DISTRIBUTED LEADERSHIP IN HEALTHCARE: LEADERSHIP DYADS AND THE PROMISE OF IMPROVED HOSPITAL OUTCOMES

ABSTRACT

Purpose: This paper extends the consideration of distributed leadership in healthcare settings. Leadership is typically studied from the classical notion of the place of single leaders and continue to examine distributed leadership within small teams or horizontally. Our purpose is to develop a practical understanding of how distributed leadership may occur vertically, between different layers of the healthcare leadership hierarchy, examining its influence on healthcare outcomes across two hospitals.

Design/Methodology: Using semi-structured interviews, data were collected from 107 hospital employees (including executive leadership, clinical management, and clinicians) from two hospitals in Australia and the United States. Using thematic content analysis, an iterative process was adopted characterized by alternating between social identity and distributed leadership literature and empirical themes to answer the question of how the practice of distributed leadership influence performance outcomes in hospitals?

Findings: The perceived social identities of leadership groups shaped communication and performance both positively and negatively. In one hospital a moderating structure emerged as a leadership dyad, where leadership was distributed vertically between hospital hierarchal layers, observed to overcome communication limitations. Findings suggest dyad creation is an effective mechanism to overcome hospital hierarchy-based communication issues and ameliorate healthcare outcomes.

Originality: Our study demonstrates how current leadership development practices that focus on leadership relational and social competencies can benefit from a structural approach to include leadership dyads that can foster these same competencies. This approach could help develop future hospital leaders and in doing so, improve hospital outcomes.

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INTRODUCTION

Leadership has long been recognized as a social exchange between leaders and followers, reinforcing the notion that behavior is contingent on transaction and exchange relationships (see Carter, DeChurch, Braun, & Contractor, 2015; Homans, 1950; Uhl-Bien & Ospina, 2012; Weber et al., 1947). Defined as how individuals within an organization influence and facilitate action that contributes to the achievement of an organizational purpose, leadership has a variety of healthcare performance indicators: hospital star ratings (Shipton et al., 2008), patient safety outcomes (McFadden et al., 2009), and patient care and mortality indexes (Jiang et al., 2009). With this knowledge, there is increasing scholarly focus in healthcare on the concept of leadership, typically referring to senior positions of power (Currie & Lockett, 2011; Ham & Dickinson, 2008) constructed as the heroic act of individuals who exercise skillful and creative managerial techniques (McKee et al., 2013; Spillane, 2005). Corresponding discussions often focus on identifying the type of person that can fill this role (Tasi et al., 2019) or a set of competencies that can be fostered within them (Fulop, 2012; Onyura et al., 2019). Relatedly, leadership development is widely recognized as a critical activity for improving healthcare outcomes (Garman et al., 2020; Gilmartin & D'Aunno, 2007). Missing in this discussion, but still part of this effect, however, how we talk about and invoke leadership has implications for the discussion of leadership development, particularly in healthcare where communication is intrinsic to both task and outcome.

In contrast to the classical portrayal of leadership as the act of a heroic individual, the type of leadership emerging in complex environments such as hospitals is increasingly characterized as a property shared by multiple individuals, known as distributed leadership (Denis et al., 2001; Gronn, 2002). Distributed leadership is focused on mobilizing leadership expertise through multiple organizational members to create opportunities for change and build capacity for improvement (Chreim et al., 2010; Hallinger & Heck, 2009; Harris, 2013). It entails leadership practices that are shared and emerge collectively through interaction (Leithwood et al., 2009). In this context, the development of

leadership competencies in healthcare have been updated to include social and relational capabilities that facilitate such interaction (Garman et al., 2020).

Despite this update, gaps remain in our collective understanding of distributed leadership and associated leadership development in hospital settings. Empirical studies have focused either on distributed leadership of small groups, or distributed leadership where groups are formed by combining people across departments where leaders are brought together from a similar position in the hospital hierarchy (e.g., clinical and administrative; Chreim & MacNaughton, 2016; Denis et al., 2010). In this paper, we highlight that the value of dyads and triads – where two or three leaders come together to jointly share leadership responsibilities – can formally structure this leadership combination. Within this context, distributed leadership is typically studied from a horizonal perspective, combining competencies at the same level of the hierarchy (Sanford & Moore, 2015). There has been limited study of distributed leadership vertically, meaning between the various hierarchical structures in healthcare; for instance, between nursing, medicine (and/or administration). As for leadership development, practices continue with a competency perspective seemingly ignoring recent evidence that system-level features, such as dyads, can positively influence performance (Bartunek, 2011). Drawing from the latter perspective, the goal of this paper is to explore *how does the practice of distributed leadership influence performance outcomes in hospitals?*

Broader leadership discussion identifies two forms of distributed leadership; one where leadership is dispersed among many team or organizational members (termed collective leadership), and the other where specific units of people collaborate in terms of plans, decisions and actions (termed co-performing leadership; Denis et al., 2001; Gronn, 2002; Kavanagh & Ashkanasy, 2006). Co-performing leadership implies structurally formed dyads where leadership responsibilities are shared formally between two people. These structures can emerge spontaneously or be imposed structurally. In healthcare, empirical studies of distributed leadership have focused on collective leadership; either studying small, usually clinical, teams (Chreim & MacNaughton, 2016), or larger transformation

efforts where multiple departments are brought together to reach a consensus on the way forward (Denis et al., 2010). This focus has taken a horizontal perspective, either within or between teams. As such, the possibility of distributed leadership vertically, between different layers of leadership or areas of influence (i.e., senior executive leadership and clinical leadership coming together as a leadership dyad), has not yet received the same attention.

Through a two country hospital study, we examined the aforementioned research question with a study of 107 health professionals in Australia and in the U.S. In the study we establish effective communication as a proxy for good healthcare outcomes, and breakdowns of communication blocking efforts to improve care (as per Gittell, 2002; Hudelson et al., 2008; Leonard et al., 2004). In this context, we identified social identity theory (SIT; Tajfel & Turner, 1986) as a core framework to interpret and explain communication between stakeholder groups, extending extant discussion on healthcare leadership. Findings highlight that positive ingroup perceptions (e.g., by clinical managers within disciplines/departments) disrupted intergroup communications (i.e., transfer of communication between leadership layers) and exacerbated tensions. Extending this knowledge, we explain social identity driven differences in the magnitude of communication breakdown and engagement. The U.S. hospital had significantly fewer breakdowns and more accommodative engagement, mitigating social identity limitations by formally structuring vertical leadership dyads and triads between executive leaders and clinical managers from different professional and service area groups. Whereas the Australian hospital revealed an absence of leadership dyads or triads, and more breakdowns.

