer to positive, transparent, and intimate work relationships. They treat leaders and group members as equal partners, eschewing expectations of individual profit, especially at another’s expense. Leader-based relationships foster the growth and development of group members by improving their sense of identity, self-worth, cognitive performance, and physical health. The group’s effectiveness increases as the leader establishes and uses relationships to infuse meaning into the group.

The leadership literature has begun to appreciate relationships’ critical role in the effective exercise of leadership. Recent leadership theories identify relationships as the
foundation of leadership. DLT also emphasizes this association, recognizing that leader-based relationships are crucial to the ability of a leader to infuse meaning into a group.

This review of the literature finds strong support for constructive leadership’s dependence on strong, intimate relationships. The first hypothesis of DLT states, “Leader-based relationships are a) positively associated with Constructive Leadership, b) negatively associated with destructive leadership, and c) are not associated with ineffective leadership.” This hypothesis will be tested in the quantitative study that follows this literature review.

5.4 Positivism

The participants in the qualitative study identified leaders’ positivism as a key characteristic of constructive leadership. Positivism encompasses leaders’ abilities to focus on the positive, optimistic meaning in their work environment, and to help other team members to reflect a “can-do” and “we’ll make this happen” attitude.

In this brief review, I will examine selected literature on positivity and its support for positivism as a building block of DLT. I will then discuss the ways in which positivity can be developed and its significance for group functioning and leader effectiveness.
5.4.1 Definition

Positive organizational behavior, or POB reflects “the study and application of positively oriented human resource strengths and psychological capacities that can be measured, developed, and effectively managed for performance improvement” (Luthans & Church, 2002, p. 59). Leaders can develop and enhance positivity, thereby improving their group’s performance (Youssef & Luthans, 2012).

Positivism consists of an individual’s or group’s traits and characteristics. One group proposed that in order to qualify as a core attribute of positivism, proposed attributes must conform to current research and theory, be measurable, be able to be developed in an individual or a group, and stimulate improved performance (Youssef & Luthans, 2012).

Hope, efficacy, optimism, and resilience meet these criteria. Hope is defined as “a positive motivational state that is based on an interactively derived sense of successful agency (goal-directed energy) and pathways (planning to meet goals)” (Snyder, Irving, & Anderson, 1991, p. 287). Efficacy is defined as “one’s belief about his or her ability to mobilize the motivation, cognitive resources, and courses of action necessary to execute a specific action within a given context” (Stajkovic & Luthans, 1998, p. 66). Resilience is defined as “the developable capacity to rebound or bounce back from adversity, conflict, and failure, or even positive events, progress, and increased responsibility” (Luthans, 2002, p. 702). Optimism comprises individuals’ expectation of positive outcomes of their efforts (Carver & Scheier, 2002). Taken together, these four psychological
resources constitute an entity known as “psychological capital,’ or “psycap” (Youssef & Luthans, 2012).

5.4.2 Positivism and individual identity

Positivism is a natural state of most individuals, as most individuals hold positive views of themselves (Gecas, 1982), and want to be viewed positively by others (Swann, Pelham, & Krull, 1989). As a result they construct a self-identity based on positive traits and characteristics (Roberts & Dutton, 2009), a tendency towards establishing a positive identity that carries over into individuals’ work lives as well. Positive work identity consists of four perspectives which are discussed below: the evaluative perspective, the developmental perspective, the structural perspective, and the virtue perspective (Dutton, Roberts, & Bednar, 2010).

Virtuous identities manifest qualities characteristic of people of good character, such as wisdom, integrity, courage, justice, transcendence, redemption, and resilience (N. Park & Peterson, 2003). The evaluative perspective of a positive work identity holds that an identity is positive when it is held to be positive by the person, the relationships, and the group of which the person is a part (Roberts & Creary, 2012). The developmental perspective holds that a work identity is positive when it is consonant with the standards of the group or institution of which the individual is a part, and resists oppression and stigmatization (Creed, DeJordy, & Lok, 2010). The structural perspective holds that an identity is positive when the various parts of the identity are in agreement with each other and not in tension or conflict (Powell & Greenhaus, 2010). By following this road map, a
leader can develop members’ positive identities by pursuing positive actions and discourse.

Social identity theory proposes that individuals’ identities reflect the different groups to which they belong, and therefore possess emotional involvement with the way in which these groups are evaluated by others, particularly other groups of which they are a part (Tajfel & Turner, 1979). For example, a Boston Celtics basketball fan would have an increased emotional interest in the Celtic’s success if other group members at his work were fans of a different basketball team. Positive identity flourish when favorable cross-comparisons occur between the individual’s groups (Tajfel & Turner, 1979). Group identifications are “relational and comparative: they define the individual as similar to or different from, as better or worse than members of other groups” (Tajfel & Turner, 1979, p. 110)

Identity theory holds that social connections, including those within work groups, define an individual’s identity. It also proposes the existence of multifaceted identities that connect identity and behavior (Roberts & Creary, 2012), and holds that social ties shape identity, and identity shapes organizational behavior (Stryker & Burke, 2000). Individuals’ identities provide the meaning necessary to align behavior with their sense of self (Burke & Reitzes, 1981).

The critical role of this dynamic in developing and exercising effective constructive leadership cannot be overstated. The development and maintenance of positive work environments provides a crucial substrate for the creation of positive individual identities. As leaders infuse positive, aligned meaning into the group, group
members with positive identities respond with positive behaviors and beliefs (Roberts & Creary, 2012).

Individuals derive a sense of self from their role-based interpersonal relationships, which in turn shapes patterns of behavior and interaction (Sluss & Ashforth, 2007). A positive identity, particularly at work, can be developed by applying positive psychological resources to the work environment (Luthans, Avolio, Avey, & Norman, 2007). Positive psychological resources facilitate a “developmental capacity representing one’s positive appraisal of circumstances and probability for success based on motivated effort and perseverance” (Luthans, Avolio, Avey, & Norman, 2007, p. 550). Research has shown that the development of positive emotions leads to the cultivation of positive workplace climates and fosters new ways of thinking that generate more sustainable and healthier business practices (Sekerka, Vacharkulksemsuk, & Fredrickson, 2012).

5.4.3 Benefits of positivism

The significance and utility of psychological capital goes beyond human capital (what an individual knows), social capital (who an individual knows), and deals with “who you are” and “who you can become” in the future if your psychological resources are developed and nurtured in the workplace (Luthans, Luthans, & Luthans, 2004). As this additional capacity is developed, positivism in group members leads to improvements in group productivity and capabilities (Roberts & Creary, 2012).

In a study of 144 employees performing various roles in a midsized insurance services firm, positive psych cap scores correlated with employees’ performance and
satisfaction (Luthans, et al., 2007). In another study of 336 employees from a cross-section of organizations and jobs, positivism showed a positive association with voluntary organizational citizenship behaviors (group members devoting energy and efforts to group needs) and a negative association with organizational cynicism, intentions to quit, and counterproductive workplace behaviors (Avey, Luthans, & Youssef, 2010). Employees with higher levels of positivism facilitate positive changes in organizations (Avey, Luthans, & Mhatre, 2008), with investments in positivism generating returns of over 200% (using utility analysis of the data) (Luthans, et al., 2007).

Positive attitudes also produce non-economic benefits. They mediate the relationship between authentic leadership and workgroup’s performance and behavior (Walumbwa, Luthans, Avey, & Oke, 2011). Positive emotions shape favorable attitudes and outlooks which correlate with organizational learning and improved work efforts; they are also associated with improved organizational citizenship behaviors, such as prosocial behaviors, group development, establishing ethical cultures and the stimulation of ongoing learning (Arnaud & Sekerka, 2010; Triliva & Dafermos, 2008).

Positive attitudes and emotions benefit both individuals and the organization as a whole. According to the ‘broaden and build theory of positive emotions’ (B. L. Fredrickson, 1998, 2009), positive emotions such as joy, interest, and appreciation function in the short term to broaden one’s attention and quell heightened bodily reactivity and to build one’s cognitive, social, psychological, and physical resources over the long term, while negative emotions narrow people’s attention and mobilize cardiovascular and other bodily systems to support quick, survival-promoting action. (Sekerka, et al., 2012, p. 169)

Positivism not only benefits groups and their members by building positivity, they also improve groups’ perceptions of their leadership abilities. Leaders’ expression of
positive emotions in the workplace created positive perceptions among employees of leader’s effectiveness, and also increased their desire to work for them (Bono & Ilies, 2006). Workers rewarded leaders demonstrating positivism with increased productivity, while external stakeholders’ perceptions of the group’s success improved (Bagozzi, 2006; Zapf & Holz, 2006).

Ultimately, sustainable organizations must achieve a balance of economic, ecologic, ethical and social aims in order to remain viable and prosperous regardless of the environment and challenges they may face. By fostering individuals’ commitment and engagement towards these organizational aims, positivism provides a pathway to develop this balance (Potocan & Mulej, 2007; Sekerka, et al., 2012). The individual and group-level returns of positivism provide a robust basis on which to pursue its development in leaders and groups. The promise of long term organizational success coupled with benefits realized by the leader and group members make positivism a critical element of effective leadership.

### 5.4.4 Summary of positivism

Multiple literature streams inform the concept of positivism. It has been defined as the possession of positive psychological capital consisting of hope, optimism, resilience, and efficacy. Other authors refer to positive emotions, positive identity, and other categories of positivity such as passion, compassion, and trust when speaking of positivism. Positivism imparts leaders and groups with an optimism and hope about their
likelihood of success. They have a ‘can-do’ attitude and look for positive meaning in times of adversity and challenge.

Positivism is a tool of leadership. A positive atmosphere in a group enhances a leader’s ability to develop strong, robust relationships that enable the infusion of positive, purposeful meaning into a group. Group members with a positive outlook analyze situations more effectively, consider a wider palette of potential solutions, and implement more effective action plans. Positivism produces a tremendous return on the economic and emotional investments required for its development. It enhances group members’ creativity and satisfaction, and creates better perceptions of leadership.

Positivism results from the development of positive group characteristics. Leaders are crucial to this process, as group members often adopt their leaders’ examples of behavior and meaning. Positivism enhances the ability of leaders to infuse meaning into a group by creating a more supportive group environment, and by creating individual identities that are drawn to meaning-based direction and support.

This literature review provides robust support for positivism as a moderator of the leader-based relationships that facilitate constructive leadership. Hypothesis 2 of DLT states “positivism has a positive association with leader-based relationships.” This hypothesis will be tested as part of the quantitative study that will be proposed at the conclusion of this literature review.
5.5 Communication

DLT proposes that Communication is a foundational element of constructive leadership, enabling the infusion of meaning to individuals, groups, and organizations by strengthening positive leader-based relationships. The participants in the qualitative study consistently identified communication as a key characteristic of constructive leadership, while also noting that the failure of leaders to communicate effectively led to a weakening of their leadership effectiveness and, eventually, to their failure as leaders.

In this section, I will explore the significance of communication in the leadership and organizational behavior literature. I will first review the definition of communication, and then review the components of which communication is comprised. I will conclude this section with a discussion of the ways in which communication contributes to effective leadership and effective organizations.

The significance of communication to the exercise of effective leadership is a recurrent theme in the leadership literature. The ability to master and deploy key communication skills is essential for effective leadership. Specifically, these skills consist of: reading, writing, listening, and speaking (Hussain, Siddiqi, & Rahat Ul Ain, 2011). Modern communication technology, particularly digital technology (email, texts, video, etc.) serves to enhance the ability of leaders to communicate effectively by providing increased access to group members, allowing them to use a large variety of media as a means of exchanging ideas and information. “Communication and language are the mechanisms through which social identity is created, maintained and modified”
Thus, leaders’ attempts to shape group identity depend heavily on their effective use of communication skills.

Communication forms a part of an organization’s foundation. As one author stated, “Organizations are a communicative event built upon the communication behaviors of the organizational members” (Pepper, 1995, p. 18). Another said, “Talk is not about the state of the organization; talk is the state of the organization” (Clifton, 2006, p. 208). Members each bring unique experiences, strengths, and knowledge to the organization, and strengthen it with their diversity (L. Browning & Shetler, 2000).

Because communication forms the backbone of the organization, successful organizational change depends on leaders’ ability to change communication behaviors (Ford, 1999).

Communication is a powerful enabler of positive leadership because it generates understanding, spreads knowledge, overcomes isolation, enables coordination, and improves problem solving (L. Browning, Morris, & Kee, 2012). However, communication also can cause negative outcomes, distraction and disappointment, disruption, and even destruction of group meaning and purpose (L. Browning, et al., 2012). It can serve to hide errors and harmful behavior (Deetz, 2009).

5.5.1 Definition

Communication is a process which helps individuals arrive at a mutual understanding that is “sensible, accurate, consensual, contemporary, and workable of the meaning of a situation and the events surrounding it” (L. Browning, et al., 2012, p. 567).
Positive communication enhances organizational intelligence (Johnson, 1977) by providing clear, concise, reliable information transfer between organizational members. Group members who engage in positive communication enhance the positive atmosphere in the group and stimulate additional positive communication through consideration of others’ goals and interests (Brown & Levinson, 1987). Positive communication practices are integrative, connect people across geographical and organizational distances, ideological divides, language barriers, and diverse cultural and individual experiences and enable them to integrate diverse ideas, opinions, experiences, aspirations, and goals into a cohesive group mission and purpose (Gibbs, 2009).

5.5.2 Positive communication

Lessons from the field of psychotherapy provide helpful insights into the benefits of positive communication. Therapists’ relentless positive communication styles overcome couples’ tendencies to focus on problems and revert to blaming (De Shazer, 1985). By focusing couples on how things would be different if the problem was resolved, how they have made positive contributions and their strengths and capabilities (Fredrickson, 2003), the therapists promote a positive atmosphere in the session and are more likely to achieve a positive outcome. Positive communication in an organization, in a similar manner, helps to engender a positive morale in the group, and focus its members on achieving positive solutions to the challenges they face.

An example of positive communication is comforting communication, in which a leader conveys personal warmth, validating the feelings of other group members, and
encouraging discussion about troubling events (Jones & Wirtz, 2006). Advice and directions are given in a way that does not undermine group members’ self-confidence or competence (MacGeorge, Lichtman, & Pressey, 2002).

Similarly, leaders can use positive communication to offer social support, defined as “a desire and willingness to help others succeed by encouraging someone whose confidence is wavering” (LaFasto & Larson, 2001, pp. 14 - 15), which is “enacted through interpersonal communication” (Segrin, 2003, p. 318). Leaders use socially supportive positive communication to engage workers who may otherwise lose their focus and commitment in negative or demanding situations.

5.5.3 Integrative Communication

Integrative communication, another category of communication, serves to bring organizational members together by overcoming gaps in their understanding and awareness of the organization, its culture, its mission and its purposes. “Integrative communication integrates distant parts, even through hard-fought discussions, and gives them a single voice.” (L. Browning, et al., 2012, p. 568) To have a voice means becoming part of the whole and joining the discussion (Putnam, 2006). Integrative communication enhances employee engagement as they become central to information flow, demonstrating the leader’s regard for the group (Giddens, 1984). Integrative communication motivates knowledge workers for whom authoritarian leadership approaches are less effective (Vie, 2012).
Sharing knowledge through integrative communication facilitates group integration by building group knowledge, memory, and culture. It helps new members become integrated into the group by familiarizing them with the group’s norms, traditions, expectations, practices, and symbols (Corbett, Faia-Correia, Patriotta, & Brigham, 1999). Reliable, appropriate, and adequate information shared through integrative communication techniques promotes successful socialization of new members into the group, and as they assimilate cultural norms of communication they become better integrated with group members (Flanagin & Waldeck, 2004).

Integrative positive communication focuses on the future. “In the language of the cooperation literature, participants are conscious of a ‘shade of the future’ which means that their day-to-day activities are conducted with an awareness that their long-term relationship makes a difference” (L. Browning, et al., 2012, p. 573; M. D. Cohen, Riolo, & Axelrod, 2001; Kee & Browning, 2010). As a “public good” in integrative communication, and shared without regard to power or position, information serves a potent integrating function (Gastil, Black, Deess, & Leighter, 2008).

Integrative communication creates constructive interactions, a process in which group members use positive communication methods to conceptualize and develop solutions to challenges facing the group (L. Browning, et al., 2012). This form of communication, called ‘illusionment,’ focuses on solving problems, rather than on the problems themselves (L. Browning, et al., 2012), and thus “creates a framework of possibility” (Zander & Zander, 2000, p. 160). Integrative communication overcomes barriers between individuals or groups, such as cultural barriers, academic barriers, and
perceptual barriers (L. Browning, et al., 2012), thus facilitating the kinds of constructive interactions needed for group cohesiveness.

Integrative communication also encompasses collaboration. Pursuing appropriate behavior, helping to overcome errors, and continuously assisting fellow group members make sense of their environments all contribute to integration of a group (Morris & Hopper, 1987; Stokes & Hewitt, 1976). Group members attempt to align their own conduct with other members’ expectations, utilizing a variety of tools and resources to achieve this including communication style and content. (Morris & Hopper, 1987; Stokes & Hewitt, 1976).

Communication takes place partially through dialogue, which is the process of elaborating on the information and perspectives under discussion. It is “the exchange of information and perspectives, individual-level processing of information and perspectives, the process of feeding back into the group, and discussion and integration of its implications” (Van Knippenberg, De Dreu, & Homan, 2004, p. 1009). In other words, dialogue allows individuals to engage in the organization’s key processes as both recipients and suppliers of information and ideas.

5.5.4 Listening as communication: Projective hearing

Listening is a core characteristic of effective communication. Because of the passive connotation of this term, researchers coined a derivative term, ‘projective hearing,’ to describe an engaged, active process in which leaders and others utilize listening as a tool for effective communication (L Browning, et al., 2012).
Simply stated, in projective hearing, involvement breeds involvement. The enthusiasm of the manager is translated into a habitus of active listening, encouraging the other and bringing about new ideas (content), a stimulating encounter (process), and a pleasant relationship. (van Woerkum & Aarts, 2011, p. 179)

Projective hearing is similar decision-making process in a complex environment. Because of the large amounts of information available to a leader facing a decision opportunity, and the need for expedited decisions, the decision-making process often occurs largely in the subconscious mind. If a leader attempted to make a rational decision in such circumstances, the amount of information and number of choices could potentially overwhelm him or her; and even if the rational analysis were possible to accomplish, the time frame available for rational decision-making is often inadequate to accommodate such a process (Dijksterhuis & Nordgren, 2006; Zizzo, 2000).

Group-oriented integrative communication, of which projective hearing is a key component, functions in a similar fashion to a subconscious decision-making process. Following the principles of Simon’s “bounded rationality,” (Simon, 1965), in which the goal is to reach not the best solution, but a ‘good enough” solution, group communication processes allow for “parallel processing” by group members, thus bringing to bear a diversity of thoughts, experiences, understandings and insights which allow for a group-supported decision. By bringing employees into the decision making process, they have increased engagement and buy-in of both the process and its outputs (Eisenberg, Goodall Jr, & Trethewey, 2010).

As employees engage in integrative communication, leaders must provide them with prompt, appropriate, and socially adept feedback in order to maintain their
involvement (Zaccaro, Foti, & Kenny, 1991). Projective listening is a key part of this
group-based process. Group members, because of their acculturation within the group,
are often expert at picking up non-verbal clues in both the speech and body language of
speakers and listeners (Hoogervorst, van der Flier, & Koopman, 2004). These clues give
powerful indications of the depth of commitment of the speaker or the listener to the
message being delivered, their comfort level with the message, and their confidence in
communicating it (Hoogervorst, van der Flier, & Koopman, 2004).

Because projective hearing enhances relationships with group members, and is
strongly associated with the effective infusion of meaning from a leader into the group, it
is a characteristic of leadership as opposed to management (Christensen, Cheney, Zorn,
& Ganesh, 2010). It starts with the leader’s clear, rich mental image of the organization’s
vision which generates the meaning he or she is attempting to infuse. This cognitive
backdrop informs the action of projective hearing. It connects the leader’s listening ear
with his or her reactions, gestures, words, and body language in a way that sends a
reflexive message to the participants about the leader’s intended meaning. The process
by which meaning is imparted to group members as they observe and internalize the
leader’s unspoken reactions to the conversation can be a powerful tool by which the
leader can further change the group’s cognitive processes by infusing meaning (van
Woerkum & Aarts, 2011).

In addition to the active component of listening that characterizes projective
hearing, it also encompasses a leader’s flexibility and willingness to actively consider
messages generated by group members. Projective hearing supports integrative
communication by ensuring each group member’s thoughts and ideas are considered and
weighed for inclusion into the group’s overall meaning. As leaders demonstrate a willingness to both actively listen and flexibly adjust to the information and ideas transferred through dialogue, group members exhibit greater engagement reflecting the group’s direction and goals (van Woerkum & Aarts, 2011).

5.5.5 Composition of effective communication

Effective communication is characterized by: 1) rhetorical effectiveness, 2) a focus on attentiveness, assertiveness, directness, openness, friendliness, and empathy (D. Cameron, 2000), 3) technological efficiency, using technology appropriately to achieve optimal efficiency and effectiveness in the communication process, and 4) a reflection of organizational culture and needs (L. Browning, et al., 2012). In order for the group to devise, plan, and implement effective change strategies, group members must have access to accurate communication about the evolving environment. In many organizations, unreliable information could have disastrous consequences; communication therefore must reflect trust, respect, and honesty (K. Weick, 2003). In a study of healthcare workers, respectful communication results in maintenance of motivation, improved decision making, and better patient care (L. Browning, 2007; Grant et al., 2007).

Group diversity enhances effective communication, allowing the group to benefit from different perspectives and outlooks on the issues being discussed. “Homophily in gender and race had no significant impact on the development of either instrumental or expressive ties” (Yuan & Gay, 2006, p. 1069); in other words, lack of diversity led to inadequate development of leader-based relationships, and group members were better
able to develop effective relationships using communication with diverse group members.

5.5.6 Communication technology

The use of assistive communication technologies enhances communication between group members. For instance, computer-mediated communication, such as emails and video communication techniques, results in lower levels of deception and higher levels of satisfaction, possibly due to the assumption that digital messages are easily recordable (Giordano, Stoner, Brouer, & George, 2007; Hancock, Thom-Santelli, & Ritchie, 2004). In addition, information shared via digital technology tends to be positive (L. Browning, et al., 2012), and group integration improves through the use of digital technologies. “The web tends to reduce the significance of offline hierarchies in accessing information – thereby ‘democratizing’ access to worldwide resources” (Caldas, Schroeder, Mesch, & Dutton, 2008, p. 679).

Increased accessibility of communication through internet use, as measured by time spent sending emails exerted a positive impact on collaboration (Sooryamoorthy & Shrum, 2007). Organizations that promote sharing of information through such mechanisms as copying emails, and by providing wider employee access to the internet, experienced higher organizational and employee performance as employees formed common information pools and alliance networks (Lai, 2001; Skovholt & Svennevig, 2006). In addition, knowledge sharing via digital technology gave the added benefit of strengthening employees’ customer-centered attitudes (Reychav & Weisberg, 2009).
Integrative communication promotes the creation of social ties that enhance dialogues and that are critical for organizational integration (L. Browning, et al., 2012). Digital technology can be a powerful tool to this end. For instance, “social users of the internet have more social ties than nonusers do. Among social users, heavy e-mail users have more social ties than do light users. Email users communicate online with people whom they also contact offline.” (Zhao, 2006, p. 844)

5.5.7 The importance of leaders to effective communication

Leader involvement in communication processes can be crucial in creating effective communication. For instance, in one study of cadets in a military academy, leader integrity mediated the relationship between transparent communication and worker engagement (Vogelgesang, Leroy, & Avolio, 2013). Military cadets who rated their leader’s communication as transparent rated themselves as being engaged and were found to be more productive.

In another example of the importance of leader involvement in group communication processes, another study found that the support and involvement of the group leader was crucial to successful implementation of a knowledge-management system. Leader’s communication of crucial information to knowledge workers enhanced the information’s relevance to group members, and increased their attentiveness and engagement in the change process (Anantatmula, 2008).