In what follows, we overview three themes relevant to our research question, focusing on leadership, social identity, and communication. Then we detail our study and its approach, followed by findings and analysis. The paper concludes with a discussion on the contribution these findings make to our collective understanding of healthcare leadership and hospital outcomes.

THEORETICAL BASIS

Leadership and Distributed Leadership in Healthcare

In contrast to leadership literature focusing on delineating management (i.e., operating current systems efficiently) and leading (i.e., developing new systems Kotter, 1996; Weick, 1993), healthcare research tends to combine these two as a single notion of "leadership". Effective leadership in healthcare is thereby viewed as influencing outcomes through a variety of established processes, such as: creating effective workplace cultures (McFadden et al., 2009), building collaborative relationships (Mannion et al., 2004), paying close attention to patient perceptions of performance (Javetz & Stern, 1996) and establishing rigorous oversight and governance mechanisms (Jiang et al., 2009). Historically, in healthcare, leadership is presented as an individual and typically senior role, within an organizational hierarchy (Brown et al., 2011; Chreim & MacNaughton, 2016; Grice et al., 2006). However, as with wider leadership contexts, the concept that any one leader has a monopoly on leadership has been challenged (Kotter, 1996; Schein, 2010) and current discussion in healthcare assumes that the success of patient care requires leadership to be a collective, social process (Günzel-Jensen et al., 2018). Such *distributed leadership* is used to define this approach, where leadership is less attributed to a role and more towards a process of influence that any individual can exert over outcomes (Yukl, 1999). In this way, in healthcare settings, leadership shifts between people with appropriate areas of expertise.

As perceptions of leadership have changed from leadership concentrated in formal power positions to leadership emergence across multiple levels and positions (e.g., Lord, Day, Zaccaro, Avolio, & Eagly, 2017; Hoch et al., 2018), so too have corresponding approaches for leadership development. Whereas classical leadership rests on a set of individualistic leadership competencies (Academy, 2011; Calhoun et al., 2008), the perspective that leadership can be a distributed function extends these competencies to include relational and social processes that facilitate interactions (Garman et al., 2020). Yet, research continues to show that, in practice, leadership development programs rarely focus on competencies that help to develop distributed leadership (Brewer et al., 2016; Lucas et al., 2018). A recent review identified that leadership training often ignores systems-level approaches and almost exclusively focusses on individual development (Onyura et al., 2019). Even so, a structural solution for

bringing leaders together as suggested by co-performing distributed leadership will potentially involve intergroup relational issues.

In this context, a structural solution to planning and developing distributed leadership in the form of co-performing leadership that fosters structurally, for instance by imposing leadership dyads to sit alongside exiting competency-based approaches. Any advance of this consideration must also consider the implication of such an imposed structure on individual behaviors and beliefs, both within the dyads themselves as well as those who are interacted with on a daily basis.

Social Identity Theory

Social identification "is the perception of oneness with or belongingness to some human aggregate" (Ashforth & Mael, 1989, p.21). Social identity theory (SIT) explains that individual behavior is influenced by group membership (see, Tajfel, 1975; Tajfel & Turner, 1986). It suggests that rather than an individual's personal identity, it is often a person's social (ingroup) membership that is most salient in shaping their behavior (e.g., Schwarz, Watson & Callan, 2011). In healthcare, the functional approach to training staff (e.g., physicians, nurses) results in different groups of "well-inculcated professional identities that have been forged over years" (Bartunek, 2011, p.i63). These ingroup identities influence resulting behavior. For example, a study of nurses found that the more nurses identified with nursing and the profession, the more likely they were to get vaccinated (Falomir-Pichastor et al., 2009). In the context of between-group comparisons, individuals often view their own group as more complex and diverse and value its contributions more highly and more favorably compared to other groups. For instance, one study found that doctors perceived nurses to be incompetent at certain roles even though such roles are successfully conducted by nurses elsewhere (Setchell et al., 2015). Under conditions of threat or conflict, like those that arise in emotionally charged healthcare contexts, this social identity becomes highly salient (Hewett et al., 2009a, 2009b), resulting in behaviors that maximize intergroup distinctiveness and impair interdisciplinary collaboration (with attendant patient harm).

For healthcare leadership, SIT presents an opportunity to identify and resolve these intergroup boundaries, by emphasizing values such as partnership, trust, respect, and liking (Hogg et al., 2012). Research shows that intergroup friendships have a strong impact on fostering expansive ingroup identities and behaviors that are more accommodating and positive to out-group members (Tropp, 2008). For example, a nurse unit manager's links with medical staff can promote effective communication and defuse conflict (Richter et al., 2006). Leadership can mimic these friendship-based benefits by developing 'boundary spanners', people who have strong links between groups (Callister & Wall, 2001), or by bringing leaders from different groups together as leadership dyads (Sanford & Moore, 2015).

Communication

Effective communication is consistently and significantly associated with healthcare performance outcomes (Gittell, 2002; Hudelson et al., 2008; Leonard et al., 2004). Conversely, communication breakdowns are often symptomatic of subtle but pervasive intergroup dynamic problems (Bartunek, 2011), can erode patient safety culture (Singer & Vogus, 2013) and reduce overall quality of care (Hewett et al., 2013, 2015). Healthcare leadership is exposed as critical in improving communication, and as such relations, between different groups of hospital staff (Fulop, 2012; Michael West et al., 2015). In healthcare, as elsewhere, intergroup communication is influenced by social identity. For instance, health communication researchers explain that hospital doctors, in both written and oral interactions, communicate with their colleagues as members of specialty groups rather than as individuals (Hewett et al. 2009a, 2009b; Watson, Hewett & Gallois 2012). This social identity when salient leads to favorable ingroup perceptions and unfavorable intergroup perceptions. For example, a study of communication using SIT showed that despite all teams reporting that they sent the same quantity of communications to all groups, these same groups reported that they received less communication from groups that were outside of their domain (Bourhis et al., 1989; Lipworth et al.,

2013; Lloyd et al., 2011). Further, hierarchical and status differences exacerbate these tensions and disrupt intergroup communication.