Leaders’ communication styles are also critically important to increasing the effectiveness of group processes. Much of managers’ time is spent communicating with
employees (Henderson, 1987) and the group members’ perceptions of this communication shapes their understanding of the leader and his or her focus and purpose. For instance, leaders who communicate to group members as part of an “inclusive” group, as opposed to an “other” group, create group unity. One set of authors described this as using the adult ego state, in which both communicants are considered to be on an equal status, as opposed to a parental ego state, in which one communicant “talks down” to the other (Hicks & McCracken, 2010).

5.5.8 Ineffective Communication

Hierarchical communication is perceived to be top-down, unidirectional, and poorly received (Brownell, 2003). For instance, in describing transformational leadership, one set of authors described appropriate communication as essential and consisting of 1) the message content being delivered, and 2) the way in which it is delivered (Holladay & Coombs, 1993). These same authors also felt that transformational leaders need to communicate in dramatic, dominant, and animated ways, and focus on a strong delivery style (W. L. Gardner, 2003).

Communication focused on delivery rather than content and process may sacrifice leader-generated meaning for entertainment. Without incorporating group members into an integrative communication style, the leader becomes a group outsider, delivering the message as a “they” rather than a “we.” Because it has the disadvantage of separating the leader from the group and the task, and making it and them “out there”, hierarchical communication compromises a leader’s ability to infuse meaning. A leader cannot
extricate him or her self from either the group or its objectives. The task and mission are his or hers as much as they are the group’s, and require the leader’s involvement and engagement to be successful, thus suggesting an integrative communication style may be most effective at infusing meaning as opposed to one that is stuck in the “sending” mode (Barge, 2004). Yukl, for example, said that it was “uncommon to find a leader of a major corporation who was ‘larger than life, delivering spellbinding speeches, to manage impressions’” (Yukl, 1999, p. 37).

Organizational meaning cannot be infused solely via one directional communication. Leaders only influence group members through the use of these techniques when group members engage cognitively in the change process, and are willing to “hear” the message. On the other hand, when leaders engage in projective hearing as a part of their overall communication strategy, they realize much greater communication effectiveness. By showing engagement, interest, satisfaction and enthusiasm in the messages from group members through projective hearing, leaders develop a positive spiral in which their own projective hearing stimulates coworkers, thus validated and energized, to engage in the same behavior (Shotter & Cunliffe, 2003).

Unidirectional communication may be destructive to group processes and meaning. Leaders failure to pay attention to group members messages correlates with employees’ depression and emotional exhaustion (Theorell et al., 2012). One reason leaders do not listen is that it can be threatening to certain types of leaders, who equate it with conceding control or power to group members. On the contrary, however, leaders were found to receive greater trust when they are perceived as listening attentively
(Simmons, 2011), giving them greater influence with group members, and increased ability to achieve successful outcomes.

In bi-directional integrative communication with projective hearing, leaders withdraw from their positions at the presumed apex of the hierarchy, and work alongside group members in the chaos and turmoil of an organization’s daily existence. The leaders’ purpose is not to deliver one-directional directives to the group, telling members what they should do and how to feel, but rather to engage them in ongoing interactions that allow group members to bring their values, knowledge, and wisdom to bear on the challenges facing the group. Using this form of communication, leaders’ have the opportunity to manage, not the actions of the group, but the interactions of its members (Cunliffe, 2001; Shotter & Cunliffe, 2003). In this way, leaders “are much more like bricoleurs than like engineers... fixing things on the spot through a creative vision of what is available and what might be done with it – people, ideas, resources” (Thayer, 1988, p. 239). Projective hearing, in conjunction with other integrative communication techniques is a powerful tool to help align diverse group members’ ideas and recommendations. (van Woerkum & Aarts, 2011).

The processes leaders use to communicate and the relationships they form with group members influence their ability to communicate effectively. Successful leaders know well that the effectiveness of their leadership depends upon having a shared vision with group members and stems from their ability to stay connected with group members, taking full advantage of group members’ knowledge, wisdom and insights as they develop mechanisms for the group to tackle its challenges. Effective leaders use projective hearing as part of an integrative communication strategy,
combining their own ideas and knowledge with that of the group to advance the group’s mission and purpose (Tannen, 2005).

5.5.9 Summary of communication

Communication plays a unique and powerful role in the practice of leadership. Communication creates the conduit through which leaders build and utilize relationships to infuse positive meaning into the group. Organizations are communicative events; their very existence depends on the presence and the effectiveness of positive communication.

Different forms or components of communication inform leader-based relationships, and thus the practice of constructive leadership. “Positive” and “comforting” communication describe ways in which communication can be used to strengthen the group and overcome challenges group members face. “Integrative communication” refers to robust interactions between group members in which each has access to the exchange of ideas and the making of decisions. Integrative communication is a powerful tool for constructive leaders as they go about building strong and unified groups.

Projective hearing is an enhanced form of listening through which leaders are able to convey powerful meaning by the use of body language, facial expressions, and patterns of responses. Projective hearing is a form of integrative communication in that it engages group members in meaning-making through leaders’ communication with them even as they communicate with leaders.
The effectiveness of a leader’s communication is enhanced by his or her appropriate use of various communication technologies, by encouraging diversity in the communication processes, by focusing on the strengthening of relationships during the communication process, and by using integrative communication techniques. Through the development of these communication skills and abilities, leaders accomplish their key objective of infusing meaning into a group with greater effectiveness and reliability.

The literature strongly supports the use of communication as a means of creating constructive leadership through leader-based relationships. This review lays a strong foundation for the hypothesis “communication has a positive association with leader-based relationships,” which will be tested by the quantitative study proposed at the conclusion of this chapter.

5.6 Leader Self-efficacy

Self-efficacy has garnered considerable attention over the past several decades in the organizational behavior literature, and more recently in the leadership literature. Its meaning and significance have evolved over this period, and our understanding of the term has grown considerably. One author stated,

To establish agency and ownership over their area of responsibility and to fully engage themselves, leaders must be efficacious in a number of ways. For example, they must believe they can generate leadership solutions, motivate themselves to engage in leadership challenges, enact appropriate behaviors, and find support in the various means in their environment to ensure success. (Hannah, Avolio, Luthans, & Harms, 2008, p. 8)
As an important characteristic of an individual’s identity, self-efficacy has been incorporated into key derivative concepts which also have a significant bearing on leadership and its effectiveness. I will first explore definitions of the term, and then examine the psychological characteristics that contribute to it. Finally, I will review the organizational dynamics of which efficacy forms a core part.

5.6.1 Definition

An early definition of the term self-efficacy states, “It is people’s judgments of their capabilities to organize and execute courses of action required to attain designated types of performances.” (Bandura, 1986, p. 391). In a more recent article, self-efficacy is defined as “the mechanism through which experience and thought lead to agency. Self-efficacy represents “an individual’s overall judgment of his or her capacity to successfully organize and execute the tasks required to reach a specific goal.” (Goddard & Solloum, 2013, p. 644). These definitions suggest that self-efficacy is a cognitive process or event, a set of beliefs about one’s own identity as it relates to the environment in which one is functioning. These definitions imply that a person, notably a leader in this case, understands both the needs and expectations of the situation at hand, their own capabilities with respect to those needs, and at some level a calculation of the relative balance between the two.

Self-efficacy plays a critical role in assisting individuals to generate effective solutions. It facilitates the ability to recall significant information, including memory of group history and other dynamics useful in overcoming challenges facing the group
Higher self-efficacy is associated with better cognitive performance (Schunk & Gunn, 1986), the ability to acquire and use complex skills (Kanfer & Ackerman, 1989), and with enhanced data generation (Gist, 1989).

Self-efficacy has a number of sub-components. For instance, as part of their general self-efficacy, a person has a learning efficacy encompassing his or her ability to incorporate knowledge and events into their mental model of a situation or process. He or she also has, as a part of their self-efficacy, an action efficacy which describes their ability to collect the necessary cognitive, physical, and emotional wherewithal necessary to undertake a course of action in a given circumstance. Important to our discussion is the idea of leader self-efficacy (LSE), or the efficacy to provide leadership, which is addressed further below.

5.6.2 Leader self-efficacy (LSE)

An individual’s cognitive ability to construct and evaluate different potential solutions to a challenge is a key determinant of LSE. People’s perceptions of their efficacy influence the types of anticipatory scenarios that they construct and reiterate. For example, those that have a high sense of efficacy visualize success scenarios that provide positive guides for performance and they cognitively rehearse good solutions to potential problems. (Wood & Bandura, 1989, p. 729)

In social cognitive theory (Bandura, 1986), efficacy results from human agency which is comprised of three entities: 1) a person’s thoughts and motivations, 2) their actions and 3) their perceptions of the context in which they operate. Leader self-
efficacy maps onto these three facets of human agency (Hannah, Avolio, Walumbwa, & Chan, 2012). As leaders face difficult challenges, they draw upon their efficacy, including learning, action, and leader self-efficacy, to construct, initiate and manage their response. (Gist & Mitchell, 1992).

Leader self-efficacy (LSE) describes an individual’s possession of confidence in their knowledge, skills, and abilities to provide leadership to others, and is distinct from the knowledge, skills, and abilities required for other tasks or roles, such as teaching, performing, etc. (Hannah, et al., 2008). LSE reflects a leader’s belief that he or she is able to gather the emotional strength, drive, resources, and cognitive skills needed to achieve effective and sustainable leadership (Hannah, et al., 2008). Effective leaders with strong LSE demonstrate engagement, adaptability, and flexibility when facing leadership challenges (Hannah & Luthans, 2008). LSE enhances leaders’ ability to enact solutions, contributing to their effectiveness (Semadar, Robins, & Ferris, 2006), group performance (Murphy, 1992), and ability to achieve change (Paglis & Green, 2002).

Leader self-efficacy determines the extent and manner in which leaders utilize their cognitive abilities (Wood & Bandura, 1989) such as their general memory functioning (Hultsch, et al., 1988) and their cognitive performance (Schunk & Gunn, 1986). LSE improves their ability to focus on a particular situation or detail, and to process data and cognitive inputs (Berry, West, & Dennehey, 1989).

Four categories of experience inform leader self-efficacy (Bandura, 1997). Mastery experience refers to the effect of recurrent success bolstering self-efficacy, and recurrent failure diminishing it (Bandura, 1997). ‘Modeling’ and ‘vicarious experience’ refer to the phenomenon in which watching others successfully perform a task enhances
one’s ability (self-efficacy) to do the same task (Bandura, 1997). Verbal persuasion refers to convincing one’s self (increasing one’s self-efficacy) of their capacity to achieve their mission (Bandura, 1997). Physiological and affective states such as excitement and enthusiasm (enhanced self-efficacy) positively impact a person’s belief in their success, while fear and anxiety negatively impact it (Bandura, 1997). Leaders’ self-concepts are complex, comprised of multiple selves (Lord, Hannah, & Jennings, 2011) and representing numerous domains of knowledge about their self, their context, and their capabilities as leaders (Hannah, Woolfolk, & Lord, 2009); leaders awareness of these factors, and their control of them partially determines their level of efficacy.

This cognitive ability contributes to leadership capacity (Mumford, Zaccaro, Harding, Jacobs, & Fleishman, 2000) and predicts leaders’ emergence and effectiveness (Atwater, Dionne, Avolio, Camobreco, & Lau, 1999). Leaders’ self-efficacy for decision-making enhances their cognitive abilities and analytic strategies (Wood & Bandura, 1989). “People need a sense of efficacy to apply what they know consistently, persistently, and skillfully” (Bandura, 1997, p. 223).

LSE affects leaders’ self-perceptions, which in turn determines their motivation and perseverance (Bandura & Locke, 2003), an effect that perpetuates itself over time in a process referred to as ‘spiraling.’

5.6.3 Efficacy spirals

The term ‘spirals’ refers to the mutual influence performance and efficacy have on each other. Better performance leads to better efficacy, and negative performance
decreases efficacy (Lindsley, Brass, & Thomas, 1995). These spirals cause people with similar levels of skill but different levels of efficacy to perform at different levels (Bouffard-Bouchard, Parent, & Larivee, 1991)

Alternatively, high levels of self-efficacy can have negative effects on leader development and learning. For example, a well-performing leader with high efficacy may not feel the need for further development (Machida & Schaubroeck, 2011). For instance, students with high self-efficacy perform worse on exams than those with low or moderate self-efficacy (Vancouver & Kendall, 2006), while those with very low levels of self-efficacy also perform poorly (Bandura & Locke, 2003). Moderately low self-efficacy may enhance leader development by conferring greater desire and willingness to learn on leaders (Machida & Schaubroeck, 2011).

Nevertheless, high LSE exerts a positive effect on leaders’ effectiveness. For example, learning efficacy promotes leader development by building leaders’ confidence in their ability to develop the skills they are being taught (Pintrich, 1991). Similarly, self-efficacy mediated the relationship between Leader Member Exchange (LMX – an assessment of a leader’s relationship with group members) and role performance, and between LMX and positive organizational civil behavior (Hu & Liden, 2013).

5.6.4 Development of efficacy

Although LSE has been described as state-like and fixed (Luthans & Avolio, 2003), more recent evidence suggests otherwise. One study showed executive trainees’ LSE increased with education, enhancing their leadership capacity (Finn, Mason, &
Bradley, 2007). In another study, union shop stewards encouraged to serve as leaders developed higher levels of LSE than those without such encouragement (Mellor, Barclay, Bulger, & Kath, 2006). In another study, leaders’ use of motivational language resulted in follower self-efficacy that was 34% higher and performance that was 20% higher than in control groups, and employees’ performance was 10% higher in groups with higher levels of self-efficacy than those with lower levels (Mayfield & Mayfield, 2012).

5.6.5 Environmental effects on efficacy

Leaders’ control of their environment also correlates directly with their LSE. Wood & Bandura (1989) found that managers who felt they had control of their environment increased their LSE and set increasingly challenging goals. Conversely, managers’ who perceived their environment as outside of their control experienced decreased levels of self-efficacy and deterioration of performance. This occurred even with achievable goals (Wood & Bandura, 1989). Similarly leaders with high LSE view situations as more controllable than as crises, which strengthens their approach to difficult challenges (Paglis & Green, 2002).

LSE also increases ratings of leaders’ effectiveness and of their motivation to lead (Chan & Drasgow, 2001). LSE results in greater organizational commitment by leaders (Paglis & Green, 2002), and groups’ perceptions of their leader’s performance improve with higher levels of LSE (Chemers, Watson, & May, 2000).
5.6.6 Collective efficacy

A group’s efficacy, made up of both LSE and group members’ self-efficacy is referred to as collective efficacy (Hannah, et al., 2008). Collective efficacy reflects “a group’s shared belief in its conjoint capabilities to organize and execute courses of action required to produce given levels of attainment” (Bandura, 1997, p. 477). Collective efficacy measures the degree to which a group generates the combined emotional, intellectual, and physical capacity required to achieve their goals (Goddard & Solloum, 2013).

Leaders’ influence plays a critical role in this process. The leader needs both high levels of personal and collective efficacy to fully engage the group in its mission (Bandura, 2000). For example, a recent study found strong associations between leadership and collective efficacy \( (r = .64) \), trust \( (r = .72) \), and commitment \( (r = .60) \). Perceptions of an “iron cage,” or a follower’s perception of leaders’ level of control were unrelated to collective efficacy beyond the effects of transformational leadership (Arnold, Barling, & Kelloway, 2001).

Effective leadership helps develop collective efficacy. For instance, in a study of school leaders, leadership strongly predicted differences in the levels of relational trust with faculty, implying that leaders exert a strong influence on their organization’s level of collective efficacy (Bryk, 2010). Leaders also influence collective efficacy by sharing appropriate information, such as socially persuasive communication that positively affects workers’ sense of their own and their group’s capability to achieve their goals (Skrla & Goddard, 2002). A study of 2585 soldiers in 85 combat units found that
leadership climate was the most powerful predictor of collective efficacy, even after controlling for soldiers’ self-efficacy beliefs (Chen & Bliese, 2002).

### 5.6.7 Efficacy and performance

A well-documented relationship exists between leader self-efficacy and group performance. For instance, one group found a weighted correlation of 0.38 between the two variables (Stajkovic & Luthans, 1998). Effective leadership (LSE) facilitated the relationship between the group’s focus on goal achievement and leaders’ level of motivation to lead, which in turn was positively associated with group performance (Hendricks & Payne, 2007). As one author stated, “Regardless of the level of aggregation involved in the conceptualization of the group or the particular group goal examined, collective efficacy beliefs have consistently predicted group success on diverse measures of attainment” (Goddard & Solloum, 2013, p. 645). Thus, the higher the group’s collective efficacy, the better their performance in achieving goals, and the lower their collective efficacy, the worse their performance.

LSE partially mediates the relationship between employee engagement, a powerful contributor to group performance, and leader effectiveness (Luthans & Peterson, 2002) which suggests that the effect of LSE on group performance may be more of a mediating effect than a directly causative effect. LSE also positively correlated with leadership experience, with individuals’ desire to assume a leadership position, (McCormick, Tanguma, & López-Forment, 2002) and with leaders’ perceived LMX (Leader-member Exchange) score (but not with followers’ scores), and also with
follower performance (Murphy & Ensher, 1999). The association between LSE and group performance is likely to be a complicated one, and may occur on several different levels.

LSE also impacts group performance through its association with leaders’ performance. For instance, LSE results in greater engagement by leaders in leadership tasks, such as leading others to success (Eden, Ganzach, Flumin-Granat, & Zigman, 2010). Similarly, LSE improves leaders’ motivation, with higher levels of LSE associated with greater levels of motivation (Bandura & Cervone, 1986). This effect results in leaders and their team setting goals which stretch the group’s abilities (Kane, Zaccaro, Tremble, & Masuda, 2002), and groups that establish more difficult goals perform at higher levels (Bandura, 1989). LSE produces both better leader performance as well as better group performance.

5.6.8 Summary of efficacy

Efficacy refers to an individual’s or group’s beliefs in their ability to successfully achieve their objectives. When applied to individuals, this is described as self-efficacy. When it is applied to leaders, it is termed leader self-efficacy, or LSE. Collective efficacy reflects the beliefs and judgments of group members about the ability of the group as a whole to achieve its collective goals.

Self-efficacy, leader self-efficacy, and collective efficacy help determine the effectiveness of individuals, leaders and groups and their ability to set and achieve objectives that reflect their purpose and meaning. The ability of a leader to establish
strong, effective relationships with group members is enhanced by his or her levels of efficacy as well as that of the members of the group. In order for leaders to establish the robust relationships needed to provide constructive leadership, not only must they have high levels of self and leader efficacy, but they must also work closely with group members, and ultimately with the group as a whole to develop and optimize their levels of efficacy as well.

Not surprisingly, leader effectiveness and group performance are strongly associated with levels of efficacy. As leaders develop their own and group member’s efficacy through relationships that reflect these beliefs, they are better able to infuse positive meaning into the group, which in turn leads to the group’s success. This meaning includes the positive affirmation that the group is fully capable of achieving this success, and that the leader is fully able to provide the necessary leadership to support the group’s endeavor.

The literature on efficacy strongly supports the importance of efficacy to the effective exercise of leadership through its influence on relationships between leaders and group members as proposed by DLT. Hypothesis 4 of the theory states, “Self-efficacy has a positive association with leader-based relationships.” This hypothesis will be tested as part of the quantitative study that will be proposed at the conclusion of this review of the literature.
5.7 Resilience

The clinical leaders who were interviewed for the qualitative study portion of this dissertation identified resilience as a key component of the performance of effective leadership. Hypothesis 5 from DLT states, “Resiliency has a positive association with leader-based relationships.” In this section, I will explore resilience in the leadership and organizational behavior literature, including its definition, its significance to the exercise of leadership, and ways in which it might be developed.

Social stress and negative events at work may cause emotional tension and stress (Maslach, 2001), but they do not have to damage leaders’ and group members’ emotional well-being. Some individuals recover and even thrive as a result of stressful events (Bonanno, 2004), and others recover from adversity with increased competency, growth, and confidence (Sutcliffe & Vogus, 2003). These characteristics determine an individual’s resilience.

5.7.1 Definition

Resilience is the ability of leaders to persist in a state of positive performance despite difficult or challenging circumstances. It is the maintenance of positive adjustment under challenging conditions (Masten, Reed, Snyder, & Lopez, 2002; Sutcliffe & Vogus, 2003). It is the manifestation of a positive affect in a challenging or threatening event or situation, and the ability to adapt to adversity (Luthar, Cicchetti, & Becker, 2000), where positive adaptation is defined in terms of behaviorally manifested social competence. Resilience is the combination of individual resources, social
conditions, and developmental challenges or problems (obstacles, deficits, and losses) (Caza & Milton, 2012; Greve & Staudinger, 2006).

Resilience at work encompasses behavioral, affective, and psychological manifestations of positive adaptation and professional growth within the context of significant adversity (Caza & Milton, 2012). Resilience is comprised of "persistence, determination and optimism" (Gupton & Slick, 1996, p. 28).

More than an event or a trait, resilience is a developmental process. It consists of the positive developmental outcomes of coping processes, meaning that resilience follows a “developmental trajectory” (Leipold & Greve, 2009, p. 41).

The resilient leader bounces back after a crisis or difficult situation (Gittell, Cameron, Lim, & Rivas, 2006). Resiliency facilitates the development of patience, tolerance, responsibility, compassion, determination, and risk-taking in leaders as they overcome challenging situations (Janas, 2002). An example of this ability is found in the airline companies that survived the 9/11 disaster. Because of the public’s increased fear of flying following the terrorist attacks, many airlines suffered significant economic losses, forcing several airlines to declare bankruptcy. Nevertheless, the airlines which survived the challenging period had a viable business model before the disaster which was dependent on strong relationships, and emerged even stronger afterwards (Zolli & Healy, 2012). This example highlights an example of resilient organizations, as well as a powerful pattern of resiliency that led to perseverance and growth with and through adversity.

The resilient leader maintains flexibility during stressful experiences (Lazarus & Folkman, 1984). The role of adversity in defining resilience is a point of contention
between various authors. Some refer to adversity as an impediment to the development of resilience, or at best, incidental to it (Luthar & Cicchetti, 2000), while others propose that adversity provides a key stimulus for growth and development, helping the individual to emerge with new skills, knowledge and competence (Roosa, 2000), thus making adversity indispensable to resilience.

The resilient leader is transformed during adversity by learning new skills and changing his or her approach to leadership in order to persevere through future encounters with hardship (Grotberg, 2003). As discussed by another set of authors, resilient leadership, “not only survives/thrives by positively adjusting to current adversity, but also in the process of responding strengthens its capabilities to make future adjustments” (Sutcliffe & Vogus, 2003, p. 97). Adversity need not be a major emotionally or psychologically significant event – resilience might emerge in moments of day-to-day adversity, such as a negative interaction with another person (Caza & Milton, 2012), or even during the emotional and organizational upheaval that accompanies positive change and events.

Thus, resilience is not merely treading water in the face of adversity; it includes positive growth, and the development of some new capacity as the result of adversity (Sutcliffe & Vogus, 2003). Resilience is not uni-dimensional, and may be situational. A person may demonstrate resilience in one aspect of his or her life, and less so in another (Masten, et al., 2002; Werner & Johnson, 1999). For example, a police officer may cope well with the death of a spouse, but enter a downward spiral after experiencing adversity at work (Caza & Milton, 2012).
Resilient individuals are energetic, optimistic, and enthusiastic in approaching work. Attributes of resilience include positive emotions and attachment styles, and self-enhancing biases in response to adversity at work (Mancini & Bonanno, 2006). The mechanism of this association has not been completely elucidated. For instance when evaluated along with hope, self-efficacy and optimism, resilience lost some of its predictive power of group outcomes, perhaps as the result of these traits’ close association with resilience (Wisner, 2011).

Highly resilient individuals are flexible in their approaches to challenges and embrace opportunities for learning. They have a high level of emotional positivity (Block & Kremen, 1996). Resilient people accept reality without resentment or discouragement and find meaning for themselves and others in their organization and work experiences. They are creative in devising solutions to difficult situations (Coutu, 2002).