Integrating Leadership, Communication and Social Identify

In this study we bring together the three aforementioned themes to explore distributed leadership in hospitals. Whereas previous studies have used SIT to understand communication and its impact on performance, as we note earlier, few have done so from the perspective of how distributed leadership relates to communicative interactions, despite its increasing topicality (e.g., Sanders et al., 2020). Noting this gap, we extend distributed leadership in healthcare by using SIT to investigate intergroup communication between hierarchical leadership layers to understand how leadership interacts vertically through these layers, and how the distributive function of leadership shapes hospital performance (e.g., perceptions of quality care, financial performance). With this add-on, we explore this theme by testing: *how does the practice of distributed leadership influence performance outcomes in hospitals?*

METHOD

Data Collection

The research team consists of several researchers who were closely involved with data collection and analysis, which allows for corroborating evidence and findings (Creswell, 2007). Data were collected from a two-hundred bed Australia-based study hospital (part of a large metropolitan hospital and health service) and in a six-hundred bed U.S.-based study hospital (Academic Medical Centre and Quaternary Care Centre). To include representative clinical and senior hospital staff perspectives, purposeful sampling was used (Fulop, 2012; Onwuegbuzie & Leech, 2007). To ensure data trustworthiness (Eisenhardt, Graebner, & Sonenshein, 2016), the research team engaged deeply with the partner by visiting the hospital sites regularly. To ensure sufficient in-depth information and to enable triangulation, a variety of sources (interviews, site visits, observation) were used during data collection over a period of 36 months. Data collection was stopped once sufficient data were collected to support a test of the research question.

Interviews (n = 107) with different groups of health care professionals were collected at both sites. To ensure comparability between sites, we interviewed a representative sample of executive-level managers, clinical managers, and clinicians across both study hospitals (see Table 1). Interviewees were only interviewed once by members of the research team, unknown to hospital staff. Interviews followed a semi-structured protocol commencing. The interviewer opened the interview with a question about what helps and what hinders patient care in hospitals, allowing for probing and clarification questions to explore key themes. Participants volunteered to be interviewed and prior to commencement of each interview, the interviewer provided information and assured confidentiality. On average interviews lasted approximately 30 minutes (Range: 9:12 to 80:35 minutes). A second source of data consisted of notes that we took during our nonparticipant observations of the meetings and site visits throughout the life of the project. During these visits, we took notes on every issue discussed and as many quotes as possible, providing us with rich field data on interactions and roles that the different participants assumed.

[Insert Table 1 About Here]

Data Analysis

Our data analysis was driven by our observation of effective communication and communication breakdown between different leadership groups in two hospitals between change initiatives, which we then sought to explain through the lenses of distributed leadership and social identity theory. Our analysis moved through iterative cycles (Miles & Huberman, 1994) between relevant literature and empirical themes (Locke, Golden-Biddle, & Feldman, 2008) to identify the most revelatory insights. We developed insights by focusing on plotting the process of distributed leadership, effective communication, social identification with leadership group (i.e., executive leadership, clinical management, and clinicians) and the narratives that establish a connection between these core themes.

First, data were reduced by thematic content analysis. Interview data were read for overarching common stories to obtain an understanding of any causal processes and to justify linkages among

stories. This approach separated distributed leadership, effective communication, social identification, expectations, and fact versus opinion. Next, data displays were developed by using QSR NVivo, coding transcripts iteratively, generated through the themes raised in the preliminary content analysis. Different nodes were created to organize these data, focusing on hospital hierarchy, effective care, and leadership. This analysis was initially done by an independent coder, followed by the author and a colleague (intercoder kappa was .86). This coding consisted of identifying data and clustering them in the nodes across the interviews. These data were arranged into data displays in NVivo.

Second, we conducted a cross-case comparison of themes between the two hospitals, and within hospitals we compared the data from perceived groupings of leadership positions in hospital healthcare (executive leadership, clinical management, and clinicians). "Executive leadership" (EL) covers participant references to managers and leaders with senior (executive) positions (from both non-clinical and clinical backgrounds). We use "clinical management" (CM) to cover lead clinical, research, or teaching roles together with administrative and resource management roles in their respective units (e.g., unit management roles in intensive care, nursing emergency medicine). We use "clinicians" for frontline service providers (nurses, physicians in training, allied health practitioners) without necessarily having formal management roles. Going forth and back between literature and emerging themes, our analysis suggests that these categorizations foster group-based social identities, shaping both within- and between-group perceptions. In this context, drawing from SIT literature we explored the emergence of leadership and how this rich body of literature on social identity helps to make sense of the observed intergroup perceptions of leadership. In doing so we identified a consistent construct of what facilitates effective care and performance, communication. Specifically, we investigated what participants said with respect to how effectively or not their ability to negotiate patient care was enhanced or compromised by the leadership shown from different intergroup professions. From this cross- and within case-analysis, clear differences emerged between hospitals.

Finally, to ensure the trustworthiness of the findings and our study, we followed Lincoln and Guba's recommendations (1985). More specifically, the use of multiple sources of data (i.e., interviews and field notes), providing a thick description of the themes under observation, and quoting extensively from participants helped us to contribute to the trustworthiness of our research. However, the most important technique used to establish credibility was the reliance on member checks from participants who confirmed that our formulations and interpretations of quotes were good representations of the realities at the research settings.

FINDINGS

Data Connections. As the data structure of our content analysis unfolded (see Figure 1), it became apparent that three hierarchal groups emerged with different perceptions of leadership roles (Executive leadership, Clinical management, and Clinicians). These different groups of employees belong to a variety of professional groups (physicians, nurses, non-clinical staff) that are often governed by different organizations that subscribe to different views and have varying interests which shape their professional identities. We explored the communication between these different layers of healthcare leadership (i.e., effective communication and communication breakdowns) as a proxy of healthcare outcomes. Next, relying on the framework of social identity theory, we examined ineffective communication (i.e., communication breakdowns) in the light of intergroup identities and tensions experienced by executive leadership, clinical management, and clinicians. More specifically, honing it at the leadership role level, our analyses showed that intergroup tensions and communication breakdowns were most prevalent in the clinical management subgroup, introducing a multilevel aspect to our data, and acknowledging the challenging role of CMs in sustaining intergroup relations by ensuring effective communication groups within the hospital hierarchy as well as between functional groupings. Although tensions in both sites between EL and CM, as well as those between clinicians and EL were omnipresent, we explored whether a structural approach to distributed leadership in the form

of vertical leadership dyads operates as an antidote against poor and ineffective intergroup communication in healthcare settings.