Resilience also confers an ability to develop and maintain psychological stability, when presented with a threat, leading to fewer mental health problems (Bonanno, Wortman, & Nesse, 2004). The Challenge Model describes seven characteristics of resilient people (Wolin & Wolin, 2010), including insight, independence, relationships, initiative, creativity, humor, and morality (Christman & McClellan, 2012).

Resilience is distinct from similar concepts including recovery, thriving, and post-traumatic growth. Recovery implies that individuals return to the same level of functioning (Sonnentag, Niessen, & Neff, 2012) that existed prior to an adverse event, while resilience requires emotional and leadership growth during adversity. Resilience differs from thriving in that resilience is closely related to adversity while thriving is not
Post traumatic growth (PTG) also requires growth following adversity; however, PTG results in a significant change in an individual following a challenge or adversity, such as starting a new profession or undertaking a new calling, while resilience means persevering but growing stronger in the same context (Tedeschi & Calhoun, 2004).

5.7.2 Development of resilience

Whether resilience can be developed or not is a matter of some controversy in the literature. Considerable information describes ways in which leaders are able to improve their resilience and capacity to weather difficult circumstances while demonstrating positive growth.

For instance, leaders maintain a positive affect during trying circumstances by developing and deploying positive coping strategies, such as 1) looking for positive meaning in adversity, 2) focusing on ways to overcome adversity, and 3) evaluating a situation in positive terms (Folkman & Moskowitz, 2000). Resilience improves leaders’ ability to recover and grow from adversity by conferring psychological hardiness on them, which is comprised of commitment, control, and challenge (Maddi & Khoshaba, 2005).

Other authors proposed similar mechanisms for building resilience in leaders. One group asserted that individuals develop their capacity to overcome adversity (and thus build resilience) by viewing difficult circumstances through four lenses: 1) looking for ways to control the factors causing the crisis, 2) understanding the way in which
management’s decisions and actions contributed to the crisis, 3) gaining an appreciation of the breadth of the crisis, and 4) trying to reasonably predict the duration of the situation (Caza & Milton, 2012). By approaching adversity with an eye to these factors, leaders view the crisis positively, thus enhancing the resources and potential solutions available to overcome it.

Members of organizations, in order to fully develop resilience, need the help and support of their organization. When organizations adopt an ideology that supports a pattern of beliefs, values, and ideals that are consistent with and advance resilience, organization members are better able to develop and maintain resilient attitudes (Trice & Beyer, 1993).

An individual’s self-perception constitutes another key mechanism through which individuals cultivate, mobilize and maintain resources that support resilience (Caza & Milton, 2012). The individual’s sense of self is a key contributor to resilience (Edward, 2005)

Resilient individuals’ reactions to adverse events are enhanced or improved by an understanding of the experience in terms of their self-identities (C. L. Park & Folkman, 1997). His or her identity is a primary source of practice schemas and resources that the individual can rely on and combine creatively to react appropriately to adverse circumstances (Caza & Milton, 2012). Complex identities enable individuals to engage in flexible adaptation to adversity, and serve as a source of meaning that will help them to understand and grow from adversity. Identity construction is critical for sense-making behavior in organizations (Pratt, Rockmann, & Kaugmann, 2006). Making sense of
adversity is crucial in helping individuals follow a positive developmental trajectory and emerge with increased learning and competence.

Positive relationships with others facilitate the development of resilience at work (Peterson, 2006). High quality relationships are particularly potent in exerting a positive impact on how individuals respond to adversity (Dutton & Heaphy, 2003). Having a strong identification associated with a social group increases an individual’s ability to respond to stressors by giving him or her the tacit support of the group (Haslam & Reicher, 2006). Individuals with a strong social support system are likely to feel empowered when facing an adverse event (Caza & Milton, 2012).

Positive emotions experienced by individuals in the midst of stress confer the benefit of a broadened mindset, which enables them to successfully regulate their reaction to negative emotional experiences (B. L. Fredrickson, 2001). Broaden and Build Theory proposes that negative emotions limit an individual’s repertoire of potential actions to a limited number of options (e.g., attack when angry, escape when afraid) (B. L. Fredrickson, 2004). In contrast, positive emotions (e.g., joy, contentment, interest) broaden individuals’ potential repertoire of responses to a situation by expanding their range of possible behaviors. These broadened mindsets, in turn, strengthen individuals’ physical, intellectual, and social resources (B. L. Fredrickson, 1998, 2001).

Positive emotions contribute to individuals’ abilities to achieve efficient emotional regulation. Individuals who find positive meaning in negative circumstances experience faster cardiovascular recovery after adversity than those who focus on the situation’s negativity (Tugade & Fredrickson, 2004).
Individuals with both high and low levels of resilience experience equal levels of frustration when facing adverse events. Nevertheless, highly resilient people report a positive situational perspective both before and during adverse incidents, while low-resilient individuals were more likely to report negative or neutral emotions before and during the same incidents. Individuals with high levels of resiliency reported greater levels of interest, engagement, happiness and enthusiasm during and following an adverse event compared to those individuals with low levels of resiliency (B. L. Fredrickson, 1998, 2001). Individuals with positive emotions surrounding adversity find positive meaning in such an event, a trait that is fundamental to the exercise of constructive leadership in these situations (B. L. Fredrickson, 2001).

Positive emotions and positive meaning-finding are similar, yet distinct, concepts. Positive emotions result in positive-meaning finding, which in turn produces positive emotions. Positive meaning-finding represents the broadening of one’s mind-set when coping with adversity, which subsequently helps to build psychological resources, like resilience. This continues in an “upward spiral,” enhancing emotional well-being as a result (B. L. Fredrickson & Joiner, 2002).

Leadership plays a crucial role in developing resilience in organizations (Gittell, 2008; Gittell, et al., 2006), particularly as leaders develop robust relationships. The ways in which individuals relate to one another before, during and after an adverse event weigh heavily on the group’s resilience. Relationships buffer individuals from the impact of adversity (S. M. Cohen & Wills, 1985), and allow individuals to function at a higher level in the face of adversity (Shih, 2004).
5.7.3 Summary of resilience

In summary, resilience is a crucial attribute of constructive leaders. It is the ability of a leader to go through a challenging or chaotic experience, and emerge having become a better, smarter, or more capable leader. Resilient leaders respond to adversity by infusing meaning into a group and by identifying positive meaning in the adversity, and then working with group members to develop and deploy meaningful solutions to the challenges they face.

Constructive leaders use their own resilience to help develop group members’ resilience by 1) demonstrating resilient attitudes, 2) being aware of the ways in which group members experience challenges and adversity, 3) identifying processes to enhance their resilience in those particular situations, and 4) by developing positive, intimate relationships through which they can help group members build their own resilience.

The association of resilience with constructive leadership and its dependence on leaders’ relationships with group members is wholly consistent with DLT. The literature supports its inclusion as a moderating factor of relationships in carrying out constructive leadership. The quantitative study proposed at the conclusion of this review will examine the ways in which healthcare leaders perceive resilience in their practice of leadership, and test the hypothesis from DLT, “resiliency has a positive relationship with leader-based relationships.”
5.8 Forms of leadership

DLT proposes three types of leadership: 1) constructive leadership, characterized by the infusion of positive meaning, 2) ineffective leadership, which is characterized by the lack of leader-infused meaning in leader-group members exchanges, and 3) destructive leadership, in which the group’s core meaning and purpose are lessened or destroyed. Much of this review focused on constructive leadership through the infusion of positive meaning facilitated by the development of leader-based relationships. The following discussion explores ineffective leadership and destructive leadership styles, placing them in the context of DLT, and using the literature to support the contention that they are significantly distinct from constructive leadership.

5.8.1 Ineffective Leadership

The second point on the spectrum of leadership types proposed by DLT is ineffective leadership, or leadership in which there is no infusion of positive meaning. It characterizes interactions between leaders and group members in which meaning is neither infused nor taken away, and in which group cognition is unaffected. The clinical leaders in the qualitative study described prototypical managers as emblematic of this form of leadership. They used terms such as “lacking a vision” and “detail oriented” to describe ineffective leaders. They described ineffective leaders as those whose “heart was not in it” and who were more concerned about the organization’s policies and procedures than about their mission or group members’ values.
Zaleznik’s landmark article (1977) “Managers and leaders” describes the differences between leaders and managers. Managers maintain order and control as opposed to leaders who strive to achieve team-oriented cohesion and purpose. Managers lack relationships with group members, relating to them in bureaucratic and impersonal ways, while leaders develop robust relationships with group members through which they are able to effectuate the infusion of meaning.

Since Zaleznik’s original article, other leadership scholars have supported his premise that managerial roles often exclude leadership (Bennis & Nanus, 1985; Kotter, 1996; Yukl, 2006). Significant differences between these two roles include 1) leaders strive for change, while managers protect the status quo; 2) leaders infuse meaning and purpose into the group, while managers base decisions on policy; and 3) leaders focus on emotions, trying to instill energy and enthusiasm in the group by virtue of their emotional energy while managers operate on a logical level, ensuring that decisions are supported by facts and figures (Gabriel, 2011).

This distinction does not devalue managers. Complex institutions require skilled individuals who attend to the myriad details, operations and processes confronting them. Leaders may or may not personally have the operational skills necessary to ensure institutional viability, although it is incumbent on organizational leaders to ensure these organizational needs are met as part of their duty to achieve their mission. Kotter (2013, p. 1) stated, “We constantly underestimate how complex this task really is, especially if we are not in senior management jobs. So, management is crucial — but it's not leadership.” Leaders’ roles differ from managers’ roles, each having different objectives and purposes. Confusing or conflating the two may create institutional tension as
workers strive to understand and meet leaders’ and managers’ expectations (Stringham, 2012). Kotter (2013) proposes the confusion between leaders and managers deters organizations from optimal structure, function, and likelihood of achieving success. Nothing precludes managers from exercising leadership; in fact, leadership skills enhance the ability of managers to achieve success. Sun (2013, p. 1) stated, “A perfect manager who attains the status of a true leader will be able to lead people effectively and draw on the correct strengths and knowledge of every key individual in the company.” In order to accomplish their complex tasks, managers benefit greatly from organizational members’ engagement and loyalty manifested by their contribution of skills, ideas and experience to the manager’s tasks. Managers’ secure this assistance most readily by establishing robust relationships, and employing communication, positivism, resilience and efficacy to infuse meaning and purpose into the organization in a way that creates engagement and loyalty. Managers’ use of leadership skills underscores the fact that leadership is not defined hierarchically, but can emerge at any level of the organization as group members perceive organizational needs and utilize leadership principles to meet them.

Individuals engage in ineffective leadership outside of the role of a traditional manager. For instance, a leader becomes ineffective if they fail to develop the relationships or engage in the communication necessary to infuse meaning successfully into the group. The failure to employ leadership moderators, such as efficacy, communication, resilience, and positivism, also leads to ineffective leadership.
5.8.2 Destructive Leadership

The third point in the spectrum of leadership behaviors or types is destructive leadership, which is the logical inverse of constructive leadership. Destructive leadership results from leaders causing a change in group members’ cognitive processes in a way that destroys or removes meaning from the group, resulting in the destruction of group dynamics such as synergy, values, and long-term commitment. For instance, abusive supervision has been estimated to cost US companies more than $23 Billion annually due to increased absenteeism, turnover, and decreased worker effectiveness (Tepper, 2007). Other effects of destructive leadership extend outside of the workplace, including decreased family well-being (Hoobler & Brass, 2006) and health issues (Harvey, Stoner, Hochwarter, & Kacmar, 2007).

In addition to its destructive influences on the dyadic leader-follower relationship, destructive leadership’s ill effects extend to the group as a whole. For instance, abusive supervisors’ behavior can result in abusive behavior throughout an organization (B. Schyns & Schilling, 2013), creating emergent destructive leadership. Group members, powerless to protect themselves from destructive leadership, may exhibit symptoms of learned helplessness (Seligman, 1975) and diminished motivation due to loss of meaningfulness. Group members who perceive injustice may engage in retributive behavior against the leader, which is destructive of the group’s meaning and purpose (Bies & Tripp, 2005). Destructive leadership may influence susceptible group members in a particularly negative manner, resulting in significantly negative outcomes. This
condition, referred to as the “toxic triangle” (Padilla, Hogan, & Kaiser, 2007), results in cataclysmic destruction of group meaning, purpose and commitment.

Leadership’s ambiguous definition in the academic literature extends to destructive leadership as well. In a recent review of destructive leadership, Schyns and Schilling (2013, p. 141) define it as “a process in which, over a longer period of time the activities, experiences and/or relationships of an individual or group members are repeatedly influenced by their supervisor in a way that is perceived as hostile and/or destructive.” This differs in two crucial aspects from destructive leadership as proposed by DLT. The first is that DLT defines destructive leadership as more than just outright hostility and obstruction. Any activity that removes meaning from the group, such as a focus on the leader, or placing financial success above mission-driven activities, constitutes destructive leadership. For instance, DLT would label a “kind narcissist” or a “charismatic” financially-driven leader as destructive, while these would fall outside of the definition proposed by Schyns and Schilling.

The other significant difference between the two definitions of destructive leadership is DLT’s acknowledgement that leadership can shift between constructive and destructive approaches relatively rapidly, with the implication that whether destructive leadership is represented by a single threatening outburst or repeated destructive behavior over a prolonged period, it is still destructive (admittedly with varying outcomes). On the other hand, Schyns and Schilling’s definition excuses temporary lapses into such behavior from their definition of destructive leadership.

In both of these examples, the distinction between the two definitions of destructive leadership is highlighted by the authors’ core definition of leadership. Schyns
and Schilling adopt Yukl’s definition of leadership: “the process of influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives” (1989, p. 10). This definition is distinctly different from DLT, which defines leadership as changing the cognitive processes of a group or individual, and constructive leadership as infusing positive meaning and purpose into a group. Leaders may create influence through both constructive and destructive mechanisms. For instance, a leader may influence a process through the infusion of meaning, through the enforcement of a policy, or through the use of threats or rewards. Each of these instances would qualify as leadership in Yukl’s definition of leadership, while only the first would qualify as constructive leadership in DTL’s definition of leadership. The use of Yukl’s definition, therefore, makes it difficult to distinguish different forms of leadership, such as destructive from constructive, without invoking other psychological dynamics or diagnoses.

Organizational change brought about through coercive means, or through the pursuit of misaligned values is not sustainable (Parry, 2011). Destructive leadership was described often by the clinicians in the qualitative study, with many examples offered of leadership failures by leaders who turned to destructive methods. Destructive leadership results from a number of different leadership behaviors, most of which revolve around actions that undermine leader-based relationships. These include bullying, micromanagement, inaccessibility, and delusional collusions (Kets de Vries & Balazs, 2011).
5.9 The dynamic nature of leadership

In addition to the various types of leadership, and the factors of which they are comprised, DLT also proposes that leadership is not structured as a monolithic dyadic relationship, but rather is a process in which individuals and other organizational entities (groups, teams, etc.) perform different roles at different times.

Dynamic Leadership Theory does not distinguish between leaders at various levels of the group or organization. It proposes that the same principles underlying successful strategic leadership by top management teams (Denis, Kisfalvi, Langley, & Rouleau, 2011) also govern the effective practice of leadership that emerges outside of the organization’s hierarchy. For instance, Upper Echelon Theory (UET), proposed by Hambrick and Mason (1984), recognizes group cognition as the substrate for leadership by strategic leaders in an organization, thus reflecting the principles of leadership espoused by DLT. UET also recognizes, similarly to DLT, the critical impact of leaders’ personal motivation as the foundation of their leadership efforts to infuse meaning into the group (Denis, et al., 2011; Kets de Vries, 1996), further supporting the position-neutrality of DLT’s principles of leadership.

Despite the similarity of effective leadership at the top level of management of institutions to that at lower levels, in today’s knowledge-based organizations in which the flow of information rather than the flow of materials creates organizational success, bureaucratic hierarchical leadership structures may impede the ability of an organization to achieve its objectives (Palmisano, 2006). Rather than a vertical dyadic relationship, to be effective in such environments, leadership needs to evolve quickly from the dyad
model to a network model and back (Nye, 2010). This does not obviate the need for relationships as a foundation for constructive leadership and may even increase their relevance to the success of a leadership venture. As proposed by complexity leadership theory (Marion & Uhl-Bien, 2007), group intelligence depends on the number and quality of relationships between group members, suggesting that leaders’ ability to successfully infuse meaning into a group is directly proportional to his or her ability to form robust relationships across the breadth of the group’s members.

DLT applies not just to the formal hierarchical power structure, but recognizes that leadership opportunities may arise spontaneously at any level in the organization. Since leadership is defined as changing a group’s cognitive processes, any individual who is able to infuse positive meaning through robust, positive relationships has the potential to perform as a leader. Conversely, emergent destructive leadership may also occur, either when a formal leader adopts destructive leadership methods as the result of personal shortcomings interacting with environmental factors (such as low self-efficacy, a hostile environment, or an urgent situation), or when an emergent leader reverts to negative leadership behaviors (a bully, for example, who uses threats to coerce a co-worker).

5.10 Summary of situating DLT’s building blocks in the literature

The review of the literature to this point has examined the individual components of DLT in the literature with the goal of linking major organizational behavior and leadership theories with DLT. I reviewed the literature support for the concept of
constructive leadership as the infusion of meaning, the importance of leader-based relationships to the effective exercise of constructive leadership, and the influence of communication, resilience, positivism, and leader self-efficacy on these relationships as they apply to constructive leadership. I also explored the literature on ineffective and destructive leadership, distinguishing these approaches from constructive leadership. Finally, I reviewed the dynamic nature of leadership, noting that it exists outside of the formal organizational hierarchy, and that an individual’s approach to leadership can shift in response to group membership, the work environment, or other contextual factors.

I will now turn to a comparison of DLT with major theories of leadership. In this section of the review, I use DLT as an integrated theory of leadership instead of focusing on its parts. I will then conclude the review with a discussion of the unique contributions of DLT.

5.11 Comparison of Dynamic Leadership Theory with existing theories

I will next compare and contrast DLT with selected major leadership theories, most of which espouse principles and ideas similar to those included in DLT. The purpose of this review is not to present a detailed description of each of these theories, but to highlight those areas in which they are similar to and distinct from DLT. For the purposes of this comparison, I have chosen to discuss relationship-based theories (LMX – Leader-member Exchange Theory), positive and charismatic theories (Authentic, Transformational, and Charismatic Leadership Theories), contingency leadership theories...
(Complexity Leadership and Least-preferred Coworker Theories), and theories exemplifying alternative leadership structures (Complexity Theory).

5.11.1 Relationship-based leadership theories

5.11.1.1 Leader-Member Exchange (LMX) Leadership Theory

LMX is a relationship-based leadership theory that posits organizational change based on the quality of leaders’ associations with followers (Graen & Uhl-Bien, 1995; Sparrowe & Liden, 2005). It focuses on the development of relationships as a means of exercising leadership influence (Gerstner & Day, 1997), and has shown high quality relationships create improved job satisfaction, work commitment, turnover, role clarity, and competence. Proposing that effective leadership correlates with the quality of leader-follower relationships (Ilies, Nahrgang, & Morgeson, 2007), LMX also recognizes a gradation of leaders’ relationships with group members, with some having close, strong ties to the leader, and others having lower quality relationships bordering on task-based supervision (Anand, Hu, Liden, & Vidyarthi, 2011).

LMX’ endorsement of this gradation generates considerable controversy, with researchers finding that the positive effects of differentiated relationships were nearly counter-balanced or even out-weighed by their negative effects. For instance a study of 357 firefighters and other fire station employees in Australia found that differentiation of relationships between leaders and group members led to decreased satisfaction, perceptions of inequality, and increased group conflict (Hooper & Martin, 2008).
LMX Theory has been significantly enhanced by more recent authors. For instance, Sparrowe proposed that the quality of the leader-member relationships mediates the balance between leaders’ downward influence on followers, and followers’ willingness to engage in helping behaviors. Others propose that the quality of relationships determines organizational outcomes such as job satisfaction, workers’ commitment, and workers’ feelings of well-being (R. Martin, Thomas, Charles, Epitropaki, & McNamara, 2005).

In comparison to DLT, LMX theory captures the critical association of relationships with effective leadership; however, it conflates relationships with leadership, rather than identifying them as a pre-requisite for effective leadership. It proposes that relationships automatically infuse meaning into a group, which may not be the case. For instance, nurses in the qualitative study identified situations in which relationships undermined effective leadership when they gained a higher priority than the group’s goals.

5.11.2 Positive values-based and Charismatic Leadership Theories

5.11.2.1 Transformational Leadership

Transformational leadership receives the greatest amount of attention in the literature, indicated by the 2643 articles on transformational leadership printed in academic journals since 2000 (search performed 2/15/2013). It was first presented by Burns in his classic book Leadership (1978), and proposes that Transformational
Leadership contains four sub-categories, namely idealized influence (leaders as ideal role-models), inspirational motivation (leaders imparting a clear vision, and proposing a pathway to achieve the vision), intellectual stimulation (leaders encouraging innovation and creativeness), and individual consideration (leaders demonstrating concern with group members’ needs, abilities, and concerns). Bass subsequently incorporated the theory into his *Full Range Leadership Theory* which also includes three additional sub-categories (contingent reward, management by exception – active, and management by exception – passive), and laissez faire leadership, defined as non-leadership (Bass, 1985).

Transformational leadership successfully predicts effective leadership in a number of settings, including top management teams, military leaders, and leadership roles in multiple cultures across the world (Diaz-Saenz, 2011). Nevertheless, this theory suffers from a number of shortcomings. One common problem is followers’ misattribution of success to transformational leaders (Avolio, Walumbwa, & Weber, 2009; Weber, 2001). Another concern is the prevalent use of the MLQ survey instrument in transformational leadership research (Bass & Avolio, 1985), and little development of the theory through qualitative research. A third criticism is the theory’s significant overlap with charismatic leadership. Charisma was originally included in transformational leadership theory by Burns, but was subsequently removed when it was subdivided into the four sub-categories listed above; nevertheless, transformational leadership continues to be labeled as charismatic leadership by researchers (Diaz-Saenz, 2011). Yukl (1999) contends that the two are significantly different, with transformational leaders focusing on empowering coworkers, while charismatic leaders encourage followers to commit to the leader’s vision. These aims may not be mutually exclusive.
DLT shares much with Burn’s transformational leadership theory. Both recognize leaders strive to achieve group objectives through infusing meaning into (DLT) or transforming (transformational leadership theory) group members. Nevertheless, despite this core similarity, there remain significant differences between the two theories.

Dynamic Leadership Theory proposes that leaders infuse positive meaning by helping individual group members align their values and goals with those of the group or organization. It recognizes the importance of achieving group synergy resulting from the collective individual commitment, but still proposes that leadership occurs through high-quality, intimate relationships between leaders and group members. Transformational leadership theory, on the other hand, focuses on change at the team and organizational level (Parry, 2011), admittedly by showing individual attention and concern, but not by creating meaning at that level.

Transformational leadership is a vertical dyadic leadership theory, contemplating leaders’ interactions with followers from positions of power. In fact, some have criticized transformational leadership as being overly focused on group performance, making it a manipulative form of leadership in which the leader co-opts group members through their enhanced relationships with the leader (Bolden, Wood, & Gosling, 2006) as a means convincing them to invest extra effort in a project. DLT, on the other hand, proposes constructive leadership results when leaders and group members develop close cognitive ties through intimate relationships that de-emphasize the power and position differences between them, and focus on integration and unity.

Transformational Leadership Theory is also a partial leadership theory, failing to explain destructive leadership styles, and how destructive leaders use transformational
tactics to accomplish destructive ends. It concentrates on effective leadership, implying that ineffective and destructive leadership lack sufficient prevalence so as to warrant inclusion in a theory of leadership. DLT, on the other hand, recognizes and explains these alternate forms of leadership, distinguishing the use of leadership tools (relationship-building as a means of infusing meaning, communication as a means of strengthening relationships, etc.) from the form of leadership. If a leader uses these tools to decrease or destroy a group’s meaning, then he or she is a destructive leader. It is not the use of the tools that defines the leader; it is the intent and meaning for which they are used that is critical in defining their leadership form.

None of this takes away from the tremendous success transformational leadership theory has enjoyed over the past several decades. Based as it is on true principles of leading through the infusion of meaning (transforming) into group members, one would expect it to show significant promise as a tool to predict leadership effectiveness. DLT builds on this considerable success by further refining our understanding of the nature of leadership as a process rather than a person, and as a spectrum of events that may serve to either enhance (constructive leadership) or diminish (destructive leadership) group cohesion, meaning, and effectiveness.

### 5.11.2.2 Authentic Leadership Theory

George (2003) in the practicing community, and Avolio and Luthans (2003) in the academic community both introduced authentic leadership theory (ALT) in the same year. ALT was built upon the foundation of transformational leadership, and attempted
to address the problem of pseudo-transformational leaders vs. authentic transformational leaders (Bass & Steidlmeier, 1999) by incorporating some of the findings of the burgeoning positive psychology movement (Luthans & Church, 2002) into a positive leadership theory. It is comprised of four factors; namely balanced processing, in which the leader objectively analyzes appropriate data before reaching a decision, internalized moral perspective, meaning the leader has an internal moral compass which the leader uses to guide his or her leadership actions and behaviors, relational transparency, which refers to the leader’s open sharing of information and presenting of one’s authentic self, and self-awareness, referring to the leader’s understanding of his or her own strengths and weaknesses.

Authentic leadership theory’s authors claim that it is a “root construct” of positive leadership approaches (Gardner, Avolio, & Walumbwa, 2005), meaning that it effectively conjoins other positive leadership approaches without replacing them. It combines the concepts of a positive work environment, ethical behavior, relationships of trust, and leadership development (Perrow, 1986). It defines authentic leaders as those who know and profess what they believe, display transparency and consistency in their ethics and actions, and possess and display positive psychological states such as optimism, hope, confidence, and resilience, and integrity (Gardner, et al., 2005).

It occupies a distinct space on the leadership continuum as a result of its claims of theoretical independence. Authentic leaders are not confined to an exclusive leadership style, as they may practice any of the positive leadership approaches including transformational, charismatic, and servant leadership (Stone-Romero, 2009), as well as
more traditional leadership approaches such as transactional and task-oriented leadership (Currie, Lockett, & Suhomlinova, 2009).

ALT’s foundation comprises two precedent theories; namely attribution and affective response theories (Currie, et al., 2009). Attribution theory refines transformational leadership theory by distinguishing true from pseudo-transformational leaders (Eglene, Dawes, & Schneider, 2007), noting that followers often sense their leader’s motivations (Ingraham & Getha-Taylor, 2004). In this construct, true transformational leaders behave in an ethical, moral and sincere manner, and thus qualify as authentic leaders (Currie, et al., 2009). Pseudo-transformational leaders demonstrate insincere, unethical and immoral behavior, using their transformational abilities for self-aggrandizement rather than to strengthen the organization and their followers (Eglene, et al., 2007; Moynihan & Ingraham, 2004).

Weiss and Cropanzano (2005) proposed affective events theory, also a precursor of authentic leadership, which suggests that workers’ actions result from leaders’ positive and negative motivations. For instance, workers may respond to leader-induced aggravation in a negative or antisocial manner (Rainey, 1997), or demonstrate positive behaviors in response to leaders’ uplifting behavior (Doig & Hargrove, 1990). Authentic leadership incorporates this concept by postulating that authentic leaders are confident, hopeful, and optimistic and are thus able to foster positive emotions in their followers (Hargrove & Glidewell, 1990).

ALT’s influence has steadily increased in the healthcare leadership literature. Wong and Cummings (1986) note a lack of published studies of ALT in the nursing literature, and argue that this leadership approach addresses key aspects of nursing
leadership established from other studies as essential for successful leadership, including a relational focus (Uhl-Bien, Marion, & McKelvey, 2007), ethical behavior (Hellriegel & Slocum, 2011; M. Schneider & Somers, 2006), positive leadership behavior (A. L. Schneider, 1999; Stewart, 1975), and development of followers (and future leaders) (William L. Gardner, et al., 2005). A 2005 pronouncement by the American Society of Critical Care Nurses proclaimed authentic leadership as the substrate necessary for creating an environment in which essential nursing standards of practice can be established (A. L. Schneider, 1999). The Canadian Nursing Advisory Committee recommended authentic leadership for its ability to establish a culture of trust (2004), a theme echoed by the Institute of Medicine’s report on nursing work environments (2010). The physician leadership literature has yet to adopt authentic leadership as a recommended approach.

There is significant overlap of Authentic Leadership Theory (ALT) and DLT. Both focus on the infusion of meaning into the group as the process of constructive leadership. Both contemplate the leader as an authentic individual who exemplifies and has internalized the values and meaning which he or she is trying to inculcate into the group. Both recognize that leadership is a cognitive process in which leaders attempt to modify the cognitive processes of a group.

Nevertheless, ALT also differs in significant ways from DLT. ALT is a “heroic” leadership model in which the leader has skills and abilities that are superior to his or her followers. It is also a dyadic model which contemplates a single leader interacting with a follower. Similarly to transformational leadership, it is also a charismatic leadership theory which attributes charisma to the leader as an enabling factor. Finally, it is a partial
leadership theory, describing a single type of leader, without addressing other leadership approaches.

By contrast, DLT is not a heroic leadership theory. It contemplates leadership arising from both hierarchical leaders and leaders emerging from within a group. It acknowledges that leaders shift in and out of different forms of leadership, and that an individual does not (and cannot) engage in a single leadership style continuously.

DLT accommodates dyadic leadership, but also encompasses group leadership, and even leadership substitutes (J. P. Howell, Bowen, Dorfman, Kerr, & Podsakoff, 2007), as it focuses on the process of leadership more than the leader. Constructive leadership occurs whenever leaders infuse positive meaning into a group, regardless of whether the leader has a formal position, is an emergent leader, or is one of a group of leaders.

DLT acknowledges that charisma can be a powerful contributor to leadership as it may facilitate the establishment of relationships that allow for the infusion of meaning. However, it does not confuse charisma with leadership, and it recognizes that non-charismatic leaders (i.e., introverted leaders) can be successful as well in building relationships and infusing meaning into the group’s members, while charismatic leaders may exercise destructive leadership as the group’s focus turns to the leader instead of the vision and purpose of the group.

DLT is a full-spectrum theory in that it acknowledges the existence of a range of leadership approaches, extending from constructive leadership to destructive leadership. While it agrees with authentic leadership theory that an authentic individual in a dyadic
leadership relationship can exercise constructive leadership, it also proposes that leaders engage in a diversity of other leadership styles depending on contexts and personalities.

5.11.3 Contingency Theories

I will next compare DLT to contingency theories, which highlight leaders’ ability to change their leadership style based on contextual factors. While some of these theories gained popularity in the leadership literature, they share a number of limitations (Yukl, 2011): First, they depend on unnecessarily broad capabilities of leaders and categories of leader behaviors. Second, they fail to explain which variables, whether controllable or not, determine the type of leadership the leader chooses or is forced to exercise, or the effects of these variables on leadership. Third, they do not recognize the importance of meaning-based leadership, or of relationships as moderated by communication, resilience, and positivism on leadership effectiveness. As may be predicted by these shortcomings, the literature shows relatively little research-based evidence for the ability of contingency theories (Yukl, 2010, 2011) to predict or explain leadership behaviors.

5.11.3.1 Path-Goal Theory

Path-goal theory, originally proposed by House (1971) who later updated it to reflect more recent scholarship in the leadership field (1996), is based on the “valence-expectancy theory” of motivation (Vroom, 1964). The theory proposes that workers calculate their expected level of effort, and seek a maximum return on investment. It
postulates that leaders have four choices of leadership behavior, namely 1) directive, in which the leader specifies a task and the rewards for completing it; 2) supportive, in which the leader attempts to establish a positive work environment by showing concern for the worker’s welfare and an interest in their satisfaction; 3) participative, in which the leader encourages the worker to participate in decision-making; and 4) achievement-oriented, in which the leader sets challenging goals, expresses confidence that the leader will achieve them, and establishes a positive emotional environment (House, 1996).

While path-goal theory shares some aspects of DLT, such as a leader demonstrating interest in workers’ satisfaction and abilities (which DLT suggests improves relationships and thus contributes to constructive leadership), DLT nevertheless is structurally distinct. Path-goal theory assumes a vertical power relationship in which the leader occupies a hierarchical position (House, 1996). The leader desires the worker to exert the maximum effort possible in order to achieve the group’s mission. There is no indication that the leader and the worker share a value system or that the worker is motivated by the group’s ideals and values. It is even possible that the theory endorses destructive leadership if the leader’s promise to reward the worker’s effort based on the level of productivity is perceived as a threat (an excuse to decrease the worker’s wages). DLT, on the other hand, proposes the infusion of meaning and alignment of goals motivates workers. It suggests that task-oriented supervision is ineffective leadership that can progress to destructive leadership. Like path-goal theory, DLT proposes a full spectrum of leadership behaviors, but values them differently from a leadership and organizational perspective.
5.11.3.2 Situational Leadership Theory

Originally proposed by Hersey and Blanchard (1971), and subsequently revised to incorporate decision-making processes (Blanchard, Zigarmi, & Nelson, 1993), Situational Leadership Theory proposes that leaders choose their approach to leadership based on a worker’s maturity (expertise) level. For low-maturity workers, leaders use directive leadership, including autocratic leadership, and as a worker’s maturity level increases, the leader uses decreasing levels of supervision and allows increasing levels of autonomy (Blanchard, et al., 1993).

As with Path-Goal Theory, Situational Leadership Theory is built on a foundation of vertical power relationships in which the leader is the hierarchical supervisor. While the theory may work well for managerial efforts, it says little about leadership as conceptualized in this dissertation. There is no mention of meaning or vision in the theory, and relationships between the worker and the leader are ignored as well. The theory endorses the use of destructive leadership techniques (autocratic leadership) for low-maturity workers, even while acknowledging that these workers have the potential to become valuable employees. Besides the basic premise that leaders may shift their leadership approaches, situational leadership theory has little in common with DLT.

5.11.3.3 Least Preferred Coworker (LPC) Contingency Theory

Fiedler’s Least Preferred Coworker (LPC) theory (1967) asserts that leaders’ approach varies from task-orientation to relationship-orientation. It proposes that leaders’ predilection for relationship-oriented leadership is predicted by their scores on
the ‘LPC scale’ (a survey-based score reflecting leaders’ and followers’ perceptions of their mutual relationships) (Fiedler, 1967). Leaders’ effectiveness may be contextually dependent, such as a low-LPC leader being more effective when situations are very favorable or unfavorable, while high-LPC leaders are more effective when situations are more neutral (Yukl, 2011).

While this theory recognizes the importance of relationships in at least some leadership situations, it fails to appreciate the significance of positive relationships as the conduit through which positive meaning can be infused into a group. It also endorses ineffective or destructive leadership styles by calling for task-oriented leadership behavior in certain situations. While DLT recognizes the diversity of leadership situations, and the variability in group-members’ abilities, it predicts that constructive leadership will be the most effective approach to leadership over the long run in whichever context the leader faces, although it may often be the most difficult approach as well.

5.11.4 Charismatic Leadership

First proposed by Weber as one of his three core leadership styles (Conger, 2011), charismatic leadership is a commonly cited attribute of successful leaders. For instance, charisma is predictive of subordinates’ perceptions of success in transformational leaders (Avolio & Yammarino, 1990). Similarly to Dynamic Leadership Theory’s constructive leaders, charismatic leaders have been described as those who work to move the group away from the status quo towards the group’s objectives (Conger & Kanungo, 1999).
The charismatic leader describes problems with the status quo, and then presents a vision of where the group should direct its energies and of how the future vision will fulfill the group’s goals, and the leader’s motivation and plan for accomplishing that vision (Conger, 2011).

While these attributes of Charismatic Leadership relate closely to the tenets of DLT, Charismatic Leadership Theory and Dynamic Leadership Theory differ in the former’s insistence on leaders’ use of high-energy, heroic deeds, risky behavior, and enthusiasm (J. A. Conger, 2011) to accomplish the infusion of meaning. These tactics are not excluded from DLT’s approach to constructive leadership; however, they are not required to achieve successful leadership according to DLT, and may detract from the meaning on which the leader is focused.

Authors construct charismatic leadership in a variety of ways. For instance, Charismatic Leadership Theory as originally proposed by House (1977), and subsequently (Shamir, House, & Arthur, 1993) re-named “motivational theory” focuses less on the extroverted traits of charismatic leaders, and more on constructive leadership principles as proposed by DLT, calling for leaders to change followers’ perceptions of their work, offer a future vision, develop a collective identity amongst the group, and develop an increased level of self-efficacy of group members.

This dichotomy was more fully explored by several authors (Conger, 2011; Howell & Dorfman, 1986), resulting in a dual construct of charismatic leadership that fits well with the structure of DLT. Similar to constructive leaders, socialized charismatic leaders articulate a group vision, engage group members in the achievement of that vision, and then empower them to pursue goals leading to their vision. On the other
hand, similar to destructive leaders, personalized charismatic leaders are authoritarian and often narcissistic, and have goals that center on their own self-interests. Leaders manipulate groups’ and group members’ needs and values to support the leader’s personal aspirations. Rather than open dialogue and group learning, personalized charismatic leaders demand unquestioning obedience and compliance with their dictates.

Despite the well-recognized destructive effects of personalized charismatic leadership, “charisma” remains a key ingredient of many positive leadership theories, often failing to reflect Howell’s dichotomy of charismatic leaders. Appropriately used, charismatic capabilities as described in DLT’s constructive leadership attributes can facilitate the exercise of constructive leadership. Nevertheless, personal charisma has a polar opposite effect on organizational success. It destroys the trust, confidence, and value-based synergy that exemplify constructive leadership.

Even social charismatic leaders may have negative effects on institutions, which fall into four main categories: 1) proposing an unachievable vision, 2) an inability to manage other’s impression of them, 3) obscuring their managerial incompetence behind their charismatic nature, and 4) their frequent failure to engage in succession planning given their perception that no one else should share the limelight with them (Conger, 1989, 1990). From a DLT perspective, charisma is a powerful tool that may be effective in certain leadership contexts, but it is not an indispensable attribute of effective leaders. In fact, as it may regress to destructive leadership, leaders’ use of charisma should be monitored carefully to ensure that it builds the positive meaning within an institution.

Another key distinguishing feature of charismatic leadership theory, even as modified by Howell (1988) is that it fails to recognize the dynamic nature of leadership;
that is, the potential for a social charismatic to transition to a personal charismatic as he or she becomes accustomed to the group’s deference, dependent on the personal benefits of the leadership position, or concerned about the ability of the group to meet its objectives. A positive transition is possible as well, as leaders learn principles of effective leadership. In fact, one of the physician executives in the qualitative study described his own positive transition after he realized the destructive nature of personal charisma and the critical importance of controlling its effects on the group’s ability to achieve its vision.

5.11.5 Leadership theories dealing with leadership structure

5.11.5.1 Complexity Leadership Theory

Complex Leadership Theory (CLT) was formulated by its authors partially as a reaction to the heavy emphasis of traditional leadership theories on hierarchical leadership models. It combines principles of complex adaptive systems with concepts of leadership theory (Lichtenstein et al., 2007). Complexity theory proposes that simple hierarchical leadership models do not adequately explain the complex organizational interactions that comprise leadership in modern institutions. It proposes that leadership is a dynamic process in which leaders emerge and function as part of a “complex adaptive system (CAS)” (Lichtenstein, et al., 2007). A CAS is comprised of interdependent actors whose actions are guided by a small set of relatively simple rules with the net effect that the system (group, organization, team, etc.) quickly adapts to its environmental
challenges and opportunities (Uhl-Bien, et al., 2007). The theory proposes three main leadership actions in a bureaucratic environment, namely 1) adaptive (working with a group to meet a challenge), 2) administrative (formal managerial duties like planning, staffing, etc.), and 3) enabling (removing barriers and facilitating the success of the individual/group’s efforts) (Uhl-Bien, et al., 2007).

CLT also shares valuable leadership principles with DLT. Both recognize that leadership can be an emergent process and can take many different forms. CLT focuses on the complex adaptive system (CAS) as the unit of analysis, while DLT focuses on the group, which may be a CAS. Furthermore, CLT operates in a bureaucratic environment through the three mediating functions delineated above. Despite these additions to leadership theory, CLT remains a partial theory. It focuses more on how leadership occurs than on what leadership is. It does not distinguish between different types of leadership (constructive, ineffective, and destructive in DLT) nor does it acknowledge that formal hierarchical leaders may, in fact, be the actual leader in some situations. As is frequently seen in modern leadership theories, CLT is difficult to research using quantitative methods. The current qualitative study found abundant evidence of effective emergent leadership in a heavily bureaucratized environment, but qualitative data is underappreciated in the leadership literature (Bryman, 2004). As a result, there is relatively little literature supporting CLT as a leadership paradigm.
5.11.5.2 Shared or Distributed Leadership

Derived in part from complexity theory, shared or distributed leadership theory proposes that leadership emerges from amongst team members as they interactively influence one another, building and reinforcing meaningful relationships, and using them to progress as a team (Day, Gronn, & Salas, 2004). The theory eschews strictly hierarchical vertical leadership relationships, embracing horizontal influence between peers instead (Pearce & Conger, 2003). It defines leadership as a “simultaneous, ongoing, mutual influence process within a team that is characterized by ‘serial emergence’ of official as well as unofficial leaders” (Pearce & Barkus, 2004, p. 48). There is little research support for this theory, although shared leadership was envisioned as early as the 1920’s in Mary Parker Follet’s (1924) writings.

Shared/Distributed Leadership Theory utilizes some of the same theoretical underpinnings found in DLT, including the idea that leadership can be emergent and that it needn’t focus on a single individual. It also envisions leadership as a process of influence, which is the first step in DLT’s infusion of meaning, but falls far short of the full definition of changing a group’s cognitive processes through the active process of infusing positive, purposeful meaning. Shared/Distributed Leadership Theory classifies each leadership approach (constructive, ineffective, and destructive) as equally representative of leadership, while DLT considers only the infusion of meaning as determinative of constructive leadership. Shared/Distributed Leadership Theory advocates for “relationships of meaning” between group members, but it rejects the concept of an individual accepting ownership for the use of these meaningful
relationships to help the group progress through the alignment of group members’ ideals and purposes with those of the group.

Other significant differences between the two theories include the observation that Shared/Distributed Leadership is a partial model that does not identify components of leadership, or the propensity of individuals to migrate from one leadership style to another under the influence of a multitude of personal, group, and environmental pressures. DLT embraces these leadership dynamics, including them as crucial contributors to a full understanding of leadership.

5.11.6 Followership

Despite receiving relatively little attention throughout the history of leadership research, followers’ characteristics were recently found to determine a significant portion of leaders’ success. For instance, a recent meta-analysis found that followers’ perceptions of transformational/charismatic leadership helped to explain variance in leadership ratings (Schyns, Felfe, & Blank, 2007). Similarly, followers’ negative perceptions of their work environment were often attributed to their leader’s actions (M. C. Bligh, Kohles, Pearce, Justin, & Stovall, 2007).

Baker (2007) theorized that followership consists of four key principles: 1) that a follower, like a leader, is a role, not a person; 2) that followers are active, not passive; 3) that leaders and followers have a common purpose, and 4) that it is the relationship between leaders and followers, rather than the actions of either one individually, that determines leadership outcomes. Several authors proposed a central role of followers in
organizational leadership, including Kelley (2008) who describes followership as being at
the center of the leadership ‘map’ rather than at its periphery, and Hollander (1992) who
also argues for the critical contribution of followership to the process of leadership. Lord
and Brown (2003) place followers in the center of the leadership process, suggesting that
leadership should be studied by observing followers’ actions, values and development,
and then working backward to determine how leadership affects these dynamics. In
summary, leaders and followers are crucial actors in the process of leadership, and
focusing on one without considering the impact of the other leads to a partial
understanding of this process at best (M. Bligh, 2011).

DLT embraces the central importance of followers, proposing that leadership is
built upon their values, ideals, and goals. Rather than treating leaders and followers as
separate entities, DLT proposes that leaders and followers share a common vision, goals,
and objectives. DLT also encourages the development of followers into leaders, such
that the infusion of meaning is replicated across a group, with the goal of inculcating
positive, aligned meaning rather than establishing ownership of the leadership process
and position.

Followership is an incomplete theory of leadership, failing to explain the
spectrum of leadership processes (constructive to destructive in DLT). It does, however,
in company with DLT, embrace the fact that leadership is a process rather than a person,
and that leaders and followers can be interchangeable roles depending on the context.
Perhaps its most significant shortcoming is that while it proposes that followers’ goals,
values, and vision are crucial to the leadership process, it does not go far enough in
explaining what the leadership process is supposed to accomplish with those inputs (the
infusion of meaning in DLT). The failure of classical leadership theories to consider the role of the follower is a serious weakness in their ability to explain the leadership process fully.

5.12 Summary of situating DLT in the literature

This review of the literature supports the key dynamics comprising DLT as indispensable to the practice of leadership. It also provides a comparison of DLT to several categories of major leadership theories which further refines the meaning of DLT and its contribution to the field of leadership.

Missing from the literature, however, is a consistent definition of ‘leadership’ and ‘leader,’ and an understanding of the relationships between the various components of DLT. This review, which examines DLT in the context of the current literature, has set the stage for a quantitative study of the theory as a means of gaining a better understanding of these relationships and the mechanisms by which they result in different approaches to leadership.

I first conducted a review of the literature surrounding DLT’s definition of leadership as changing the cognitive processes of a group, with constructive leadership resulting from the infusion of meaning, destructive leadership resulting from the removal or destruction of meaning, and ineffective leadership resulting from interactions by leaders and group members in which positive, aligned meaning is not infused. I found strong support in the literature for a meaning-based approach to leadership, as well as for
the importance of the context of meaning in which leadership occurs, or the group’s culture.

I next reviewed recent literature regarding the importance of positive leader-based relationships, making the case that these provide a conduit by which constructive leadership can occur. I followed this with a review of moderators of the association between constructive leadership and leader-based relationships, including 1) positivism, 2) communication, 3) resilience, and 4) leader self-efficacy. I provided support from the literature for their inclusion in DLT’s principles regarding leadership and its practice. As part of this review, I discussed the various components of each of these entities, and discussed their importance to leadership.

Following a review of the proposed moderators of leadership, I presented evidence from the literature for DLT’s assertion that leadership is a dynamic process, consisting of different structures of leadership than the traditional static dyadic model, including emergent leadership, shared leadership, and network leadership. I also discussed the qualitative study’s finding that leaders often shift their leadership style depending on the situation they face.

Subsequent to the review of the variables comprising DLT, I presented a comparison of DLT to various categories of leadership theories as a means of both situating it in the leadership literature, as well as to further define and refine the theory. DLT shares Leader-Member Exchange Theory’s emphasis on the importance of relationships, and adds to this foundation a proposed definition of leadership and an understanding of the mechanisms by which relationships mediate the performance of leadership. DLT is similar to contingency theories that highlight the shifting leadership
styles that leaders employ in different contexts, to which it adds a clear understanding of the different categories of leadership leaders choose, and what those categories entail. In comparison to the charismatic and value-based leadership theories, DLT also places a strong emphasis on the importance of positive characteristics of leadership including self-efficacy, positivism and resilience (which charismatic and value-based theories also endorse in the same or slight different formats). In addition DLT adds an understanding of the full spectrum of leadership styles, including ineffective and destructive leadership and ways in which charismatic leadership shifts from a constructive to a destructive approach to leadership. DLT also embraces the dynamic nature of leadership as a critical addition to these leadership theories.