[Insert Figure 1]

Perceptions of Leadership Across Hierarchical Groups

In general, across both study sites, hospital staff that were not ELs described leadership roles as belonging to those "higher up" within the hospital hierarchy. ELs tended to describe leadership roles in relation to themselves. While this view was consistent with hospital hierarchy and defined leadership roles, perceptions of what leadership entailed differed. Executive leaders (n = 35) described how they (as a shared identity) contributed to achieving organizational goals, by engaging with staff to enact the "mission" and provide the "best environment" and "safety culture" and "best care possible" to their patients. An EL from the U.S. study hospital articulated the mission in the following way:

> *Leadership is all about that understanding of what it takes to do the job, appreciating the people that are doing the job. I think that again, that is back to the respect of whatever your role is, it all rolls back into the ultimate vision and mission is patient care.* (EL; Non-Clinical; U.S.)

Broadly, members of the EL group reported that they were motivated to achieve the leadership mission through engagement with multiple managerial, medical, nursing, and allied health staff. A senior non-clinical EL from the Australian study hospital, in bringing this overarching perspective together, and acknowledging the challenges in doing this, stated:

> *Certainly, communication and access are big issues and you know, what we do with them; it's not much use agreeing with everybody and then doing nothing. We have to show how we've taken into consideration people's legitimate concerns.* (EL; Non-Clinical; AUS)

Clinical managers (n = 23) were of the view that good leaders made the difference to healthcare quality and patient safety – whether they be formal or informal leaders at the executive or clinical

managerial (unit) level – and that without strong leadership, organizational and clinical goals were compromised. Interview data revealed that their perspectives on leadership activities differed from their EL colleagues. Generally, their focus tended to land on the activities surrounding their placement as the "meat in the sandwich" – in the middle of the multi-levelled hospital hierarchy. For instance, U.S. and Australian CMs described their multiple responsibilities, as individuals, as reporting "up" to the EL group on key outcomes, and leadership engagement "downward" with unit staff to facilitate action. Compared to ELs, CMs spoke much less of the hospital's mission or goals to improve care.

Clinicians (n = 45; nurses, allied health practitioners, doctors (Resident/Registrar); experienced and "new", i.e., employed within a year) reported that their main contribution, unsurprisingly, was to provide "frontline" care in reportedly busy, resource-challenged units. Their commentary tended to focus much more on their daily work as patient care providers and their goals to deliver timely quality care. Achieving these goals involved frequent multiple intergroup interactions: between themselves and patients and families, between themselves and frontline clinicians of different professional disciplines and between themselves and managerial level staff – both within their unit and managers of other units. In contrast to the dialogue about leadership we observed from ELs and CMs, this group seemingly appeared to deliver care as if (comparatively) removed from leadership process.

Members of this group did not spontaneously include commentary about health leadership per se. However, what they did report was the intergroup tensions and communication problems that arose when leadership was not seamless. To resolve these communication breakdowns, clinicians identified the relevance of their senior colleagues, referring to clinicians with greater experience. This sub-group were viewed as helpful in the context of inter-department (i.e., intergroup) communication concerning patients who had been, or would be, transferred into in their care, as well as providing a mentoring role.

Effective Communication: A Proxy for Outcomes

Where effective communication was highlighted as an indication of effective leadership, it was also described as essential for patient outcomes. Regarding what 'helped, and hindered, patient care',

communication was a consistent theme across all groups at both hospital sites. ELs generally acknowledged the role of "strong communication" – either among EL groups, or between layers – as critical to leadership enactment. CMs discussed effective communication between groups as critical in delivering effective care. Also, most clinicians emphasized the importance of effective and timely communication.

While communication was consistently highlighted as crucial, it was most often discussed with respect to breakdowns of communication – a dysfunctional view of communication. Australian ELs acknowledged interprofessional relational and communication issues between EL groups (i.e., nursing and medical executive; nursing executive and nursing managers). They suggested these hindered (rather than advanced as expected) patient care (e.g., direct-care-related resource allocation decisions). Furthermore, and like their CMs, frontline clinicians expressed concerns about communication, verbal and written. For instance, they told us of their worries about poor written communication (brief incomplete patient notes; abbreviation use; access to and documentation in electronic health records) and problematic verbal communication (verbal orders not followed up in written notes; communication gaps in handoffs or during codes). Clinician comments implied that communication problems were exacerbated by outcome expectations of "the hospital", that is, those that stemmed from internal leadership failings. Clinicians thought well of ELs and CMs who modeled open communication processes, and were frustrated with leaders who were disconnected from staff who deliver frontline services:

> *We have a leader that's more a delegator and sits back, [ ] whereas some other departments [ ] I have seen their director come out of her office and admit a patient; come out and help assist with a code. [ ] good staff, good leadership. You get better patient care out of that too.* (Respiratory Therapist; U.S.)

Communication executively down is often that – this is what they say, it's not open for discussion and that's hard … it does breed then an air of frustration within the ward and lower morale. (Nursing; AUS)

Where communication breakdown appeared amplified was within the CM group. More than their executive-level colleagues, these managers commented on difficulties in sustaining interprofessional relations and ensuring effective communication between hospital areas (e.g., ICU, General Medical, Surgery), and between levels of the hospital hierarchy. While occurring across both hospital sites, this breakdown was more evident in the Australian context. For both sites, this response was unsurprising given the CM group's structural role as the buffer between frontline care and EL groups. Their commentary illustrated that they often experienced differing priorities between groups, and that communication gaps (e.g., in handover and documentation of patient care) that impaired intergroup relations gave rise to tensions. Some CMs reported that enacting their mediating role (potentially, as boundary spanners) posed significant leadership challenges, saying that these stemmed from their intergroup dynamics.

How Intergroup Identities and Relational Issues Impact Communication Breakdowns

Supporting the notion that communication difficulties are often symptomatic of subtle but pervasive intergroup dynamics (Bartunek, 2011), our data suggested that intergroup relational issues exacerbated communication tensions. In general, across both study hospitals, as well as in comparison to the clinicians' managerial or executive hospital colleagues, frontline clinicians tended to be more outspoken about concerns with patient safety and the role that different groups had in this. For instance, they felt challenged in delivering timely appropriate care owing to hospital capacity, staffing levels, patient numbers, and complex patient care needs. Clinicians perceived ELs were disconnected from frontline care needs, and that EL priorities and goals posed threats to care quality and safety. These tensions posed significant barriers to achieving organizational and patient care goals. In support of clinician perceptions, we offer the following illustrative excerpts of 'EL talk':

We don't have a group that reports to facility management – but again medical staff are put up the top of the group and they report directly to the facility management – so that's a bit of a pity. [ ] We feel like we just need to be more or less an equal partner... (EL, Nursing; AUS)

Although not united by a strong ingroup EL identity, both clinical and non-clinical ELs saw the current situation as a leadership opportunity for change and improvement:

There are some issues with nursing and leadership. So there's an opportunity from the top now to re-engage. (EL, Non-clinical; AUS)

Clinicians typically referred to EL groups as "others", whose priorities or goals they believed differed significantly to their own. These intergroup perceptions appeared to precipitate communication challenges, which then perpetuated relational tension and impacted on patient care. For instance, frontline clinicians reported that they experienced difficulties in meeting the needs of patients versus administrative efficiency targets (e.g., care protocols) or surgical unit outcome goals (e.g., reducing waiting lists):

The rules that have been set from higher above sometimes, I don't feel, reflect what's going on at the floor level. And I think that can affect patient care greatly because we are all rushed and frustrated and the tension between us all gets a bit much sometimes." (Medical Registrar; AUS)

Hospital administration needs to take into consideration the unit's location when they change things. [ ] Reaching targets from higher up drives you nuts [ ] it keeps you on your toes. (Nursing; U.S.)

The use of prepositions of location and direction in the above (e.g., "from higher *above*" "at the floor level") signaled an intergroup distinction between clinical (nursing, medical) and non-clinical (administrative) groups, and their "place" in the hospital hierarchy. While this perception of ELs by clinicians was often harsh, comparative analyses of clinician comments between U.S. and Australian

hospitals revealed nuanced differences. The reported frontline clinician experience of leadership tended to be more favorable in the U.S., compared to the Australian study hospital, but differed, in both, from unit to unit:

> *A good leader is someone who makes sure you know what's important, or the priority; someone to show you what to do. I love the charge nurse; she is really helpful.* (1st year Resident; U.S.)
>
> *I feel that the hierarchy* [i.e., directors of nursing] *[ ] have got very little understanding of what's happening on the floor and how pushed we are. You see very little of them.* (Registered Nurse; AUS)

When problems occurred, both U.S. and Australian clinicians usually attributed these situations to "others". However, comparatively, clinicians from the U.S. study hospital spoke more often of respectful *intergroup* (interprofessional and interunit) relationships in achieving care goals, whereas Australian clinicians spoke more favorably of *ingroup* relations (within profession across hierarchical levels). The "other" perception and associated relational tension was mostly illustrated as between clinicians and other units or clinicians and ELs. For ingroup perceptions, Australian hospital clinicians, doctors, and nurses, tended to speak about relations with their ingroup colleagues and that they thought these generally supported their daily work. Where these favorable notions extended to other groups, it was limited to CMs. Nurses talked about the importance of having the support of their nurse unit managers and junior doctors talked about the support of their registrars and consultants. Allied health clinicians appeared to feel supported by their unit CMs, nursing and medical, in achieving both organizational and patient care goals. Similarly, U.S. hospital junior doctors spoke of respect for their interprofessional and collaborative colleagues (fellow doctors, nurses, and allied health staff), and in particular the nurses in their units. U.S. junior doctors, nurses, and ancillary staff (allied health) reported they felt their unit leaders, nursing and medical, supported their work: one exception was nursing, where nurses spoke about challenges in establishing relational ties with junior doctors.

This context provides evidence that context-specific intergroup factors affected intergroup communication and, as such, adversely affected care. Consistently, the notion "other" groups seemed to precipitate negative perceptions between either clinicians and ELs or CMs and ELs. While clinicians provided more discussion on intergroup tensions, issues were also observed in other leadership groups. For instance, although Australian ELs acknowledged the roles that other ELs performed, and appeared to value them, there were few references to engagement with *each other* as members of the EL group, and no reference to anyone in a position to resolve communication gaps or intergroup tensions. Commentary implied that intergroup relational aspects of Australian EL roles were informal and ad hoc. Whereas, in the U.S. ELs often spoke of their own role in relation to the EL group and multiple members of it, and in particular their "leadership partner".

The 'Meat in the Sandwich' of Communication Breakdowns – Clinical Managers

Where intergroup relational tensions culminate was often observed at the clinical manager role. This position sits between the vision and mission leadership of ELs and frontline clinical care. Where clinicians spoke of the intergroup relational issues that affected care, CMs recognized their role in sustaining intergroup relations by ensuring effective communication groups within the hospital hierarchy as well as between functional groupings (e.g., junior and senior nurses; junior doctors and consultants; junior nurses and doctors). To assist effective healthcare, CMs reported that EL support "from above" was important, as was fellow (ingroup) clinical manager support in enacting their own leadership positions within their own department. Where this support was observed, it appeared it facilitated better service delivery and helped CMs meet challenges in unit functioning:

> *You get the budget issues and the policies and … [ ] I think in general it comes from above that you feel supported. Not just with your immediate director but from the executive level as well. [ ] and it really makes a big difference.* (CM; Medical; AUS)

Many CMs reported, however, that support from their ELs in resolving these issues was lacking, and that ELs were disconnected from frontline care needs. At times, this impacted on staff trust:

Sometimes you're the meat in the sandwich, especially middle management, because you're having to keep telling the people below you what's going on to keep them informed, to keep information flowing downwards. But that information isn't coming down to you. [ ] Because of that type of communication, the team around you loses a bit of that trust and a bit of that faith in you, or the people that are above you, or the organization. (CM; Nursing; AUS)

Some CMs went further, reporting that executive leaders were unaware of the impact that intergroup relational and communication factors had on patient care or staff morale, particularly when leadership support was lacking in coordinating patient care *between* departments or units (e.g., emergency, general medical, surgical). CMs claimed that executive leadership focused on "their priority areas" (e.g., finance, organizational targets, resource provision) versus patient care. As such, they explained that ELs often ignored the needs of some units, and favored certain clinical managers (over others), their staff, and patients in those (priority) areas. CMs seemed frustrated by this, and how these issues impacted on patient safety and quality:

So, they really have no idea what is happening in these units. They just don't; [ ] they're in their offices, they're looking at numbers, crunching numbers, trying to make the number end of it work – and we're trying to make the bottom line, the safe patient care work. (CM, Nursing; U.S.)

There's a disconnect between the management and the clinical staff. [ ] things like providing non-invasive ventilation on the wards, [ ] has been blocked from (sic) executive staff who see it as too complicated. (CM, Medical; AUS)

Further commentary in this vein suggested that CMs experienced issues with communication gaps (e.g., in handover and documentation of patient care), and that impaired intergroup relations gave rise to tensions.