The fourth category of leadership theories with which DLT shares key building blocks are the so-called dynamic theories which propose alternate structures of leadership including complexity leadership, shared leadership, and network leadership theories. Similar to these theories, DLT acknowledges that leadership can be found in many different types of relationships than just the standard dyadic model championed by many traditional theories. It adds a deeper understanding of how leadership occurs, a proposal that leadership is moderated by important variables, and the concept that there are different kinds of leadership, the exercise of which carries tremendous consequences for groups and institutions.
5.13 Contributions of DLT to the leadership literature

Despite the extensive nature of the leadership literature, and its inclusion of many different contributing concepts and approaches to leadership, as well as of characteristics and attributes of leadership which contribute to its effectiveness, there remain several important gaps. I place these into two categories. The first are gaps which DLT addresses, and the second are gaps in the literature that I will address through a proposed quantitative study.

DLT addresses the following gaps in the literature:

a. The lack of a coherent, operational definition of leadership. DLT defines leadership as “changing the cognitive processes of one or more individuals.”

b. The lack of an understanding of the spectrum of leadership behaviors. DLT presents a spectrum of leadership which extends from constructive leadership to destructive leadership.

c. The lack of a coherent, operational definition of constructive leadership. DLT defines constructive leadership as the infusion of positive, aligned meaning into a group.

d. The lack of a coherent, operational definition of destructive leadership.

Destructive leadership is defined by DLT as the lessening or destruction of meaning from a group.

e. The lack of a coherent, operational definition of ineffective leadership.

Ineffective leadership is defined by DLT as interactions of leaders with group members in which meaning is not infused or changed.
f. The lack of an understanding of the variables that comprise or enable leadership. DLT proposes that communication, resilience, positivism, and self-efficacy moderate the ability of leaders to infuse positive, aligned meaning through strong, intimate relationships.

g. The lack of an understanding of the dualistic nature of some of these variables, in that they are able to influence the exercise of leadership behavior in either constructive or destructive directions. DLT proposes that leaders can use relationships, as moderated by communication, positivism, resilience and efficacy, to create constructive or destructive leadership depending on the leaders’ purpose and intent.

h. The lack of an understanding of the detrimental effects of gaps in the leadership literature on the selection, training, monitoring and evaluation of leaders in modern groups, teams, institutions, and political entities (discussed in Chapter 8).

Finally, a critical gap in the literature, in addition to those enumerated above, is the lack of an understanding of how moderating variables affect the practice of leadership. As outlined below, I propose a quantitative study of leadership to address this gap in the literature.

5.14 A proposed study of DLT

As I have shown from the review of the literature, many of the tenets of DLT already have extensive empirical support, with the key contribution of DLT being a better understanding of the relationships between the different variables affecting leadership.
Specifically, I have shown support for the concept of constructive leadership as the infusion of positive meaning into a group through strong, positive relationships that are moderated by communication, positivism, self-efficacy and resilience. I have also presented support for the concepts of ineffective and destructive leadership.

In light of this background, I will present in the next chapter a quantitative, survey-based study of the correlation of relationships and their moderators with constructive, destructive and ineffective leadership. The study will test the following hypothesis regarding DLT:

**Hypothesis 1**: Leader-based relationships are a) positively associated with Constructive Leadership, b) negatively associated with destructive leadership, and c) are not associated with ineffective leadership

**Hypothesis 2**: Positivism has a positive association with leader-based relationships

**Hypothesis 3**: Communication has a positive association with leader-based relationships

**Hypothesis 4**: Self-efficacy has a positive association with leader-based relationships

**Hypothesis 5**: Resiliency has a positive association with leader-based relationships

**Proposition**: Leadership is a dynamic entity, varying with respect to time, situation, group membership, and the needs of the group.

Following the presentation of the quantitative study in Chapter 6 along with the testing of these hypotheses, I will discuss the results in Chapter 7, along with the
conclusions I derive from the study and the contributions of DLT to the leadership literature. The final chapter of the dissertation will be a summary chapter in which I will discuss opportunities for future study of this theory, as well as recommendations for the development and training of leaders based on this theory.
Chapter 6

A quantitative survey study of Dynamic Leadership Theory

The following is a description of a quantitative survey study testing the hypotheses derived from Dynamic Leadership Theory after a review of the literature. I chose to evaluate DLT using this method to add statistical support to the theory that emerged from the qualitative study. I also chose this method as the most direct and practical approach to testing the five hypotheses enumerated in Chapter 4, and summarized in Figure 6-1. Combining qualitative and quantitative methods to identify and test the theory provides an excellent foundation from which to understand and develop it further.

6.1 Study Methods

This study utilized two standardized, fully validated leadership survey instruments. The first was the MLQ 5x developed by Bass and Avolio (B. Bass & Avolio, 2010; Carmines & Zeller, 1979). It consists of 45 questions with Likert 5-scale responses addressing building blocks of Transformational, Transactional, and

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<td>Dynamic Leadership Theory (DLT) Hypothesis:</td>
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<td>Hypothesis 1: Leader-based relationships are</td>
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<td>a) positively associated with Constructive</td>
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<td>Leadership, b) negatively associated with</td>
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<td>destructive leadership, and c) are not</td>
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<td>associated with ineffective leadership</td>
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<td>Hypothesis 2: Positivism has a positive</td>
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<td>association with leader-based relationships</td>
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<td>Hypothesis 3: Communication has a positive</td>
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<td>association with leader-based relationships</td>
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<td>Hypothesis 4: Self-Efficacy has a positive</td>
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<tr>
<td>association with leader-based relationships</td>
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<tr>
<td>Hypothesis 5: Resiliency has a positive</td>
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<td>association with leader-based relationships</td>
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<td>Proposition: Leadership is a dynamic</td>
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<td>situation, group membership, and the</td>
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<td>needs of the group.</td>
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217
Laissez-Faire Leadership. The second questionnaire was the Authentic Leadership Questionnaire (ALQ) developed by Avolio and others (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008). It has been thoroughly validated (Bryman, 2011) and uses 16 questions to cover the four main components of authentic leadership, including: 1) self-awareness – the degree to which the leader is aware of his or her impact on others, and of his or her strengths, weaknesses, and limitations; 2) transparency – the commitment of the leader to maintain openness with others and provide them opportunities to give input; 3) ethical/moral – the extent to which the leader establishes a high moral and ethical code of conduct for him or herself and others; and 4) balanced processing – the way in which the leader solicits opinions and ideas for significant decisions.

Both the MLQ 5x and the ALQ survey instruments are owned and managed by Mind Garden, Inc. located in Menlo Park, California. I purchased the rights to use the instruments for this study from Mind Garden, and also used their web service to administer the surveys to participants and collect the results. Mind Garden maintains the responses to the combined surveys on a secure server protected from physical accident and outside incursion by state-of-the-art security measures (Garden, 2012). Mind Garden agreed to provide me with data from the surveys from which identifying information had been removed.

These two questionnaires were chosen based on two factors. The first is that between them, they collect information about a wide range of leadership ideas and behaviors. Although the leadership types included in the “Full Range” leadership theory (Laissez-Faire, Transactional, and Transformational approaches to leadership) and
Authentic Leadership Theory are distinct from DLT as discussed in Chapter 5, Authentic, Transformational, and DLT share many of the same basic building blocks (relationships, communication, efficacy, positivism, and resilience), which the questionnaires incorporate into the respective surveys. Transactional and Laissez Faire leadership theories share concepts with Ineffective and Destructive leadership approaches proposed by DLT, which are also incorporated into the surveys. Therefore, by using these surveys, I was able to collect information from the participants about key aspects of their approaches to leadership that is directly applicable to an evaluation of DLT.

The second rationale for using these two survey instruments is their wide acceptance in the leadership literature, and the extent to which they have been tested for reliability and validity. I used the survey responses to individual questions to calculate scores reflecting participants’ leadership behaviors along the Constructive, Ineffective, and Destructive Leadership axes proposed by DLT. The validity of the questions included in the surveys to gather information about these leadership building blocks has been thoroughly tested and established in the literature. The use of these questions to calculate scores reflecting leadership styles proposed by DLT will require additional validation through further study.

In addition to the standard MLQ and ALQ study questions, four additional questions were added to the survey requesting the participants’ gender, age range, race and educational background. The security of participants’ personal information was established through the use of a password protected account with Mind Garden prior to participants taking the survey. Mind Garden’s confidentiality and security policies
guarantee confidentiality of participants’ contact information. Data from completed surveys is backed up on a remote server on a regular basis.

6.1.1 Participants

The following sections provide a description of the institutions from which participants in the survey were recruited, and the types of individuals that were invited to participate in the study.

6.1.2 Study institutions

Pinnacle Health System, Penn-State Hershey Medical Center, and Wellspan Health System were chosen for this study both because they are prototypical of non-profit community and academic hospital systems in the United States. They share a number of characteristics which enhance their value as study institutions: 1) they all serve as teaching campuses for Penn-State Hershey Medical Students, 2) they are tertiary referral centers, 3) they have cooperated on a number of joint community-based initiatives, 4) they are co-located in Central Pennsylvania, and 5) my connections with their executive teams allowed me access to their clinical and non-clinical leadership.

Pinnacle Health System is a 650-bed non-profit integrated health system located in Harrisburg, Pennsylvania. It is comprised of two acute care community teaching hospitals, two specialty hospitals, thirty ambulatory facilities, a medical staff of 800 physicians, and it sponsors thirteen residencies and fellowships. The author served as an
executive at this institution during the study period. The potential risk of study participants changing their responses because of their relationship with the author is mitigated by ensuring (and reassuring study participants) that 1) study results were de-identified and cannot be traced back to a specific participant, 2) participation or non-participation could not impact evaluations of performance or opportunities for promotion, and 3) the results would be kept completely confidential.

Penn-State Hershey Medical Center is a 500-bed academic medical center located in Hershey Pennsylvania. It has nearly 850 faculty members, 600 medical students, 22 residencies and 33 subspecialty fellowships with a combined total of over 500 residents and fellows. Penn-state Hershey residents and students receive portions of their education at both Pinnacle and Wellspan facilities. Participants from this institution were assured of the confidentiality of the results.

Wellspan Health is a two-hospital non-profit community teaching health system located in the communities of York and Gettysburg, Pennsylvania, with a combined total of approximately 700 inpatient beds. The system has close to 700 attending physicians and sponsors ten residencies and fellowships. Participants were assured of the confidentiality of their results.

### 6.1.3 Invitation of participants

In order to get input from a wide spectrum of leaders who are representative of US non-profit hospital systems, I invited three categories of healthcare leaders to participate in the study: 1) physician leaders, 2) nursing leaders, and 3) non-clinical
business leaders. In each of these categories, I invited both executive leaders, defined as those with formal high-level hierarchical positions in their respective organizations, and non-executive leaders whose leadership position was in the operational or clinical arenas.

Each institution was requested to provide email addresses for 25 individuals in each of the categories mentioned above. In cases in which there was insufficient contact information provided in a particular category at a given institution, all of the available names from that institution in that category were invited to participate in the survey. In cases in which there were more than 30 names available in a particular category, each name was assigned a computer-generated random number, and the 25 names associated with the lowest 25 numbers were invited to participate in the survey. If the total number available was less than 30, all were invited to participate.

Participants were invited via email using the address supplied by their institution. The invitation specified the purpose of the study, my identification and position (as a student and as an executive), and indicated that there would be no repercussions should the individual choose not to participate in the study. Before giving me email addresses, two institutions asked prospective participants if they would be willing to be invited to participate in the study, which provided an additional level of agency. The survey instrument also included a statement to participants specifying that they were free to discontinue participation in the survey at any time without repercussions. Participants were instructed as well that there would be no compensation for their participation in the survey.

A senior executive at each institution was contacted prior to making a request for contact information, and asked for institutional support for the study. Participants were
sent the initial invitation during the summer and fall of 2012. Those who had not completed the survey within two weeks of the initial invitation were contacted a second time via email with a repeat invitation. Participants were assured that their contact information would not be only used for the survey. They were also assured that their survey responses would be de-identified.

A total of 308 healthcare leaders were invited to participate in the survey, of whom 142 completed the instrument, for a participation rate of 46%. Table 6-2 delineates the participation rates of the various subgroups of study participants, and table 6-3 shows the response rates from the three institutions participating in the study.
Table 6-2 Response rates of participant subgroups

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Nurses</th>
<th>Non-Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executives</td>
<td>Non-Executives</td>
<td>Executives</td>
</tr>
<tr>
<td>Invited</td>
<td>Partic</td>
<td>Invited</td>
</tr>
<tr>
<td>56</td>
<td>22</td>
<td>56</td>
</tr>
<tr>
<td>39%</td>
<td>30%</td>
<td>67%</td>
</tr>
</tbody>
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Table 6-3 Participant rates from the institutions

<table>
<thead>
<tr>
<th>Institution 1</th>
<th>Institution 2</th>
<th>Institution 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invited</td>
<td>Participated</td>
<td>Rate</td>
</tr>
<tr>
<td>157</td>
<td>86</td>
<td>55%</td>
</tr>
<tr>
<td>Invited</td>
<td>Participated</td>
<td>Rate</td>
</tr>
<tr>
<td>26</td>
<td>10</td>
<td>38%</td>
</tr>
<tr>
<td>Invited</td>
<td>Participated</td>
<td>Rate</td>
</tr>
<tr>
<td>125</td>
<td>46</td>
<td>37%</td>
</tr>
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Leaders were asked to complete the survey instrument, as opposed to asking group members to give their perceptions of the leaders because it is the leader’s own concepts of leadership that provide insight into his or her infusion of meaning into the group with whom she works. Group members’ perceptions of leader’s style may be a worthwhile topic for further study, but these individuals do not have insights into leaders’ thoughts and motivations behind their leadership styles.
6.1.4 Demographic comparisons

Table 6-4 shows demographic information for study participants. All data was obtained via self-reporting. Significance was calculated using one-way ANOVA for the three groups of participants. Educational background and gender differences between the groups were found to be statistically significant. No statistically significant differences in racial composition of the groups were found.

6.1.4.1 Education

Physicians reported the least amount of management education by a large margin, while nurses reported the most (as reflected by the percentage of participants in each group having earned a master’s degree). The majority of nursing master’s degrees are likely to have been master’s degrees in nursing, which combines clinical with administrative training. Non-clinicians, therefore, may have the greatest amount of classroom exposure to management instruction, but there are no data to verify this prediction. Physicians had a far greater prevalence of clinical doctorate degrees, as would be expected.

6.1.4.2 Gender

The difference in gender between the various groups of participants was statistically significant \((p = 0.000)\). The great majority of nurses in the study were
female, as opposed to the preponderance of physicians in the study who were male. Non-clinical participants were roughly evenly split between male and female.

6.1.4.3 Age

There were no significant differences between the groups of participants’ ages. Nurses were on average a little younger, and physicians a little older than non-clinical participants. Given the lack of significant differences between the ages, and their similar absolute values (mean ages of the groups were 44, 47, and 48), there is little likelihood that age differences between the various participants significantly affected the study’s results.

6.1.4.4 Race

There were no significant differences in the reported race of study participants as all of the major groups were predominantly Caucasian. The physician group had a small number of non-Caucasian participants, which did not reach statistical significance. The lack of racial diversity in the study group reflects the demographics of US healthcare leadership, thus contributing to the validity to the study design.
Table 6-4 Demographic Comparisons

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<thead>
<tr>
<th></th>
<th>Physicians</th>
<th>Nurses</th>
<th>Non Clinical</th>
<th>p Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master’s Degree</td>
<td>5.1%</td>
<td>59.6%</td>
<td>44.6%</td>
<td>0</td>
</tr>
<tr>
<td>Medical Degree</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Other Doctorate</td>
<td>0.0%</td>
<td>2.1%</td>
<td>12.5%</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>20.5%</td>
<td>91.5%</td>
<td>46.4%</td>
<td>0</td>
</tr>
<tr>
<td>Age</td>
<td>48</td>
<td>44</td>
<td>47</td>
<td>0.233</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td>0.176</td>
</tr>
<tr>
<td>Caucasian</td>
<td>71.8%</td>
<td>95.7%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>7.7%</td>
<td>4.3%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>5.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>10.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

Despite the significant demographic differences between the groups, I believe this remains a valid sample of leaders for the following reasons. First, this group is representative of leaders found in healthcare institutions across the US. For instance, although these demographic trends are slowly changing, nurses are largely female (92%) (Labor, 2003), and physicians are largely male (72%) (Boukus, Cassil, & O'Malley, 2009) in the United States, which approximates the percentages found in this group. Second, the diversity of leaders included in the study makes its findings more robust, potentially applicable to a broader section of other leadership settings as opposed to being limited to homogeneous groups within a single discipline.
6.1.5 Case Study

Given the single industry, the relatively small circumscribed geographical area, and the small number of institutions in which this study was performed, it meets the definition of a case study (Creswell, 2007). Healthcare meets the definition of an “extreme” leadership environment, given its dynamic nature, the many crisis with which health care is currently dealing, and its complex organizational structures, thus making it an ideal industry in which to conduct leadership research (Pratt, Rockmann, & Kaugmann, 2006).

Strong representation from each of the components of a typical healthcare system (physicians, nurses, and management) in this study allows for inclusion of their unique perspectives. Although not highlighted in the current study, it also provides a basis on which to compare leadership characteristics of these different groups and to discover ways in which they are either different or complementary.

6.1.6 Validity

I will next discuss different measures of validity of this study, and its limitations and delimitations.
6.1.6.1 Threats to Validity

I will examine internal validity, construct validity, and external validity, reaching the conclusion that the study is reasonably valid despite its limitations and delimitations, which will be discussed in the following section.

A study has internal validity when a causal relationship between variables is warranted (Kenny, 1987); that is, when the study is free of bias. Possible threats to the internal validity of this study include 1) the relationship between the researcher and study participants may have affected the results of the surveys, 2) participants’ bias resulting from each institution’s unique leadership culture; 3) effects of organizational events on participants’ survey results; and 4) the effects of various departmental functions and expectations on individual participants’ perception of the survey questions (Kenny, 1987).

The potential for bias introduced by the relationship between the author of the study and the study participants was mitigated by ensuring confidentiality of study results, reassuring participants that there would be no repercussions based on their participation or non-participation in the study, and allowing participants to withdraw from the study at any point. In addition, the fact that respondents’ information was de-identified provides additional assurance that no undue influence was exerted on participants.

Despite these precautions, the researcher’s supervisory role at one of the study institutions may have affected participants’ decision to participate in the study, or the quality of their participation. The lack of significant differences between the responses
from participants at the three institutions provides some measure of reassurance that any bias, if present, did not significantly affect the results of the study.

Another threat to internal validity is the demographic differences between subgroups of participants, particularly gender differences. This introduces the possibility of a misattribution of gender effects to leadership variables. This threat is difficult to mitigate, since selecting male nurses specifically to participate in the trial, or female physicians would introduce another strong bias into the results. Since gender is a predominant characteristic of the nursing and physician subgroups across the nation as illustrated by national demographics quoted above, rather than trying to separate it as a variable, I note that its effects are included in the measurements for those subgroups, that it enhances the applicability of the study to other healthcare institutions, and list it as an area in need of further research.

6.1.6.2 Construct validity

Construct validity determines whether a scale measures a theory’s underlying construct. The risk to the study’s construct validity is that the survey questions do not measure the variables used in DLT to which I have assigned them. The MLQ and ALQ surveys have been used extensively to study leadership, and have been rigorously validated, which provides reassurance of their construct validity (B. M. Bass & Avolio, 2004; Walumbwa, et al., 2008). Given this extensive validation, I maintain the surveys have construct validity for the components of leadership associated with DLT, and are therefore appropriate instruments to test its associated hypotheses.
This risk to construct validity is further mitigated by the variety of individual questions from these two instruments that I use to derive scores for each of the variables and leadership types. By using a broad repertoire of survey responses to support the different characteristics of DLT instead of a single question, there is less likelihood that a misinterpreted question would skew the results of the survey for that particular characteristic.

### 6.1.6.3 External Validity

External validity is a measure of the generalizability of a study’s results. The greatest threat to the external validity of this study is that it uses a case study to evaluate DLT. As a case study, it is confined to three central Pennsylvania healthcare institutions which are prototypical of not-for-profit hospitals. As an exploratory study of DLT, a case-study approach has several benefits. It allows for a more in-depth and detailed study of leadership that can be expanded in future studies. It limits the externalities that may bias the results of the study, such as local and regional political differences and differing leadership traditions. It also allows for a more meaningful interpretation of the results, inasmuch as the researcher has a greater understanding of the study institutions and their cultures and traditions.

This is a case study of DLT using participants from three institutions. The potential threats to the internal, external and construct validities of the study are partially mitigated, and the study retains a reasonable level of validity. This can be confirmed by
continued research and testing in a variety of settings using different methods and approaches.

6.1.6.4 Reliability

Reliability of an instrument is defined as the “ratio of variability between subjects to the total variability of all measurements in the survey” (Kottner, Audige, Brorson, et al., 2010, p. 96). The reliability of this survey was evaluated by calculating Cronbach’s Alpha (CA) for the data, which was determined to be 0.77. The CA values for each of the variables in relation to the dataset as a whole were also calculated, and each was above 0.7 as reflected in table 6-8. CA tests the hypothesis that the scores reflect the same internal construct; that is, that they measure the same phenomenon (leadership in this case). Inasmuch as the Cronbach’s Alpha values lie between 0.70 and 0.80, I conclude the questionnaire results have reliability, and a comparison of the variables derived from the survey scores is supported (Cortina, 1993).

6.1.7 Delimitations and Limitations

This most important delimitation of the study is its confinement to study subjects who are either employed or affiliated with three mid-Atlantic health systems. I chose to confine the study to these three health systems to limit the bias from external variables. The psychological and organizational literature supports the efficiency and homogeneity
benefits of using such a convenience sample (Berkowitz & Donnerstein, 1982; Greenberg, 1987; Highhouse & Gillespie, 2009; Kardes, 1996). This case study provides preliminary investigation of DLT, and is a useful for initial testing of a theory (Creswell, 2007). Further evaluation of DLT in larger and more diverse settings will generate useful insights into its application to the general practice of leadership.

6.1.7.1 Limitations

The first limitation of the study is its use of a relatively small sample, which limits its power (ability to avoid type II error). Of the 308 individuals invited to participate in the study, there were a total of 142 (39 physicians, 47 nurses, and 56 non-clinicians) who agreed to participate in the study, for an overall response rate of 46%.

The power of the study was calculated for a paired t-test of the population for comparisons between the different variables as an estimation of power for regression analysis comparing all variables. I note the parsimonious models resulting from the regression analysis, which in most cases devolved to a t-test of two variables. Sample size used for the calculation was 142, reflecting the combined number of physicians, nurses, and non-clinicians that participated in the study. Variance between means was estimated to be 0.15. The power of the study to detect significant differences between variables at the alpha = 0.05 level is shown in figure 6-1, which shows that for differences between means of groups in the study of 0.07 or greater, the power was 0.8 or greater, and thus adequate to reasonably exclude type II error.
An opportunity to enhance the power of the study which is accepted in the literature (Aguinis & Harden, 2009; Kervin, 1992; Sauley & Bedeian, 1989; Stevens, 1996) is to increase the acceptable type I error rate to between 0.1 and 0.2 (depending on the size of Cohen’s d). Given the adequate power of this study, and the highly significant statistical results, I have chosen to use an alpha of 0.05 as the cut-off value for statistical significance (and power calculation).

A possible limitation of the study is the combination of various subgroups of participants into a group that is treated as a single entity. Subgroups’ results were tested for homogeneity using a student’s $t$-test, and were found to lack significant group-level differences. This result supports using the combined group for analysis.

![Power Curve for Paired t Test](image)

*Figure 6-1 Power Curve for Paired t-Test*
A third possible limitation is the response rate of less than 50%, which introduces the possibility of systemic error if there were a pre-selection process amongst the potential participants. While I cannot exclude this possibility, I believe that it is unlikely given the multiple institutions and populations of healthcare workers used for the study. The overall response rate of 46% compares favorably with other survey-based studies in the literature, and provides some degree of assurance that the study results are a valid reflection of the entire population’s characteristics.

All of the executive sub-groups were limited by the number of individuals available in the different institutions; therefore, all executives in each institution were considered for invitation. Non-executives from one institution were not available to participate in the study (this institution did not provide email addresses for its non-executives). For subgroups in which the number of email addresses provided exceeded the number needed, a random number was assigned to the names of those willing to participate and used to choose the appropriate subset of participants. The participants were limited to those employed or affiliated with the three healthcare systems as already described, which are representative of other similarly-sized health systems in the country.

One of the drawbacks of using the MLQ and ALQ surveys was their weakness in measuring two of the main dependent variables in DLT; namely, ineffective and destructive leadership. While additional questions could potentially cover these additional variables, and thus increase the study’s ability to adequately test portions of DLT affected by these forms of leadership, adding additional questions may have negatively impacted the participants’ willingness to complete the survey, as well as its internal and construct validities. Therefore, only demographic questions were added to
the standardized surveys, asking participants for their age range, educational background, sex, and racial profile. Ineffective and Destructive Leadership approaches will require additional study to better evaluate their association with the key variables in DLT.

My own employment as a senior physician executive at one of the hospitals in the study could also have affected the generalizability of the results. Blinding the participants in the quantitative portion of the study as to my involvement would have been unethical. I attempted to mitigate this problem by ensuring the confidentiality of participants’ results and of individual participants’ identity, and by ensuring participants that there would be no repercussions for their participation in the study.

I will now discuss the study results and their statistical evaluation.

6.2 Data Analysis

Data were analyzed using backward stepwise regression analysis of the scores from each respondent for the five key variables of DLT (communication, relationships, self-efficacy, positivism, and resilience) to find correlations (as predicted by the hypothesis from Chapter 4) with each of the three leadership approaches (dependent variables - constructive leadership, destructive leadership, and ineffective leadership). Scores for each of these variables (predictor and outcome variables) were calculated as the mean for survey items relating to each particular variable. For this analysis, there were eleven survey questions related to relationships, ten relating to communication, six related to self-efficacy, five related to positivism, seven related to resilience, six related to
constructive leadership, six related to destructive leadership, and one related to ineffective leadership.

Sub-group analysis for each of the categories of participants including executives versus non-executives, clinicians versus non-clinicians, and physicians versus non-physicians, and of males versus females failed to show significant differences, thus supporting the use of the entire group of participants to test the hypotheses.

6.2.1 Missing Data

Three problems result from missing data: 1) decreased external validity, 2) decreased statistical power, and 3) inability to evaluate the data appropriately using certain statistical analyses. The survey responses contained a small number of missing responses to individual questions (1.0% of the data was missing). In instances of item-level non-response, in which respondents fail to answer one or more questions, I used the mean imputation method (Roth, Switzer, & Switzer, 1999) to correct for the missing data. I employed the methods suggested in the literature (Fox, Crask, & Kim, 1988; Yammarino, Skinner, & Childers, 1991; Yu & Cooper, 1983) to minimize survey-level non-response, including personalized invitations, reminders, and using participants from a limited number of institutions.
6.2.2 Results from the study

Regression analysis found a highly significant correlation between relationships and constructive leadership, with the following main effects model:

\[ \text{Constructive leadership} = 0.630 + 0.759 \text{Relationships} \]

The adjusted R\(^2\) for the model is 40.6\%, with an \(F\) of 97.41, and a \(p\) value of 0.000. This result strongly supports DLT’s proposal that relationships are a principle determinant of constructive leadership.

The association of relationships with destructive leadership was minimal, with the following main effects model:

\[ \text{Destructive Leadership} = 1.05 + 0.329 \text{Relationships} \]

\(R^2\) is 4.4\%, \(F\) is 7.51, and \(p = 0.007\). I interpret this finding as indeterminate, given the very minimal degree of correlation between the two variables.

There was no association of relationships with Ineffective leadership, as demonstrated by the main effects model

\[ \text{Ineffective Leadership} = 0.481 - 0.28 \text{Relationships} \]

The \(R^2\) for this model is 0.0\%, the \(F\) is 0.04, and \(p = 0.836\).

Communication, positivism and resilience were strongly predictive of relationships, with the following main effects model:

\[ \text{Relationships} = 0.489 + 0.392 \text{Communication} + 0.157 \text{Positivism} + 0.331 \text{Resilience} \]
The $p$ value for this model was 0.000, with an F of 87.1, and an adjusted $R^2$ of 64.7%. The $p$ value for inclusion of communication was 0.000; for positivism it was 0.004, and for resilience it was 0.000.

Self-efficacy also was found to have a significant association with relationships, with the following main-effects model:

$$Relations = 1.17 + 0.659 \text{Self-Efficacy}$$

The $p$ value for this model is 0.000, with an F of 64.7 and an adjusted $R^2$ of 31.1%. However, after controlling for the effects of communication, positivism and resilience on relations, self-efficacy no longer had a significant effect ($p = 0.250$).

The association of self-efficacy with communication, positivism, and resilience, is highly significant, with the following main effects models:

$$Communication = 0.887 + 0.683 \text{Self-Efficacy} \quad (F=72, p=0.000, R^2 \text{ adjusted} = 34\%)$$

$$Resilience = 1.03 + 0.696 \text{Self-Efficacy} \quad (F = 85; p=0.000; R^2 \text{ adjusted} = 37\%)$$

$$Positivism = 0.984 + 0.702 \text{Self-Efficacy} \quad (F = 42; p = 0.000; R^2 \text{ adjusted} = 22\%)$$

I concluded that these findings (the confirmation that self-efficacy has a highly significant association with relations, but that this association appears to be fully explained by its associations with communication, resilience, and positivism) should be reflected by adjusting the overall model for DLT to show the interactions of these variables. The updated model for DLT is shown in figure 6-2.
Regression of the leadership variable scores for the entire group against their scores for their perceptions of destructive leadership showed a significant correlation between resilience and this type of leadership, with a main effects model as below:

\[ \text{Destructive leadership} = 0.665 + 0.454 \text{Resilience}. \]

The adjusted $R^2$ for this model is 8.26%, with a Mallows Cp of 2.5, an $F$ of 13.69 and a $p$ value of 0.000.

Regression of the leadership variables for the entire group combined against their score for ineffective leadership failed to show evidence of predictability by any of the variables, as was hypothesized from the theory.

Bonferroni correction for multiple comparisons of the data did not affect any of the relationships shown above, given the highly significant $p$ values found for each of the relationships.

6.2.3 Analysis of moderator effects

As presented above, although self-efficacy has a statistically significant association with relationships, after controlling for the effects of communication, positivism and resilience on relationships, self-efficacy’s association with relationships was no longer significant. This suggested that self-efficacy’s effect on relationships is a function of its association with these three variables (communication, resilience and positivism), which was shown to be statistically supported. Therefore, I proposed a revised model for DLT which acknowledges this nuance, in which self-efficacy is shown
to have an association with these three variables, while the three variables have a direct association with relationships. This revised model is shown in figure 6-2.

Figure 6-2 Revised Dynamic Leadership Theory Model

The revised model predicts that communication, resilience, and positivism moderate the effect of relationships on constructive leadership, and that self-efficacy moderates the effect of communication, resilience, and positivism on relationships. The following discussion shows the statistical testing of this hypothesis.

Fairchild and MacKinnon (Fairchild & MacKinnon, 2009) proposed a general model for testing moderation of one or more variables on the effect of an independent variable on a dependent variable. For the simplest test, in which variable Z moderates the effect of independent variable X on dependent variable Y, the main effect model is

\[ Y = i + B_1^*X + B_2^*Z + B_3^*X^*Z + e \]
In this model, \( B_j \) is the estimate the moderating effect of \( Z \) on the independent variable \( X \)'s effect on dependent variable \( Y \) (Fairchild & MacKinnon, 2009). For each additional variable, interaction coefficients with \( X \) (the independent variable) and with each other are added to the effects model.

\[
Y = i + B_1 X + B_2 Z_1 + \ldots + B_N Z_{N-1} + B_{N+1} X Z_1 + \ldots + B_{2N} X Z_{2N-1} + \ldots
\]

Therefore, for the purposes of this study, I tested the moderating effects of communication, resilience and positivism on the effect of Relationships on Constructive Leadership with the following model:

\[
\text{Constructive Leadership} = i + B_1 \text{Relationships} + B_2 \text{Communication} + B_3 \text{Resilience} + B_4 \text{Positivism} + B_5 \text{Relationships} \times \text{Communication} + B_6 \text{Relationships} \times \text{Resilience} + B_7 \text{Relationships} \times \text{Positivism} + B_8 \text{Relationships} \times \text{Communication} \times \text{Resilience} + B_9 \text{Relationships} \times \text{Communication} \times \text{Positivism} + B_{10} \text{Relationships} \times \text{Resilience} \times \text{Positivism} + B_{11} \text{Relationships} \times \text{Communication} \times \text{Resilience} \times \text{Positivism} + \epsilon
\]

In order to simplify the model, and because second and third order interactions have no meaning for the leadership model, I assumed that \( B_8 \) – \( B_{11} \) are not relevant, and tested the model:

\[
\text{Constructive Leadership} = i + B_1 \text{Relationships} + B_2 \text{Communication} + B_3 \text{Resilience} + B_4 \text{Positivism} + B_5 \text{Relationships} \times \text{Communication} + B_6 \text{Relationships} \times \text{Resilience} + B_7 \text{Relationships} \times \text{Positivism} + \epsilon
\]

This yielded the following coefficients:
As is evident from the table, the coefficients reflecting the moderating effects of positivism, communication, and resilience ($B_5$, $B_6$, and $B_7$) were all significant ($p=0.000$ for each), and relatively large (0.3, 0.178, and -0.109). $R^2$ adjusted for the model as a whole was 99%, supporting the decisions to not include higher order interactions in the moderating model. Additional support for this decision arises from the non-significant coefficient for relationships’ effect on constructive leadership in this model, inferring that the effect is fully moderated by the three variables.

### 6.2.4 Self-efficacy’s moderating effect on the effects of communication, resilience, and positivism on relationships

The CLT model predicts that Self-efficacy exerts a moderating effect on each of communication, resilience, and positivism’s effects on relationships. Each of these
predictions is tested using a single moderating variable on an independent variable’s effect on a dependent variable as shown above. For this study, this becomes:

1. \[ \text{Relationships} = i + B_1 \cdot \text{Communication} + B_2 \cdot \text{Self-Efficacy} + B_3 \cdot \text{Communication} \cdot \text{Self-Efficacy} + e \]

2. \[ \text{Relationships} = i + B_1 \cdot \text{Resilience} + B_2 \cdot \text{Self-Efficacy} + B_3 \cdot \text{Resilience} \cdot \text{Self-Efficacy} + e \]

3. \[ \text{Relationships} = i + B_1 \cdot \text{Positivism} + B_2 \cdot \text{Self-Efficacy} + B_3 \cdot \text{Resilience} \cdot \text{Self-Efficacy} + e \]

Each of these models was evaluated using regression analysis, with the following findings shown in table 6-6.
Table 6-6 Table of coefficients for SE as a moderator

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Moderating Coefficient ($b_3$)</th>
<th>p Value</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>-0.277</td>
<td>0.005</td>
<td>61%</td>
</tr>
<tr>
<td>Resilience</td>
<td>0.11</td>
<td>0.000</td>
<td>44%</td>
</tr>
<tr>
<td>Positivism</td>
<td>0.565</td>
<td>0.009</td>
<td>57%</td>
</tr>
</tbody>
</table>

As can be seen from the table, self-efficacy has a highly significant and relatively large moderating effect on each of the independent variable’s effect on relationships, as was predicted from the DLT model.

6.2.5 Factor Analysis

The following table 6.7 shows the factor loadings for the variables in the DLT model. As can be seen from the table, total variance is greater than one for two factors at most. Loadings are greater than 0.7 for one factor only for all variables except ineffective leadership, which has an indefinite pattern of loading. This data suggests a parsimonious model is most appropriate for the data, with one, or at most two factors to explain a given variable.
Table 6-7 Factor Loadings for DLT

<table>
<thead>
<tr>
<th>Variable</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
<th>Factor 5</th>
<th>Communality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relations</td>
<td>0.873</td>
<td>-0.024</td>
<td>0.104</td>
<td>-0.027</td>
<td>0.239</td>
<td>1.000</td>
</tr>
<tr>
<td>Commun</td>
<td>0.879</td>
<td>-0.071</td>
<td>0.012</td>
<td>-0.081</td>
<td>0.246</td>
<td>1.000</td>
</tr>
<tr>
<td>Self-Effic</td>
<td>0.738</td>
<td>0.127</td>
<td>-0.118</td>
<td>-0.499</td>
<td>-0.415</td>
<td>1.000</td>
</tr>
<tr>
<td>Positivism</td>
<td>0.803</td>
<td>-0.205</td>
<td>0.211</td>
<td>0.227</td>
<td>-0.169</td>
<td>1.000</td>
</tr>
<tr>
<td>Resilience</td>
<td>-0.865</td>
<td>0.065</td>
<td>-0.035</td>
<td>-0.167</td>
<td>0.241</td>
<td>1.000</td>
</tr>
<tr>
<td>Constr. L.</td>
<td>0.782</td>
<td>-0.057</td>
<td>0.202</td>
<td>0.418</td>
<td>-0.237</td>
<td>1.000</td>
</tr>
<tr>
<td>Dest. L.</td>
<td>0.362</td>
<td>0.516</td>
<td>-0.724</td>
<td>0.269</td>
<td>-0.013</td>
<td>1.000</td>
</tr>
<tr>
<td>Inef. L.</td>
<td>-0.053</td>
<td>0.844</td>
<td>0.53</td>
<td>-0.001</td>
<td>0.022</td>
<td>1.000</td>
</tr>
<tr>
<td>Variance</td>
<td>4.216</td>
<td>1.049</td>
<td>0.9175</td>
<td>0.583</td>
<td>0.433</td>
<td>8.000</td>
</tr>
</tbody>
</table>

Table 6-8: Cronbach’s Alpha

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>0.71</td>
</tr>
<tr>
<td>Communication</td>
<td>0.71</td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>0.74</td>
</tr>
<tr>
<td>Positivism</td>
<td>0.72</td>
</tr>
<tr>
<td>Resilience</td>
<td>0.72</td>
</tr>
<tr>
<td>Constructive Ldrshp</td>
<td>0.72</td>
</tr>
<tr>
<td>Destructive Leadership</td>
<td>0.79</td>
</tr>
<tr>
<td>Ineffective Leadership</td>
<td>0.86</td>
</tr>
<tr>
<td>Entire dataset</td>
<td>0.77</td>
</tr>
</tbody>
</table>

Table 6-9: Mean and Standard Deviation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>3.31</td>
<td>0.43</td>
</tr>
<tr>
<td>Communication</td>
<td>3.11</td>
<td>0.43</td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>3.25</td>
<td>0.37</td>
</tr>
<tr>
<td>Positivism</td>
<td>3.26</td>
<td>0.54</td>
</tr>
<tr>
<td>Resilience</td>
<td>3.39</td>
<td>0.42</td>
</tr>
<tr>
<td>Constructive Ldrshp</td>
<td>3.14</td>
<td>0.51</td>
</tr>
<tr>
<td>Destructive Leadership</td>
<td>2.14</td>
<td>0.63</td>
</tr>
<tr>
<td>Ineffective Leadership</td>
<td>0.39</td>
<td>0.69</td>
</tr>
</tbody>
</table>
Table 6-10 Covariance Matrix with p values

<table>
<thead>
<tr>
<th>Variable</th>
<th>Rltns/p</th>
<th>Com./p</th>
<th>SE/p</th>
<th>Pos/p</th>
<th>Res./p</th>
<th>CL/p</th>
<th>DL/p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relations</td>
<td>0.76/0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>0.56/0.00</td>
<td>0.58/0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>0.64/0.00</td>
<td>0.65/0.00</td>
<td>0.48/0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positivism</td>
<td>0.73/0.00</td>
<td>0.75/0.00</td>
<td>0.61/0.00</td>
<td>0.60/0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>0.64/0.00</td>
<td>0.60/0.00</td>
<td>0.45/0.00</td>
<td>0.67/0.00</td>
<td>0.56/0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Const. Ldrshp</td>
<td>0.23/0.01</td>
<td>0.27/0.00</td>
<td>0.29/0.00</td>
<td>0.12/0.15</td>
<td>0.31/0.00</td>
<td>0.20/0.02</td>
<td></td>
</tr>
<tr>
<td>Dest. Ldrshp</td>
<td>-0.02/0.84</td>
<td>-0.09/0.28</td>
<td>-0.01/0.95</td>
<td>-0.09/0.30</td>
<td>-0.01/0.89</td>
<td>-0.00/0.97</td>
<td>0.03/0.69</td>
</tr>
</tbody>
</table>

Key: Rltns – relationships; Comm – Communication; SE – Self Efficacy; Pos – Positivism; Res – Resilience; Const. Ldrshp – Constructive Leadership; Dest. Ldrshp – Destructive Leadership; Ineff. Ldrshp – Ineffective Leadership; p – p value for the covariance between the variables

Table 6-8 shows the Cronbach’s Alpha (CA), mean, standard deviation, and inter-variable covariances for each of the variables tested in the model. The CA value for each of the variables is greater than 0.7, as is the CA for the overall dataset (0.77), implying relatively good internal consistency (reliability) of the data (Carmines & Zeller, 1979).

Covariances between the variables were calculated using standardized scores (obtained by subtracting the mean for each variable from the respective score, and dividing the difference by the standard deviation for that variable). The relatively large covariances (0.562 – 0.756) for communication, resilience, positivism, and self-efficacy with relationships are reflected in the DLT model, as are the covariances for self-efficacy and the remaining predictor (relations) and moderator (resilience, communication, and positivism) variables. The covariance between communication and resilience (0.746, implying an R^2 of 56%) and positivism (0.648 implying and R^2 of 42%), and between positivism and resilience (0.604 implying an R^2 of 36%) are not reflected in the model.

I do not find it surprising that there is a significant degree of covariance between these variables, as they are each a component of “Positive Organizational Behavior” as
discussed in Chapter 5 and would reasonably be expected to co-occur in leaders. In other words, a leader who is resilient is probably more likely to have a high degree of positivism than a leader who is not. Similarly, leaders with a high degree of positivism would be more likely to engage in effective communication, as would leaders with a high degree of resilience, while those with lower resilience and positivism may be less inclined to communicate effectively. Regardless of these associations, which require additional study, the DLT model groups these three variables (communication, resilience, and positivism) together whenever they occur (as moderators of relationships, and in turn, as being moderated by self-efficacy). This also suggests, as does the factor loading analysis, that a more parsimonious model may be appropriate.

By consolidating the three variables ‘communication,’ ‘resilience,’ and ‘positivism’ into a single variable which I have labeled ‘Leader tools (LT),’ a new model of DLT emerges. This revised model is graphically presented in figure 6-3 below.

![Figure 6-3 Revised DLT Model](image-url)
6.2.6 Statistical Analysis of DLT Model with combined variable

The combined variable model has strong statistical support. The main effects model for this variable’s association with relationships is:

\[ \text{Relations} = 0.575 + 0.283 \times LT \]

The \( p \) value for this model is 0.000, the \( F \) is 247.9, and the adjusted \( R^2 \) is 63.6\%, which is in line with the \( p \) value and \( R^2 \) for the main effects model for the three original variables reported previously.

The main effects model for the association of self-efficacy with the combined variable LT is as follows:

\[ LT = 2.91 + 2.08 \times SE \]

This model is highly significant, with a \( p \) of 0.000, an \( F \) of 90.8, and an \( R^2 \) of 38.9\%. These statistical parameters are very similar to those found for the association of self-efficacy with each of the contributing variables to LT (communication, positivism, and resilience).

Factor analysis using the combined variable is illustrated in Figure 6-3

---

**Figure 6-4 Correlation matrix for the revised DLT Model**

<table>
<thead>
<tr>
<th></th>
<th>Relations</th>
<th>LT</th>
<th>Self-efficacy</th>
<th>CL</th>
<th>DL</th>
</tr>
</thead>
<tbody>
<tr>
<td>LT</td>
<td>0.799/0.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>0.562/0.000</td>
<td>0.627/0.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CL</td>
<td>0.641/0.000</td>
<td>0.701/0.000</td>
<td>0.445/0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DL</td>
<td>0.226/0.007</td>
<td>0.254/0.002</td>
<td>0.288/0.001</td>
<td>0.200/0.017</td>
<td></td>
</tr>
<tr>
<td>IL</td>
<td>-0.018/0.836</td>
<td>-0.075/0.375</td>
<td>-0.005/0.935</td>
<td>-0.003/0.969</td>
<td>0.034/0.685</td>
</tr>
</tbody>
</table>
Key: LT – Leader tools; CL – Constructive leadership; DL – Destructive leadership; IL – Ineffective leadership.

As the table shows, there is a significant correlation between relations and LT and self-efficacy, which the DLT model also predicts. Likewise, there is a significant correlation between LT and self-efficacy, which the DLT model predicts. The relationship of LT with constructive leadership is through its association with relationships, which also applies to self-efficacy. The association of these variables with destructive leadership, while highly significant, is not practically significant, with an $R^2$ of 5 – 8%. The DLT model predicts this association, but suggests that it should be greater.

The new LT variable will need further testing to define its composition better. While it behaves in a way that is similar to the three contributing variables, one could still question whether other variables might also contribute to it, and if so, to what extent. It is to be remembered that the original composition of these variables (communication, efficacy, resilience, and positivism) was determined from the comments of many different interviewees describing their thoughts, ideas, and experiences about leadership. The author coded these statements, and using his professional judgment, insight, and understanding of the leaders, their context, and the literature behind the variables, to aggregate them into a parsimonious collection of key leadership factors. One of the ways in which this theory could be further refined is through further study of the ‘Leader Tools’ variable, generating a better understanding of its composition, effects, and other potential moderators.
6.3 Summary

This quantitative study was performed using combined MLQ and ALQ questionnaires along with a small number of demographic questions. Of 308 leaders invited to participate in the study, 142 individuals completed the surveys, for a response rate of 46%. Although significant demographic differences existed between the subgroups of participants, no significant differences were found between the groups’ responses, and therefore the participants’ responses were analyzed as a whole.

Important validity issues and limitations of the study were discussed, including the sample size, the case study methodology, the selection of participants, and the confinement of the study to a small number of institutions in a limited geographical area. These problems were mitigated by safeguarding the confidentiality of the study results and blinding the author to the identity of survey respondents.

The study results were strongly supportive of DLT, as will be discussed in detail in the following chapter. Relationships’ association with constructive leadership was robust and strong. Communication, resilience, and positivism were all strongly associated with relationships, and fulfilled the criteria to be considered as moderators of the association of relationships with constructive leadership. Self-efficacy was also found to have a significant association with relationships, but after controlling for the effects of communication, resilience and positivism, this association was no longer significant. Since this suggested an association between self-efficacy and the remaining variables, I tested the data for such an association and found that it was highly significant, with an $R^2$ of 34%, 37% and 22% for communication, resilience and positivism, respectively. This
finding led me to conclude that the model for DLT should be modified to reflect these relationships, and the revised model is shown in Figure 6-2.

There was no association of any of the independent variables (positivism, resilience, efficacy, or communication) with ineffective leadership. The results regarding destructive leadership were ambiguous, and will require further study. The study method was clearly more robust for the evaluation of constructive leadership than it was for the evaluation of ineffective and destructive leadership approaches.

Factor analysis supports the use of the survey instruments to study these dependent and independent variables. Cronbach’s alpha was >0.7 for each subset of survey questions supporting individual variables, as it was for the survey results as a whole, supporting its reliability. Factor loadings suggested that a more parsimonious model of DLT would be appropriate, since the variance for a second factor was just above 1.0, and fell below one for additional factors. Analysis of the covariance tables supported this finding, which showed a significant covariation not reflected by the model between communication, resilience, and positivism. This finding suggested that the three variables could reasonably be considered different manifestations of a combined variable constructed by adding the results of these three variables. I tested this combined variable in the model, and found that it retained the same properties as the model in which the three variables were considered to be independent. In other words, the $R^2$ of the association of the combined variable with relationships (63.7%) was nearly the same as the main effects model using these three variables separately (64.6%).
Therefore, I revised the table one more time to reflect this more parsimonious model of DLT, with a combined variable “Leader Tools” reflecting the combination of communication, resilience, and positivism. The revised model is shown in Figure 6-3.