Some CMs reported that enacting their mediating role, potentially, as boundary spanners, posed significant leadership challenges, saying that these stemmed from intergroup differences in care priorities and goals. With respect to CMs and clinicians, while these are typically different groups, many CMs viewed them as one and the same. These CM (U.S. and Australian) comments on their own leadership, which they perceived as one of engagement with "their" staff, suggested that in their role they promoted unit culture, and supported and educated "their" clinicians (nurses, allied health practitioners, doctors). They spoke of the importance of good intergroup relations within their units in achieving this: "*We try to have a good relationship with each other* (nursing and medical staff)*; make it as comfortable as possible."* (CM; Medical; U.S.) *"My door is open, and staff can come in and out with their concerns."* (CM; Nursing; AUS). Indeed, data suggested that an emphasized aspect of U.S. CMs' own leadership role was relational coordination *between* units. It appears strong dyad partnerships between CMs and clinician supported their clinical management work. This dyad partnership included work to resolve interprofessional conflict (reportedly often because of poor communication between nurses and doctors) and nurture a positive working environment to promote effective communication within "their" units. One CM described the positive effect of this approach:

> *I have worked with people in the past who [ ] didn't really take their role as a leader very seriously, and so it was very frustrating. [ ] Whereas [the current partner] is amazing. Huge physician buy in. He really does take what we discuss and the issues that we are having back to the physician group.* (CM; Nursing; U.S.)

In sum, CMs in both hospitals, with the Australian hospital in particular, drew attention to intergroup tensions in the hospital system by giving examples of their frustrations and how intergroup relations and (ineffective) communication between ELs and CMs impacted on their work and patient outcomes. U.S. perspectives showed similar concerns although the hospital seemed aware of these issues and acted to reduce analogous tensions (see section below), and through this advanced patient

care quality and safety. Nevertheless, at both study hospitals, CMs reported that competing administrative and clinical priorities negatively impacted healthcare work and patient safety.

Vertical Leadership Dyads: Improving Inter Group Communication

While tension between EL and CM groups as well as clinical and EL groups was a general observation, our comparative analysis between hospitals noted more favorable intergroup perceptions of communication in the U.S. hospital that more effectively supported harmonious intergroup relations. As shown above, U.S. CMs claimed their own partnerships with clinicians supported their role in delivering patient care. In addition, we observed U.S. ELs advocating strongly for respectful relationships between ELs, and CMs and professional identity groups (e.g., medical, nursing). In this way, a recent shift in the U.S. hospital to an intentional intergroup structural approach to facilitate EL and CM interaction was explained as:

> *We bring our group together* (i.e., ELs and CMs) *[ ] One of the things we talk about is team building and transparency and communication. Before we were – it was more of a higher level saying, "Hey, we need to do this". Now it's more driven from their level up (i.e., CMs). [ ] "Why don't we start communicating this?"* (EL, Non-clinical; U.S.)

This perspective introduces the concept of dyadic leadership partnerships between ELs and CMs. As the name implies dyadic leadership is a team of two who work together as co-leaders (Sanford & Moore, 2015). The positive effects of this approach were noted by a nurse unit manager, who was in a dyad leadership partnership with the unit medical director (an EL):

> *I do some work with our nursing [ ] dyads – but I really love them. [ ] I think it's a great format because it's me but then my dyad - maybe someone who is, has business or nursing experience or usually both. [ ] The chair of my hospital medicine department [ ] has a dyad [ ] and it's been fantastic because he does the clinical side of things and she helps out with the management and scheduling.* (CM; Medical; U.S.)

Specifically in the U.S. hospital, EL leadership partnerships were formalized, organizationally into dyads (between an ELs and CMs) and sometimes triads (with two CMs from different functions). These dyad partnerships reportedly brought business, clinical, and quality and safety expertise together to advance improvements to organizational functioning and patient care. Further, EL commentary implied that close ties with dyad partners facilitated boundary spanning work which minimized intergroup conflict around competing clinical versus administrative goals, and that this significantly contributed to resolving department and unit-level challenges (clinical and relational), and improving care quality and patient safety:

> *I think this is a great environment, the dyad environment; [ ] because you do have the person [ ] with the finances, the management, the staffing, the resources, the processes, the policies. But you also have the clinician [ ] saying, "this won't work, this isn't good for the patient, or this is going to cause safety issues…".* (EL, Education; U.S.)
>
> *You have the physician leader handling a lot of physician-related clinical issues; you have your nurse leader who really kind of – the quality, the safety, and you have your business leader. And when you've got those three, kind of your three-legged stool, working – it's a pretty powerful thing.* (EL, Non-clinical; U.S.)

Discussion on dyadic leadership was associated with more inclusive group language. Where common out-group references were to "them", we noticed a replacement with discipline-specific identities. For instance, in the following excerpt, the use of "administration" and "clinical", as well as "they" and "us" suggests staff experience a sense of common identity as ELs (ingroup) in parallel to a discipline-specific (intergroup) identity:

> *They certainly play a role and listen – the administration actually listens very carefully to the clinical people in terms of what we need for the patients; and then they try to deliver that if it is a reasonable request.* (EL; Medical; U.S.)

The sense of shared identity that dyadic leadership facilitated appeared to be enhanced by the group member's accommodative approach to communication among their EL colleagues (e.g., taking each other's position and goals into consideration). Commentary suggested that to advance hospital outcomes, healthcare and administrative, ELs took steps to understand and work together toward different groups' goals. For instance, one participant from the U.S. EL group (non-clinical) explicitly stated their belief that the intergroup approach contributed to a bridging of the non-clinical/clinical boundary:

> *Meetings are routinely attended by not just the people doing the clinical work but also administration, leadership, accounting, quality improvement people; there are many meetings where we actually coalesce … and the administration perspective on a clinical dilemma is different than the clinical perception and it helps with each party understanding others…* (EL, Clinical; U.S.)

In contrast to their U.S. counterparts, Australian ELs did not provide evidence of this intergroup approach to leadership, or the associated boundary spanning work. In their current organizational climate at least, ingroup identity-oriented tone of Australian ELs for the most part focused on their own (individual) position and responsibilities (hierarchical position/discipline), and how they engaged with 'their' (rather than 'our') clinical managers and unit leads to support them in their work. As such, the Australian data revealed a higher frequency of reference to intergroup tensions between ELs in different organizational positions or roles. Whereas in the U.S., EL commentary strongly suggested they highly valued the formal dyad leadership model, and their dyad partners, and acknowledged the benefits of having their respective expertise and perspectives in achieving hospital goals and advancing patient care. The dyad model of leadership, formal or informal, did not emerge in the Australian study hospital data. Reasons for this finding remain to be investigated further.