In the next chapter, I will further explore the study results, and their support of the hypotheses comprising DLT. I will also review the DLT model and discuss the association of the independent variables (relationships, communication, resilience, positivism, and efficacy) with the dependent variables (constructive, ineffective, and destructive leadership). Finally, I will describe the contributions of this study to the leadership literature, and make recommendations for future study of DLT.
Chapter 7 - Testing the Hypotheses Associated with DLT

In this chapter, I will summarize and discuss the results of the quantitative survey study, followed by a more general discussion of the implications of the study for the healthcare and leadership fields. This in turn will be followed in Chapter 8 by a discussion of future directions for this theory and opportunities for conducting further research on its proposed mechanisms of leadership. The quantitative study provides strong support for the hypotheses comprising DLT that emerged from the qualitative study. In order to reflect the specific ways in which the variables related to each other better, however, I made two adjustments to the model originally constructed in Chapter 4.

7.1.1 Changes in the DLT Model

The first change was occasioned by the finding that the association of self-efficacy with relationships lost its significance after controlling for the effects of resilience, communication, and positivism. Since this finding suggested an association between self-efficacy and these three variables, I tested for this association and found it to be robust and significant. Therefore, I adjusted the model to reflect self-efficacy’s association with relationships through its association with communication, positivism, and resilience.

I made a second change in the model after factor analysis suggested that a parsimonious model, using one or at most two variables to explain the variation in the factors would be most appropriate for the data. I also noted that communication,
resilience, and positivism had a significant level of covariance with one another that was not reflected in the model. Upon re-evaluating the DLT model, and noting that these three variables functioned together as moderators of relationships, and also that their effect on relationships was moderated by self-efficacy, I reasoned that combining these three variables into a single variable would better describe the data. I created this combined variable, Leader Tools (LT) by adding the scores for each participant for communication, resilience, and positivism. Upon statistical analysis of the new variable, I found that it retained the robustness of the three previous variables in explaining the variation in relationships, and also that it retained its association with self-efficacy. Therefore, I altered the model a second time to reflect a single combined variable in place of the original model which had the three previous variables communication, positivism, and resilience. Figure 7-1 shows the resulting model of DLT, illustrating the combined variable and the updated association of self-efficacy with the new variable.

As depicted in the graphic, self-efficacy was found to be a powerful moderator of Leader Tools (comprised of resilience, positivism and communication), which in turn was a powerful moderator of relationships. As predicted by the theory, there was no association with any of the variables and ineffective leadership. The relationships of the variables with destructive leadership were indeterminate, which I will discuss below. I will now present these findings in terms of the study hypotheses, which were presented at the conclusion of Chapter 5.
7.2 Hypothesis Testing

7.2.1 Hypothesis 1

Hypothesis 1 states that “Leader-based relationships are a) positively associated with Constructive Leadership, b) negatively associated with destructive leadership, and c) are not associated with ineffective leadership.” Relationships were found to have a strong positive association with constructive leadership as predicted by DLT ($R^2 = 40.6\%, p = 0.000$). This association is supported by extensive literature as outlined in Chapter 5 which reports the important facilitating effects of relationships on the ability of leaders to exercise constructive leadership by allowing meaningful interactions between the leader(s) and group members to occur.

Figure 7-1 Dynamic Leadership Theory
Relationships were found to have a minimal association with destructive leadership \((R^2 = 4.4\%, \ p = 0.007)\), which I concluded was an indeterminate association. This is consistent with DLT, which predicts that negative relationships are associated with this form of leadership. As shown by the study, negative relationships, or relationships based on fear, distrust, anger or other “negative” emotions, are different than the inverse of positive relationships, which refers to the negative or downside effects of positive relationships, such as feelings of decreased privacy, or of being overwhelmed by the additional energy required to participate in a positive relationship. Since the study’s variables measured only ‘positive relationships,’ and there were no variables representing ‘negative relationships,’ the results of testing for an association between relationships and Destructive Leadership were likely to be indeterminate.

While the study design was robust in terms of evaluating DLT’s theory of constructive leadership, it was far less effective investigating destructive leadership. The mean score from the study participants was 2.14 for destructive leadership, with a large standard deviation (0.63), reflecting a strong disavowal of destructive leadership approaches by these clinicians, and a significant variation in the way in which they responded to questions reflecting destructive behaviors. It would be valuable, although logistically difficult, to study a group of leaders with high scores in destructive leadership to gain greater confidence in affirming the predictions of DLT regarding this form of leadership.

There was no detectable association of relations with Ineffective Leadership \((R^2 = 0, \ F = 0.4, \text{ and } \ p = 0.836)\). This finding is predicted by the model. In summary, part “a” of Hypothesis 1 is confirmed, part “b” is not confirmed, and part “c” is confirmed.
7.2.2 Hypotheses 2, 3, and 4

Hypotheses 2, 3, and 4 are based on the association of Positivism, Communication, and Resilience (combined into the “Leadership Tools” variable in the final model) with leader-based relationships. The main-effects model for these associations is:

\[ Relations = 0.489 + 0.392 \text{Communication} + 0.157 \text{Positivism} + 0.331 \text{Resilience} \]

The \( p \) value for this model was 0.000, with an \( F \) of 87.1, and it has an adjusted \( R^2 \) of 64.7\%. The \( p \) value for inclusion of communication was 0.000; for positivism it was 0.004, and for resilience it was 0.000.

The revised model of the theory combines these variables into a single variable, Leadership Tools, which has a similar main effects model to the combined variable’s model shown above:

\[ Relations = 0.575 + 0.283 \text{LT} \]

The \( R^2 \) for this model is 63.6\%, \( F=247.9 \), and \( p = 63.6\% \).

7.2.2.1 Hypothesis 2

The second hypothesis tested by the study states, “Positivism has a positive association with leader-based relationships.” This hypothesis is confirmed. The main effects model for relationships shows that communication, positivism and resilience all have a highly statistically significant association with relationships.

The moderating effects of positivism on relationships found in this model are predicted by the literature as discussed in Chapter 5. A leader, by helping to positively mold group members’ identities as well as by inculcating a sense of empowerment, ability,
hope and optimism, builds and strengthens his or her relationships with group members, thus providing a basis by which they are prepared for meaning-based leadership.

7.2.2.2 Hypothesis 3

The third hypothesis states, “Communication is positively associated with leader-based relationships.” As shown by the main-effects model above, this hypothesis is confirmed. The association between communication and relationships was significant and powerful, with an overall predictive value for the model (which also includes positivism and resilience) of 64.7% with a $p$ value of 0.000. A strong association between these two variables is not surprising, given the support in the literature for the importance of communication in establishing and maintaining strong relationships.

7.2.2.3 Hypothesis 4

The fourth hypothesis states, “Self-efficacy has a positive association with relationships.” This hypothesis was partially confirmed. Self-efficacy has a significantly positive association with relationships as shown by the main effect model:

$$\text{Relations} = 1.17 + 0.659 \text{self-efficacy}$$

The $R^2$ for this model is 31.1%, the $F = 64.7$, and the $p = 0.000$. Nevertheless, after controlling for the effects of communication, positivism and resilience, the significance of self-efficacy is lost ($p = 0.250$ in the combined model). Therefore, I conclude that the original hypothesis is partially confirmed.
As mentioned in Chapter 6, I hypothesized that, given the effect of these three variables on the association of self-efficacy with relationships, there must be a significant association between the three variables and self-efficacy. The following main effects models confirm this association:

\[
\text{Communication} = 0.887 + 0.683 \text{ Self-Efficacy} \quad (F=72, \ p=0.000, R^2 \text{ adjusted} = 34\%)
\]

\[
\text{Resilience} = 1.03 + 0.696 \text{ Self-Efficacy} \quad (F = 85; \ p=0.000; R^2 \text{ adjusted} = 37\%)
\]

\[
\text{Positivism} = 0.984 + 0.702 \text{ Self-Efficacy} \quad (F = 42; \ p = 0.000; R^2 \text{ adjusted} = 22\%)
\]

Thus, the study identified strong relationships between self-efficacy and the three variables communication, positivism, and resilience. While the literature supports the significance of self-efficacy as contributing to effective leadership, there is little mention of how self-efficacy exerts this influence. Nevertheless, this relationship was predicted by DLT as participants in the grounded theory part of this investigation felt that self-efficacy facilitated leadership through its positive effects on leaders’ ability to optimistically and confidently communicate their visions to the group. The survey portion of the study elucidated this relationship further by showing the highly significant association of self-efficacy with the three intervening variables communication, resilience, and positivism. These results suggest an opportunity for further study of these relationships.

The association of self-efficacy and the final, combined variable ‘Leader Tools,’ formed by adding the scores of the participants for communication, resilience and positivism, is shown by the following main effects model:

\[
LT = 2.91 + 2.08 SE
\]
This model is highly significant, with a \( p = 0.000 \), an \( F = 90.8 \), and an \( R^2 \) of 38.9%. Thus, the relationship between the individual variables in retained in the parsimonious model of DLT.

### 7.2.3 Hypothesis 5

The fifth hypothesis tested by the study is that resilience is positively associated with leader-based relationships. This hypothesis is confirmed, as shown in the main effects model above, with a \( p \) for resilience of 0.000, and a factor loading of 0.31.

The association of resilience and relationships is supported by the literature as outlined in chapter five. A leader demonstrates resilience by persevering in difficult circumstances, and by showing continued growth and progression during adversity, and this in turn strengthens his or her ability to build and strengthen relationships. Group members and the leader develop a collective resilience that strengthens the relationships between group members, including the leader, and increases the groups’ ability to achieve their objectives. Group members perceive resilient leaders in a more positive light, and are more likely to develop resilience themselves as a result.

Proposition

DLT also proposes that “leadership is a dynamic entity that varies with respect to time, situation, group membership, and the needs of the group.” The quantitative study was not able to test this proposition, leaving it to future studies to evaluate further.
7.3 Summary

The quantitative study confirmed hypotheses 1a, 1c, 2, 3, and 5, partially confirmed hypotheses 4, did not confirm proposition 1b, and did not evaluate the proposition. The association of communication, resilience, and positivity with leader-based relationships was robust, showing a high level of statistical significance with a moderate factor loading. The association of self-efficacy with these three variables was likewise shown to be significant, with $p$ values of zero in each case, and loading factors also in the moderate range.

The strong association of leader-based relationships with constructive leadership was clearly demonstrated by the study. The study found no association between relationships and ineffective leadership, as predicted by DLT. The negative association of relationships with destructive leadership predicted by DLT was not confirmed. A principle reason for this is the ability of destructive leaders to use relationships to further their agendas. This provides additional opportunities for future studies exploring the association of these two variables. The quantitative study was not designed to explore the dynamic nature of leadership. This aspect of DLT also presents an opportunity for further evaluation.
### Hypothesis Statement and Confirmation

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Statement</th>
<th>Confirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Leader-based relationships a) are positively associated with Constructive Leadership, b) negatively associated with destructive leadership, and c) are not associated with ineffective leadership</td>
<td>Ia and Ic confirmed; Ib not confirmed</td>
</tr>
<tr>
<td>II</td>
<td>Positivism has a positive association with leader-based relationships</td>
<td>Confirmed</td>
</tr>
<tr>
<td>III</td>
<td>Communication has a positive association with leader-based relationships</td>
<td>Confirmed</td>
</tr>
<tr>
<td>IV</td>
<td>Self-efficacy has a positive association with relationships</td>
<td>Partially Confirmed</td>
</tr>
<tr>
<td>V</td>
<td>Resiliency has a positive association with leader-based relationships</td>
<td>Confirmed</td>
</tr>
<tr>
<td>Proposition</td>
<td>Leadership is a dynamic entity, varying with respect to time, situation, group membership, and the needs of the group.</td>
<td>Not tested</td>
</tr>
</tbody>
</table>

Table 7-1 Study hypothesis and the degree to which they are confirmed

### 7.4 Contributions to the field of leadership

DLT makes several significant contributions to the field of leadership. It comprises a new theory of leadership which is built upon and is similar to existing theories, but adds new theoretical insights. By using grounded theory methods to analyze semi-structured interviews with a population of experienced healthcare leaders, DLT was developed in a manner distinct from most other theories, such as those developed by empirical testing of hypotheses generated by academic studies of gaps in the leadership literature.

This theory does not add new variables to the leadership literature. To do so would be nearly impossible given the hundreds of thousands of pages of journal articles, books, conference proceedings and web sites devoted to the study of this topic. Nevertheless, DLT proposes new relationships between existing variables, and suggests a more symmetrical approach to leadership theory than has been the case with the vast majority of
earlier theories by defining ineffective and destructive leadership approaches, and proposing mechanisms by which they occur.

### 7.4.1 First contribution

The first contribution of DLT to the literature is defining leadership in a clear, cogent manner as changing the cognitive processes of an individual or group. Although this definition reflects the writings of some of the earliest leadership scholars, it is not incorporated into current leadership theory. Most modern leadership theories fail to specify their epistemological underpinnings, making it difficult to identify the definition of leadership upon which they are built. This in turn leads to difficulties applying these theories to real-life dilemmas such as the distinction between managers and leaders, or the question of whether individuals who exerted tremendous influences on the course of human affairs through destructive means should be characterized as leaders.

The provision of a clear statement of both the ontological and the epistemological foundations of the definition of leadership provides the foundation upon which several of the other key contributions of the theory are based, such as a clear understanding of the various manifestations of leadership, how the component

<table>
<thead>
<tr>
<th>Contributions of DLT to the Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A clear and cogent definition of leadership.</td>
</tr>
<tr>
<td>2. An understanding of the three main ways in which leadership is manifest.</td>
</tr>
<tr>
<td>3. Identification of the key components of constructive leadership.</td>
</tr>
<tr>
<td>4. Identification of a model of leadership that reflects the ways in which different component parts are interrelated.</td>
</tr>
<tr>
<td>5. An appreciation for the high-level perspective of the dynamic nature of leadership</td>
</tr>
<tr>
<td>6. A deeper understanding of the risks of treating behavioral variables quantitatively</td>
</tr>
</tbody>
</table>

Figure 7-2 Contributions of DLT to the literature
parts of leadership influence these manifestations, and the dynamic nature of the practice of leadership.

This definition of leadership also provides opportunities to study leadership as a cognitive process that influences individuals’ and group’s meaning and identity. For instance, the current emphasis in many organizations on measuring leadership effectiveness based on the group’s financial or operational performance may be misguided, as these quantities (or their substitutes) may be strongly influenced by ineffective or even destructive leadership practices. Constructive leadership, which consists of the infusion of positive meaning through robust leader-based relationships, should out-perform less effective leadership approaches over time, but it is unlikely that this would happen in a short time frame. Leaders require time to build the meaning of a group and align group member’s identity and purpose with the group’s core mission, while destructive leadership methods produce nearly immediate results (A man with a gun can coerce a person to part with their wallet much faster than another person can talk the him or her out of it. If the measure of leadership is the amount of money changing hands, the armed robber will always be the short-term winner, since this definition does not take into account the robber’s purpose or his effect on the long-term viability his or her relationships.)

### 7.4.2 Second Contribution

The second contribution of DLT to the literature is an understanding of the three main ways in which leadership is manifest as constructive, ineffective and destructive. Understandably, most leadership theories focus on optimal ways in which leadership is
practiced, or at best distinguish between leaders and non-leaders based on their exercise of certain attributes of leadership. As I discussed in the previous section, the lack of a clear definition of leadership makes such distinctions problematic at best.

The failure of leadership theory to distinguish adequately between the different manifestations of leadership has led to tremendous confusion. For instance, such topics as whether managers should be considered leaders, and whether infamous historical (and current) figures such as Hitler and Stalin should be accorded the title of ‘leader’ given their impressive (if disreputable) accomplishments surface repeatedly, but cannot be answered directly by leadership theories that do not fully define leadership and its different manifestations. DLT, on the other hand, clearly specifies that while managers can be considered leaders when they engage in the infusion of positive, aligned meaning into the group with whom they are associated, the prototypical manager who is focused only on tasks, policies and procedures practices ineffective leadership. Similarly, DLT specifies that leaders such as Hitler and Stalin, who used destructive methods (murder, conquest, force) to accomplish their mission, are clearly destructive leaders.

I hasten to separate leaders from their ideology. Communism and Nazism may have redeeming values that could potentially form the foundation for a positive, meaningful pursuit of value by individuals professing those beliefs. Thus, it was not the ideology of Hitler and Stalin that consigns them to the category of destructive leaders, but the leadership methods which they employed. Along similar lines, Joseph McCarthy, the staunchly anti-communist senator, may also be categorized as a destructive leader based on his campaign of fear, repression, and persecution as a means of pursuing his democratic ideology.
By clearly distinguishing between these three categories of leadership, individuals, groups and organizations are better positioned to understand leader selection and development, and to evaluate their current leaders. This understanding is likely to provide superior outcomes over the long term, and result in greater vitality of the group and its purposes. Conversely, the group is less likely tolerate destructive leadership or to misinterpret its short term successes. Destructive leadership may achieve short term success, but will eventually destroy the group’s purpose and meaning, and lead to organizational failure if such behavior is tolerated.

7.4.3 Third and fourth contributions

The third and fourth contributions of DLT are its identification of the key determinants of constructive leadership and the ways in which they interrelate with one another. DLT’s individual building blocks are incorporated into current leadership theories; for instance, some current theories are relationship-based, recognizing the importance of relationships to the effective exercise of leadership. Nevertheless, these theories fail to delineate the moderating factors that facilitate the effect of relationships.

The organizational behavior (OB) literature, particularly the positive organizational scholarship literature, recognizes the critical importance of these dynamics to organizations’ success. However, given the de-emphasis of leadership by the OB field, these dynamics’ association with leadership is often missing from the literature. By clearly relating them (communication, positivism, resilience, and self-efficacy) to the practice of constructive leadership, DLT not only helps further enlighten groups and organizations as to the development and practice of effective leadership, it also provides a
roadmap for further research exploring their interrelationships as well as their influence on leaders vis-a-vis their relationships with group members.

7.4.4 Fifth contribution

The fifth contribution of DLT to the literature is its identification of the dynamic nature of leadership, referring to leadership’s constant change. For instance, different individuals may provide leadership for a group over a period of time, and each leader may use different leadership styles during their leadership tenure.

It is true that other theories identify the dynamic nature of leadership, such as complexity leadership theory’s explication of emergent leadership, and the various contingency theories’ hypotheses of individuals changing their leadership style dependent on the context. Nevertheless, the currently available contingency theories suffer from a constrained perspective of the dynamic nature of leadership, limiting it to formal, dyadic, power-based leadership relationships, whereas DLT envisions leadership as a fluid entity based on clear definitions of the different manifestations of leadership, and the group and individual dynamics which help determine their effectiveness (at least in the case of constructive leadership). DLT proposes that leaders change their leadership approach as much because of the lack of time, skills, relationships, and motivation to exercise effective leadership as from intentional decisions to accommodate the group’s needs.

This contribution provides insight for leaders, groups, and organizations as to the ways in which leadership functions, allowing them to develop processes and capabilities to maximize the exercise of constructive leadership, and minimize the use of ineffective
and destructive leadership approaches. As groups learn from leadership outcomes, they can improve leadership effectiveness.

### 7.4.5 Sixth contribution

I discovered that the inverse of ‘positive relationships’ is not ‘negative relationships’ as might logically be expected, but instead refers to the negative effects of positive relationships. Negative relationships, which are characterized by power struggles, abuse, neglect, and other forms of negative behavior, may be an essential leadership dynamic, but the survey respondents were not queried about these forms of interactions with their co-workers.

The confusion between the two interpretations of these terms stems from different meanings of ‘positive’ and ‘negative’, in one case referring to their relative position on a value scale, and in the other case referring to labels applied to different forms of behavior.

The larger implication of this finding is the risks one encounters in using quantitative methods to study behavioral or other social variables. Whereas one might reasonably attempt to measure the degree to which an individual or group possesses or practices a particular behavior, applying other mathematical concepts such as negativity is problematic at best, and must be subjected to careful reasoning in order to avoid misleading conclusions.
7.4 Shortcomings of DLT

DLT has a number of shortcomings, including 1) the need for additional research to support its hypotheses, 2) the common-sensical nature of the theory, with the risk that it will be dismissed as “re-stating the obvious,” 3) its use of common leadership and Organizational Behavior building blocks, with the risk that it will be considered a restatement of current theories, 4) Its characterization of common leadership practices in unflattering terms, and 5) Its attempted birth in a field already crowded by multiple theories, controversies, and misperceptions. I will discuss each of these shortcomings and suggest ways in which they might be mitigated.

As a newly emerging theory of leadership, DLT needs to be investigated in other settings and using additional methods in order to corroborate the findings of this study. I suggested opportunities for additional investigation in this chapter, including a focused study on destructive leadership, as well as an exploration of the dynamic features of the study. The next highest priority for future study is the development and standardization of a survey tool that better reflects the principles of DLT. Among the advantages of developing such a tool are the ability to standardize the information gathered from research subjects, the

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<th>Shortcomings of DLT</th>
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ability to focus survey questions on principles precisely as they are enumerated by DLT, and the ability to coordinate the types of research studies being performed.

The second shortcoming of DLT is its common-sensical nature, with the risk of being perceived as a restatement of the obvious. Relationships, communication, resilience, positivism and self-efficacy are relatively common, well-known entities, particularly in the field of OB, and their use in DLT opens it to the potential criticism that it is an unnecessary theory that simply tells us what we already know. It is true that DLT uses a common sense approach to define and describe leadership and its practice, and makes use of common, readily “available” building blocks (communication, relationships, etc.). The strongest response to this criticism, however, is that even though the theory is built upon relatively simple, well-accepted behavioral dynamics, it is clear from the review of the literature that it presents a new way of thinking about and studying leadership, and of combining the individual building blocks in a way that leads to a highly effective leadership.

The third potential shortcoming of leadership is the risk of being considered a restatement of current leadership theories as opposed to representing a significant addition to the leadership literature. DLT shares important principles with a variety of current leadership theories, including its focus on relationships, its adoption of positive traits and attributes as key components of effective leadership, and its recognition of leadership as a dynamic entity that is frequently changing. DLT differs significantly from existing leadership theories in ways that underscore the significance of its principles, such as the distinction between the three manifestations of leadership, its use of moderating factors of
leader-based relationships as a means of strengthening the exercise of constructive leadership, and the ways in which it defines the varying manifestations of leadership.

The fourth shortcoming of the theory is the unflattering terms it uses to describe manifestations of leadership, such as “infective leadership,” and “destructive leadership.” These leadership approaches are relatively common, making it problematic to define them in negative terms. Nevertheless, it is critical to accurately characterize leadership behaviors in order to provide useful information about their use and impact. Others have used similar terms, particularly ‘destructive leadership,’ but reserved it for leadership practices that are pathological such as narcissism and outright abuse (Schyns & Schilling, 2013). These behaviors also fall into DLT’s definition of destructive leadership, but DLT extends the term to cover such practices as authoritarianism and materialism; such labeling is a direct application of DLT’s definition of destructive leadership. In other words, regardless of its prevalence, if a leadership practice fits within the definition of destructive leadership, then it should be clearly described in those terms. To do otherwise undermines the utility of the theory, and decreases its positive impact on the development and practice of effective leadership.

The fifth potential shortcoming of DLT is its emergence into a field that is already crowded with a multitude of theories, controversies and misperceptions of leadership. There is indeed a risk of adding to the dysfunction of the field by adding yet another approach to understanding effective leadership. This risk is more than offset, however, by providing a clearer understanding and appreciation of how effective leadership can be developed and practiced, ways in which leadership becomes ineffective or destructive, and
the changing nature of individuals’ approaches to leadership as they shift between constructive, ineffective, and destructive leadership methods.