DISCUSSION

In this paper we set out to explore how the practice of distributed leadership vertically influences performance outcomes in hospitals. Consistent findings from our hospital samples confirms that good communication is a key factor facilitating healthcare outcomes and acts as a target for effective hospital leadership. Both hospitals delineated leadership into three congruent layers: executive leadership, clinical management, and clinicians. By invoking social identity theory to interrogate intra-group and intergroup communication between these layers, and as a primary addition to debate, we identified that group identity, made salient by participants' hierarchical layers, impacted communication, which is known to adversely effect patient care. This finding is instructive because of the adverse healthcare outcomes it potentially represents.

Comparison between hospitals indicates that the leadership structure adopted is a key moderator for communication breakdowns. Our research identified a system-level, structural approach to leadership, of leadership dyads in the U.S. hospital (at the executive and clinical management levels). As we argue, this integrated relationship enables executive level and clinical management leadership to work together, overcoming possible intergroup social identity biases, promoting intergroup collaboration, improving intergroup communication, and resulting in a better perception of leadership effectiveness. With these observations, and given our research question, we make three key contributions to understanding healthcare leadership and its hospital placement.

First, we add to the possibilities available in the discussion on distributed leadership in healthcare. Where extant literature has studied the benefits of this notion horizontally, we extend its relevance to a vertical perspective. In line with what social identity leadership theorists posit, we identify an additional construct – that social identity salience of leadership layers positively influences their descriptions of their peers (as ingroup members), and negatively influences out-group members. This finding is consequential for hospital management. Studying this phenomenon vertically, through the leadership chain, identity salience was most widely illustrated as "other" perceptions, (i.e., "them" and "us") between either CMs and ELs or clinicians and ELs. Clinicians, in particular, claimed that

problems with patient care and safety stemmed from a disconnection between frontline care needs and hospital executive priorities (either administrative or clinical). Clinical managers, in effect, acted as a buffer and made attempts to compensate, often unsuccessfully, with noted performance effects. This depersonalization of "other" was observed to increase ingroup distinctiveness and intergroup social distance, resulting in interrupted communication lines, delayed patient care and reduced quality and safety. This situation is conflictual, and conflict exacerbates the importance of each person's professional identity. Such a situation means that individuals focus on favoring their own group and discriminating against outgroups as a means of reducing the threat they perceive to their ingroup.

Uniquely, ELs and CMs from the U.S. study hospital described a more consistent, joined up, and as such more ingroup approach to leadership. This was facilitated by a structural approach, the creation of dyads. This model promoted strong relationships and effective communication between traditional leadership boundaries (i.e., ELs and CMs) to achieve organizational goals. This approach confirms theoretical discussion that intergroup performance requires the construction of intergroup relational identify (Hogg et al., 2012) and the importance of creating structural conditions to foster distributed leadership (Bartunek, 2011). Where this finding extends this discussion is that these dyads were vertically orientated structures, in contrast to the more common approach of horizontal dyads, with related practical consequences for hospitals and their leadership roles.

This positive perspective of intergroup leadership coordination, and its perceived impact on advancing healthcare, is encouraging. Our results give promising early evidence of a structural approach to promote positive, co-performing, leadership cooperation vertically between traditional hierarchical layers. Formal leadership partnerships in dyads (and triads) appear to facilitate a deep understanding, and accommodation, of the sociocultural aspects of roles and functioning of each member of the dyad pairs and their staff (Sanford & Moore, 2015). Close dyad relationships (through their accommodative stance) afford an enhanced opportunity to align care priorities and reduce stereotypical intergroup tensions that are barriers to quality safe healthcare. Without this dyadic

approach, as our Australian data identified, we suggest that intergroup hostility can impair intergroup relations and hinder leadership activities, with associated performance consequences.

A broader, second contribution to views on healthcare organization is to the discussion on healthcare leadership development. Findings point to the changing nature of how we conceptualize leadership influences and how we develop future hospital leaders. Alongside the notion of leadership moving from (often unattainable) heroic individuals to a dyadic, distributed function, we noted a shift in leadership development towards social- and behavioral-based competencies. While our study did not specifically focus on any competency training that ran alongside this structural change to dyads, neither was this outcome mentioned by our respondents. Although we do not dispute the increasing focus on relational competencies, we challenge whether, on their own, a competency approach is enough to overcome natural and pre-programmed intergroup salient identities. Applying a structural approach in the form of leadership dyads, in combination with relational competencies, may provide for a more fruitful path to develop hospital leaders and ameliorate hospital performance.

Finally, by telegraphing an extended health leadership model, we propose that incorporating the dyad partnership at multiple levels of the hospital hierarchy has powerful potential to advancing what we already know about patient care and patient safety. While there is scope for future research to explore this opportunity, we extend knowledge linking effective communication to healthcare outcomes by suggesting that dyad based leadership relationships result in fewer communication breakdowns and, as such, facilitate the possibility of better care. In this way, leadership dyads may act as a patient outcome pathway. This type of modelling may resolve challenges in organizational leadership that rest on individual efforts (West et al., 2015), and may prove a powerful extension to the model of intergroup health leadership posited by Hogg et al. (2012). Further allied questions remain to be explored, such as how many, and which, EL members need to be involved in dyads? In what circumstances may dyads not be appropriate? Regardless, using SIT, our demonstrated approach illustrates an intervention as a way forward to explore these questions and their associated themes.

Practice Implications

Our findings offer valuable implications for hospital practice. Current leadership development practices default to focus on activities that promote leadership relational and social competencies can also benefit from a structural dyadic approach to foster these same benefits. By validating the concept of formalized dyads in hospital settings we show how pairs of leaders *sharing responsibility* is a way forward to overcome possible hospital performance issues. Applying dyads vertically between leadership layers, helps foster intergroup relational identity that extends up and down the formal hospital hierarchy. As our findings show, where observed, this response was associated with heightened perceptions of communication and better perceptions of hospital performance, with the possibility of more effective patient care. Furthermore, with the importance of creating structural conditions to foster distributed leadership already established (Bartunek, 2011), we extend practice to include the relational and social competencies to facilitate distributed leadership. By structuring formal leadership partnerships in dyads (and triads), hospitals can facilitate a deep understanding of the sociocultural and relational aspects of distributed leadership. This extension provides a fruitful avenue for understanding how to develop future hospital leaders and in doing so, ameliorate hospital performance outcomes.

An extended health leadership model that incorporates the dyad (or triad) partnership at multiple levels of the hospital hierarchy has powerful potential in advancing how hospitals organize for patient care and patient safety. In this way, our study suggests that while health leadership continues to be experienced in ways that have long been known, the dyad leadership model offers an effective contemporary health leadership model. Dyadic leadership promotes strong relationships and effective communication between traditional organizational and disciplinary boundaries to achieve organizational and clinical goals. Effective health leaders are not averse to invoking dyads to promote good intergroup and interdisciplinary relationships and communication lines, and in doing so act as boundary spanners. Practically, our study also shows that while health leaders agree that leadership is

key to advancing healthcare quality and patient safety, without adopting a formal approach to integrating leadership, it appears that such refrains fall on deaf clinician ears. Despite positive staff views on health leadership, problems remain with *who*, *where,* and *how* leadership is enacted. This response impacts on staff wellbeing and patient care and safety, and limits its achievements in advancing healthcare at individual hospitals.

Conclusion

This study contributes to the practical notion of leadership as a distributed function that emerges between multiple layers of healthcare leadership (i.e., executive leadership, clinical leadership, and clinicians). It demonstrates how leadership dyads of distributed leadership can operate as an effective mechanism to facilitate intergroup communication. Drawing from Social Identity Theory these findings extend insight on the pivotal role of a structural approach to distributed leadership in hospitals. More specifically, it shows how the creation of leadership dyads (nurse and physician) can buffer against the negative effects of in-group and out-group social comparisons between leadership groups and thus ameliorate effective communication and performance.

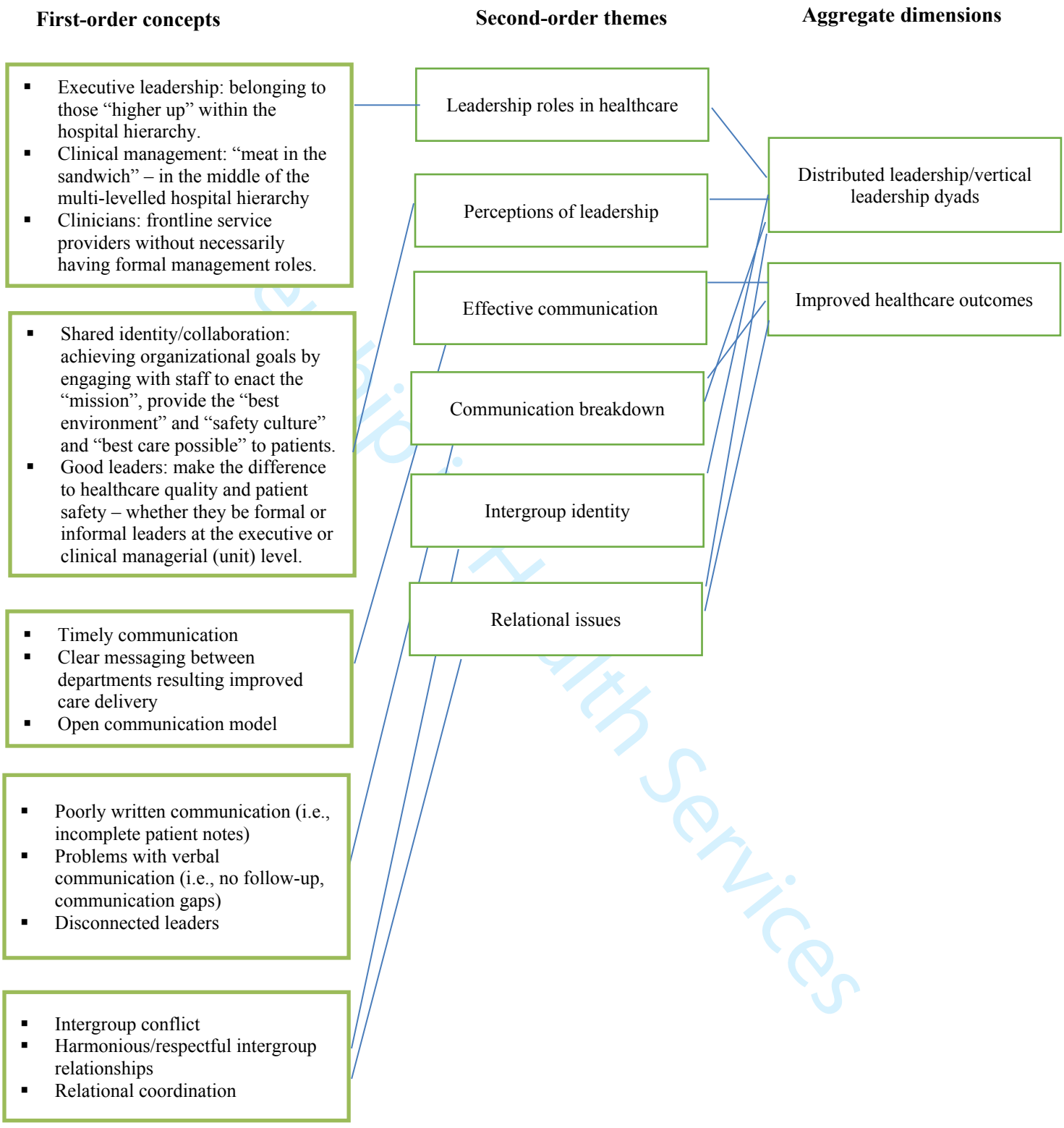
Table 1. Interview Data

Sample Descriptive Statistics by Study Hospital Site (N = 107)

Sample by Group	AUS	U.S.	AUS	U.S.	AUS	U.S.
	n		%		% Female	
	59	48	56	44	48	50
Executive Staff[a] (Total)	15	20	25	42	7	5
Administration/ Hospital Services	5	5	8	11	3	1
Medical	4	12	7	26	0	2
Nursing	2	3	3	6	2	3
Allied Health	4	0	7	0	2	0
Clinical Managers[b] (Total)	15	8	25	17	4	6
Medical	5	2	8	4	1	0
Nursing	9	6	15	13	8	6
Allied Health	1	0	2	0	1	0
Clinicians (Total)	26	20	44	41	17	13
Medical[c]	11	12	19	24	4	6
Nursing	9	5	15	11	7	5
Allied Health	6	3	10	6	6	2
OSOs Ward Orderlies	3	0	5	0	1	0

[a] CEO, Department Directors; [b] Deputy Department Directors, Staff Specialists (Medical), Unit Managers (Medical and Nursing); [c] Consultants, Doctors in Training, Registered Nurses, Physical Therapists.

Figure 1: Data Structure



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