7.5 Summary

The results of the quantitative study of the hypotheses associated with DLT provide strong support for the theory. Part of four hypotheses were confirmed, one was partially confirmed, and the proposition remains to be tested. Opportunities for new areas of research and study have been identified, such as more focused research into destructive leadership methods, testing of DLT in more diverse environments, and developing techniques of leadership development that reflect the principles of DLT.

I enumerated five ways in which DLT contributes to the leadership field, including 1) the provision of a clear and cogent definition of leadership, 2) an understanding of the three ways in which leadership is manifest (constructive, destructive, and ineffective), 3) identification of the key components of constructive leadership (relationships, communication, resilience, positivism, and self-efficacy), and 4) of their interrelatedness, and 5) an appreciation for the dynamic nature of leadership.

I also discussed five potential shortcomings of DLT, including 1) the need for additional research to support its hypotheses, 2) the ‘common-sensical’ nature of the theory, with the risk that it will be dismissed as “re-stating the obvious,” 3) the theory’s use of common leadership and organizational behavior building blocks, with the risk that it will be considered a restatement of current theories, 4) its characterization of common leadership practices in unflattering terms, and 5) its emergence in a field already crowded by multiple theories, controversies, and misperceptions.

273
In the final chapter of this dissertation, I will summarize the preceding chapters, and discuss the implications and potential applications of DLT for the practice of leadership.
Implications and Applications

This chapter contains a summary of the dissertation and its implications and possible applications for the field of leadership in general and for health care in particular.

This study began with my desire to achieve a better understanding of leadership. Despite years of practicing leadership as a healthcare executive, and studying leadership as a PhD student, I perceived a persistent deficit in my understanding of what leadership is, what it is not, and what constitutes effective leadership (and why). In order to gain a better understanding, I undertook a qualitative study using semi-structured interviews of other experienced, mature healthcare executives. Using grounded theory methodology, to analyze interviewees’ comments and thoughts, I was able to construct a theory of leadership. I then situated this theory in the literature by reviewing support for its building blocks. I then tested the hypotheses generated by the theory using a survey study of 308 healthcare leaders from three healthcare systems in the region.

I will briefly summarize the semi-structured interviews and grounded theory approach I used to construct the Dynamic Theory of Leadership, and then summarize the results of the literature review and its support for DLT. This will be followed by a summary of the quantitative survey and its findings. I will conclude this review with a description of ways in which DLT can change our approach to the practice and study of leadership.
8.1 Semi-structured interviews

Interviews were conducted with a pool of forty volunteers consisting of twenty nurses and twenty physicians. Volunteers were invited to participate based on their leadership experience and their current positions within a moderate-sized healthcare system, including vice president, department chairperson, medical director, or nursing director. The volunteers had a cumulative total leadership/management experience of well over five hundred years. The interviews consisted of questions regarding the clinicians’ experiences with their own and others’ leadership, and their opinions regarding successful and failed leadership.

The interviews were recorded and transcribed, and were then analyzed using grounded theory methodology. Participants’ expressions of thoughts and anecdotes about leadership were coded, which along with the author’s memos about the interviews provided an interpretation of the interview material. The coded material was then reviewed, sorted, and subjected to axial coding as a means of developing key themes from the data. These in turn were subjected to selective coding, which led to the emergence of a central theme with supporting sub-themes from the codes, as depicted in Table 4.1.

This process resulted in the emergence of Dynamic Leadership Theory (DLT). The theory uses clinical volunteers’ insights and experiences to construct a theory of leadership. The group described constructive leadership as processes in which positive meaning is infused into the group; that is, in which the leader(s) help(s) bring the group members’ core ideals and purposes into alignment with the group’s goals and vision. The
Interviewees identified a number of personal and group dynamics as critical ingredients of effective leadership. Principal among these is strong, positive leader-based relationships which facilitate the infusion of meaning into the group. Characteristics of effective relationships included communication, self-efficacy, positivism, and resilience.

In addition to constructive leadership, the group of volunteers also identified ineffective and destructive leadership approaches. They claimed most managers practice ineffective leadership, described as leadership interactions focused on tasks, policies, and procedures rather than on the infusion of meaning. Destructive leadership, which consists of leader(s) engaging in behavior that diminishes the meaning or meaningfulness of the group, was also described by the leaders. They described authoritarian, self-focused, financially-focused, or other leadership efforts as destructive. These behaviors divert the group’s efforts away from its primary purpose, focusing it instead on objectives that are either inconsistent with or compromise the group’s core purpose and meaning.

In addition to these different types of leadership, and the factors influencing and enhancing them, the group suggested leadership differs from the traditional vertical dyadic relationship between hierarchical authorities and followers. Examples included 1) emergent leadership, in which a person from within the group and not in a position of authority exercises leadership de novo; 2) shared leadership in which the responsibilities of leadership are shared between two or more individuals; and 3) networked leadership, in which leaders from various groups collaborate to provide leadership for one or more of the groups. The volunteers also reported leaders frequently change their approaches to leadership, shifting between constructive, destructive, and ineffective leadership methods in different contexts.
8.2 Situating Dynamic Theory of Leadership in the Literature

In Chapter 5, I conducted a literature review as a means of situating DLT in the literature, looking at the various components of DLT and their relevance to leadership as described in the current literature. Each of these has an extensive basis of empiric research in the social sciences including organizational behavior, psychology, and leadership literatures. Much of the background for constructive leadership and its associated component factors is found in the positive organizational scholarship literature, a relatively new field of study devoted to positive psychological and organizational deviance (as opposed to pathologic deviances resulting in illness of individuals or dysfunctional organizations).

In addition to the variables associated with DLT, I also compared and contrasted the theory with other major leadership theories as a means of further defining DLT, establishing its relationship to existing theories, and evaluating its ability to add to them. In comparison with relationship-based leadership theories (such as LMX, relational leadership theory and others), I demonstrated that DLT is a complete theory, providing an operational definition of leadership which allows an understanding of the underlying mechanisms (and the factors influencing those mechanisms) by which it operates. I also showed that DLT identified different approaches to leadership, and proposes an individual can shift between the different types of leadership.

In comparison to various contingency theories of leadership, I showed that DLT also acknowledges leader(s) utilization of different forms of leadership in different contexts and situations; I also explained, however, that DLT proposes different
approaches to leadership, and illustrated the impact these different forms might have on groups. I discussed how DLT envisions leadership as occurring outside of the dyadic, hierarchical, power-based bureaucratic model common to most contingency theories, thus making its dynamic nature less of an intentional choice, and more of a situational or contextual one.

I next compared DLT with the positive and charismatic group of theories which includes authentic, transformational, and charismatic leadership theories. While DLT shares much of the emphasis of these theories on positive leadership behavior, it also extends their understanding of the core meaning of leadership and provides a deeper insight into the potential for misuse of even these positive forms of leadership when the leader misuses his or her relationships to distract the group from its core mission and purpose in favor of non-aligned objectives. Thus, the key difference between DLT and positive leadership theory is DLT’s ontological basis of what leadership is (a process whereby the cognitive processes of an individual or group are changed, with constructive leadership being the infusion of positive meaning into the group), while these leadership theories are based on descriptions of how a leader leads (charismatically, transformationally, authentically, etc.). The importance of this distinction is that a transformational leader can lead a group in a direction that is opposed to their core purpose, which then brings up the age-old question, is that person a leader? Existing positive theories cannot answer that question, while DLT provides a clear and concise answer.
At the conclusion of Chapter 5, I proposed a quantitative study of DLT using survey methodology. I proposed six hypotheses, the first five of which would be tested by the study, including:

**Hypothesis 1**: Leader-based relationships are a) positively associated with Constructive Leadership, b) negatively associated with destructive leadership, and c) are not associated with ineffective leadership

**Hypothesis 2**: Positivism has a positive association with leader-based relationships

**Hypothesis 3**: Communication has a positive association with leader-based relationships

**Hypothesis 4**: Self-Efficacy has a positive association with leader-based relationships

**Hypothesis 5**: Resiliency has a positive association with leader-based relationships

**Proposition**: Leadership is a dynamic entity, varying with respect to time, situation, group membership, and the needs of the group.

### 8.3 Testing Hypotheses of DLT

I invited 308 clinical and business leaders from three health systems in Central Pennsylvania to take part in a web-based survey, of whom 142 or 46% agreed to participate. The survey instrument was a combination of the MLQ and ALQ.
standardized and validated surveys, and was administered by a third party via the internet.

Responses to the survey questions were grouped into categories corresponding to the variables identified by DLT, and were analyzed using factor and regression analysis. Regression analysis of the data suggested that self-efficacy has an indirect association with relationships, functioning through its effect on communication, resilience, and positivism. This adjustment is graphically depicted in figure 6-2 on page 254.

Factor analysis showed that a parsimonious model might be more appropriate. A covariance matrix showed that communication, resilience, and positivism were significantly correlated with one another, a finding not reflected in the original model. These findings along with further consideration led to the consolidation of the three variables into a single “Leader Tools” variable. The new variable was tested and found to fit well into the remainder of DLT (that is, it was shown to have a significant association with relationships and self-efficacy). The model was adjusted again to reflect the parsimonious use of variables to describe DLT; this model is depicted graphically in figure 7-1 on page 269. As predicted by the theory, none of the variables was associated with ineffective leadership. Thus hypotheses 1a, 1c, 2, 3 and 5 were confirmed, hypotheses 4 was partially confirmed, hypothesis 1b was not confirmed, and the proposition has yet to be tested.

This study provides several fertile areas for additional research. These include 1) a more extensive study of the theory in a larger and more diverse group, 2) a more in-depth investigation of destructive and ineffective leadership and their potential

281
moderators and mediators, and 3) use of DLT’s principles to train and strengthen leaders in groups, teams, and institutions.

**8.4 Implications of DLT**

**8.4.1 Implications for health care**

This study has a number of important implications for the field of health care. The healthcare leaders who participated in the interview section of the study identified the prevalent use of destructive leadership approaches in many hospital settings. Physician leaders who participated in the study related their extensive exposure to destructive leadership influences and examples during their medical training. Both groups of volunteers identified the growing prioritization of economic performance as potentially destroying meaning for healthcare leaders and for health care in general.

Many healthcare organizations struggle to balance their pursuit of a care-focused vision with a desire to achieve profitability, or at least financial viability. In this struggle, some individuals serving on system boards of directors (comprised of businessmen and businesswomen from a community) may misunderstand their fiduciary role in the oversight of such an institution. Instead of feeling a responsibility to ensure that the community’s needs and interests are appropriately represented in the institution’s decision-making processes, they may perceive a responsibility to guide the institution towards optimal profitability, perhaps reflective of normal business practices in other industries. One of the most potent tools at their disposal is their selection of leaders for
the system. The choice of leaders focused on profitability rather than on the core mission of the institution becomes a potential source of destructive leadership in the healthcare setting.

DLT encourages boards of directors to choose and support chief executives and other leaders who are willing and committed to focusing on the core mission of the institution, and who in turn will find and train leaders within the institution who are also committed to pursuing this purpose. This direction neither ignores nor understates the critical importance of these systems procuring the necessary resources to remain viable; it simply underscores the importance of maintaining the secondary priority of this goal. Profitability is a critical function that is subservient to, and not more significant than the institution’s core mission.

Health systems have a long tradition, corroborated by the clinical leaders in the qualitative portion of the study, of destructive leadership in the form of autocratic leaders, including members of the top management team, physicians and nurses in leadership positions, and other leaders. Many of the interviewees lamented this tradition, feeling it was inconsistent with the core purpose of the healthcare system, and that it perpetuates poor leadership practices. Positive organizational meaningfulness can produce the energy, enthusiasm, creativity, and insights needed to address persistent quality, access, utilization and cost challenges in health care, making it imperative for leaders to infuse aligned, positive, patient-centric meaning into their organizations.

DLT can also impact the ways in which physician leaders are selected and trained. Traditional leadership development in health care has focused on teaching and enhancing
managerial skills such as financial accounting, negotiations, regulatory issues, and staffing methodologies

While these skills may be necessary to preserve the viability of a healthcare organization, without being couched in a constructive leadership focus on mission and meaning, they may replace trainees’ passion for providing optimal patient care (a core mission in healthcare) with a priority on business processes. These leadership training programs harm the profession of medicine and its institutions, providers, and patients by destroying leaders’ core meaning, inculcating behaviors that are devoid of positive, aligned meaning, or worse, behaviors that further diminish the meaning of healthcare institutions and their stakeholders.

There is a pressing need to alter the structure and content of healthcare leadership training programs to reflect the tenets of constructive leadership such as those espoused by DLT. Future leaders trained in constructive leadership techniques, and taught to avoid destructive leadership behaviors have the capability to achieve healthcare’s mission, and to address the cost, quality and access crisis battering our healthcare system.

Healthcare leaders need tools and training to avoid destructive leadership behaviors. Boards of directors and community leaders should not accept destructive leadership in their community-based and community-supported institutions. Instead, they must insist that healthcare leaders demonstrate the behaviors and espouse the virtues that reflect the mission of these systems, and uphold the values and ideals of the men and women who have devoted their careers to providing high-quality care to pati.
8.4.2 General leadership applications

The application of DLT to the general field of leadership follows many of these same principles. Our country has experienced an epidemic of destructive leadership in politics, business, finance, the legal profession, and as just discussed, the healthcare industry. Leaders in these industries have been allowed and even encouraged to place their own interests and/or the interests of a chosen few stakeholders over the mission and purposes of the firms and institutions which they direct and from whom they extract resources, the most significant of which is meaning. The greed, avarice, criminality, narcissism and callousness of these destructive leaders are astounding and unprecedented for their scope and breadth. The pathways by which we have been saddled with this corps of leaders may be worthy of another doctoral dissertation, but the lessons remain the same. America can no longer tolerate the destruction wrought by these individuals to its fabric of institutions, services, and culture. Destructive leadership must be identified for what it is and what it does to institutions and ultimately to nations. Those who choose to engage in destructive behavior cannot be tolerated, nor should they be allowed to occupy positions that allow them destroy that which we cannot afford to lose. Individuals who destroy property, wealth, and businesses, whether by physical destruction, theft, or aggression, are held to account for their actions. Should not leaders who destroy values and meaning from great institutions be held to that same standard of accountability?

DLT provides five important applications for the general field of leadership. These include applications based on 1) understanding the meaning of leadership, 2)
understanding what constitutes effective, or constructive leadership, 3) understanding what constitutes ineffective leadership, 4) understanding what constitutes destructive leadership, and 5) understanding the dynamic nature of leadership.

8.4.2.1 The implications of the meaning of leadership

Understanding leadership as “changing the cognitive processes of a group or individual” provides crucial insights for organizational leaders and members. It helps them distinguish between leadership and bottom line performance. It helps them understand that they cannot excuse poor group performance, but that they should evaluate leaders' effectiveness based on the meaning and purpose with which they accomplish this and other (more important) objectives, and not excuse poor or destructive leadership tactics and leader behavior based on organizational performance.

Understanding the meaning of leadership provides tremendous insights into the ways in which leaders should be chosen and developed. Rather than finding individuals with an “anything goes, as long as it is legal” attitude towards leadership, or developing leaders that have a callous disregard for the humanness of group members and stakeholders, organizations will hopefully understand that a leaders’ ultimate success is dependent on their ability to forge close, intimate relationships of trust, and to use those relationships, strengthened by effective communication, positivism and resilience, to change the ways in which group members emotionally engage in their organization and its purposes.
Effective leaders understand that individuals’ identities are constructed upon the meaning and purpose of their lives, and that unlike the machines individuals may operate, they are complex organisms comprised of emotional, intellectual, physical, spiritual and social systems. Unless a leader uses his or her skills and talents to understand, interact with, and accommodate the “selves” of people with whom he or she works, and to engage them in pursuing a meaningful, purposeful, and aligned vision, they will at best fail to realize the tremendous potential contributions individuals might make to the organization, and at worst risk destroying individuals’ ability to make contributions to the organization by destroying their health, purpose, and meaning.

8.4.2.2 Implications of constructive leadership

Constructive leadership, defined as the infusion of positive and aligned meaning, provides a roadmap for leaders in all walks of organizational life to practice effective leadership. This concept, especially as it is constructed in DLT, transforms leadership from an elusive, ambiguous concept about making people do what they are supposed to or told to do, to being a vibrant, developable, achievable system of behaviors and beliefs that enables individuals to be effective and successful in their leadership roles.

Strong, positive, intimate relationships are not leadership, but they are a crucial tool which leaders use to achieve leadership. Leaders develop and use them to infuse meaning into a group, which is the work of leadership. It is exhausting, demanding, and at times frustrating work, but nevertheless, leadership does not happen without them.
The work of building and maintaining relationships depends on the use of leadership tools which include strong, positive communication skills, positivism, and resilience. Leaders express their vision, meaning and purpose through multiple communication technologies. They understand that communication happens as much through projective hearing as it does through articulate expression of thoughts and ideas. They use communication to strengthen their relationships, enhancing their ability to infuse meaning into the group.

Effective leader-based relationships are based on positivism, another leader tool. Positivism is the net energizing effect of hope and optimism on individuals and groups. It both strengthens relationships, and in turn is strengthened by them. It enables individuals to see past the day-to-day chaos and challenge of organizational life, and fix their gaze steadfastly on the organization’s purpose and vision. It is developed by positive leaders infusing positivity, as part of their meaning, into the group. It pays tremendous dividends on the resources expended to develop and strengthen it.

Resilience is the ability of leaders and groups to bounce back from adversity, trials, and challenges, and to grow and develop in the process. It is a leader tool that functions, together with communication and positivism to strengthen and facilitate relationships through which a leader can infuse meaning into a group. Much like positivism, it not only strengthens relationships, but is developed through and strengthened by strong leader-group member interactions.

Leader self-efficacy moderates the effect of leader tools on relationships. It is the belief of a leader in their own ability to accomplish their mission. The leader infuses this
confidence and optimism into the group as part of their meaning. The group, influenced by and in conjunction with the leader’s efficacy develops its own collective efficacy.

Thus, constructive leadership is a difficult, energy intensive approach to effective leadership, but it is also the only pathway through which effective leadership can be practiced. This concept builds upon the constructs of other major leadership theories, but adds a broader understanding of what it is, and how it can be practiced and strengthened.

Ineffective leadership is often the default mode of leaders when they succumb to pressure to rely on tasks, memos, and other mechanical efforts to attend to the needs of a group. It lacks any infusion of meaning into the group. It can degenerate into destructive leadership when ineffective leaders become frustrated or disillusioned with the results of their efforts, and either do not have the energy or the ability to practice constructive leadership. This form of leadership answers the “management-leadership” debate, and helps leader scholars and authors to readily distinguish between the two. I hasten to add that managers can readily become leaders when they go about achieving their objectives by infusing meaning into the group.

Destructive leadership is painfully common in the modern organizational world. A constant focus on achieving an optimal bottom line return has taken its toll on many organizations’ (and their leaders’) best intentions to be constructive. Authoritarianism, a self-focus, and a financial focus are some of the many forms of destructive leadership.

Destructive leadership destroys not only the meaning and purpose of the group, focusing the group members instead on an alternate meaning such as self-preservation or profitability, it also destroys workers’ health and emotional well-being through the stress, depression, and other effects of poor leadership. Organizations need to recognize
destructive leadership for what it is, understand its tremendous potential for ill effects on the organization and its core purpose, and find ways to achieve destruction-free leadership.

Finally, leaders do not behave in a single unchanging way. Their leadership style changes depending on their mood, health, and abilities, and on the context in which they exercise leadership. Leadership can be exercised by individuals or groups. It can be emergent, in which leaders arise when they are needed in exigent circumstances, or formal, in which hierarchical leaders exercise effective leadership based on the principles DLT.

DLT provides the principles and rationale for selecting, training, and evaluating leaders and leadership. It marks a pathway by which institutions, firms, and industries can begin to restore their meaning and values by selecting and strengthening leaders whose core purpose is to instill that meaning and those values. Leaders currently serving in positions of authority can use DLT as a guide for their actions, plans, and behavior to ensure that they become and remain constructive leaders and that they avoid decisions and behaviors that result in destructive leadership.

8.5 The process of theorizing

One of the most significant contributions of this dissertation is a greater understanding of the process by which theory is conceptualized, constructed, situated, tested, and applied to practice in organizational life.
I conceptualized the need for a study of leadership based on years of experience and accumulated dissatisfaction with the leadership practices and behaviors I experienced in multiple institutions and settings, coupled with disappointment in the ability of a multitude of writings on the topic to answer basic questions about leadership. As a practicing executive in a major complex healthcare organization, I felt a pressing need to grasp the concept of leadership, and to teach trainees how it is best practiced.

Driven by this passion, I undertook the study described in this dissertation. In the process of doing so, I discovered several key principles of the theorizing process.

First, theorizing is best accomplished by starting in the “real” world, by gaining a rich understanding and appreciation of the behaviors, frustrations, needs, experiences, beliefs, and ideals of mature practitioners in the field. Building upon that knowledge base creates an opportunity to build a theory with far greater value to the practicing community than one built upon an academic exploration of existing research and teachings.

The second lesson I learned about theorizing is that it is a demanding, recursive process, requiring multiple visits to the data, asking questions in different ways, searching for many types of knowledge and inference, and then having a willingness to return again and again to the data.

Statistical testing does not tell you what the theory is; it only, at best, tells you where the problems are with the theory. The rigor required in this process is not in devising increasingly sophisticated statistical tests of data, but rather in understanding the meaning of those tests, and more importantly, to use that information to develop and refine the theory. In this dissertation, I described three related, but slightly different
models of DLT. I revised the first two based upon information from the statistical analysis, and then returning to the data to gain a better understanding of it. The first model is theoretically sound, but it lacks both the simplicity and the insight of the final model.

Thus, the process of theorizing is a dynamic one, unlikely to achieve a “perfect” or “optimal” model, at least not at the very beginning of the process. A theorist must commit to that process, and persist in refining and improving the theory as additional information and research become available, similar to the continuous improvement of a software program to take advantage of changing technology, improved understanding of practitioners’ needs, and better insight into the program’s function.

8.6 Conclusion

The dynamic theory of leadership is a robust approach to understanding, developing, and measuring leadership behaviors. By providing an explanation of important relationships among key determinants of leadership variables, DLT provides a pathway by which leaders can be developed, trained, and evaluated. It provides a basis for further academic research into these relationships and their effect on different types of leadership. It provides a definition of leadership which allows the field to move forward in a unified and coherent manner. This study demonstrates the crucial importance of developing theory from real-world observations, and then testing hypotheses derived from theory using established research techniques.
The implications of DLT for health care and leadership are extensive and profound. Nevertheless, by adopting and utilizing its precepts leading to the development and installation of constructive leaders in leadership positions, and identifying and holding to account individuals who choose to engage in destructive leadership practices, tremendous benefits of effective leadership will accrue to businesses, governments and cultures.

I have identified opportunities for further inquiries into DLT and its applications to leadership and healthcare. Perhaps the most powerful of these is a confirmatory study in a larger and more diverse population of leaders. As part of this further testing, the development of a standardized measurement tool that reflects the principles of DLT and its applications is of paramount importance as well. Evaluation of DLT’s application to front line leadership practice will provide opportunities to develop the theory further.

This study provides a solid foundation for further research and development of the theory. It adds several important dimensions to the fields of leadership and healthcare, building upon the base of existing leadership theory, and expanding our understanding of leadership as practiced at the front lines. I believe that with continued validation, development and implementation of DLT, institutions dependent on strong leadership practices will recognize tremendous value to their culture and mission.
References

References for Chapter 1


References for Chapter 2


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353


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Appendix

Sample Questions from the MLQ and ALQ Survey instruments

Note: Copyright restrictions prevent me from listing all of the questions from the survey instruments. Nevertheless, I received permission to list five sample questions from the MLQ survey, and two from the ALQ survey.

MLQ

1. I say exactly what I mean
2. I emphasize the importance of having a collective sense of mission
3. I encourage everyone to speak their mind
4. I tell others the hard truth
5. I display emotions exactly in line with my feelings

ALQ

1. I am effective in meeting others’ job-related needs
2. I express confidence that goals will be achieved.
VITA

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Fellow  ACHE  2003
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