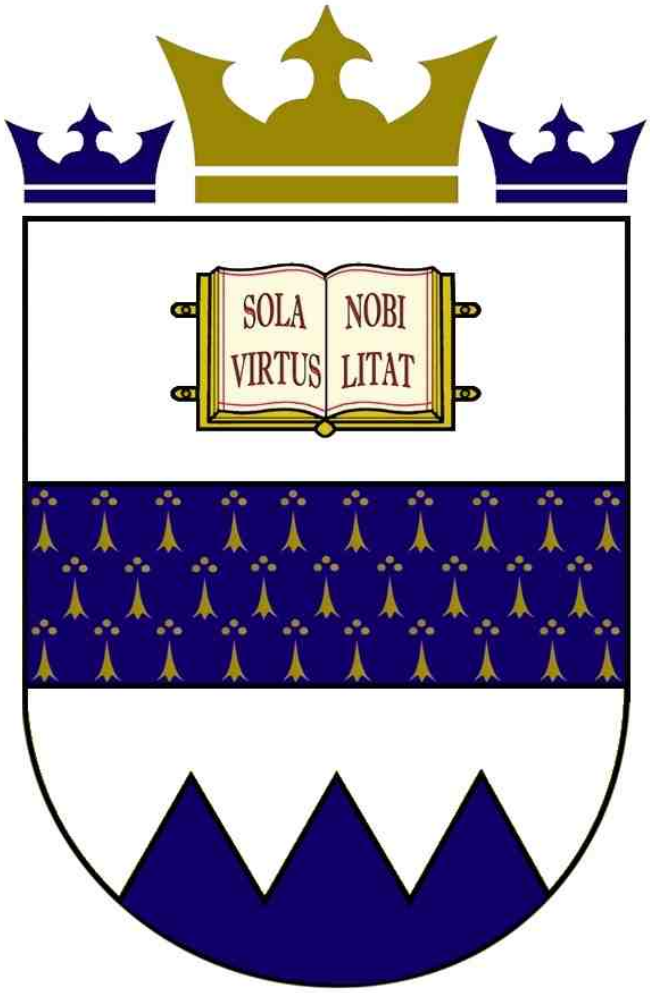



# Monarch Business School
# University For Graduate Studies In Management

## The Respiratory Therapist:
## A Study of Followership Within Critical Care Environments

| | |
|---|---|
| PROGRAM: | Master in Philosophy in Business Research |
| SUBMISSION DATE: | May 31, 2010 |
| CANDIDATE: | Mr. Donald Oxford York, BA, RRT, ECC INST-TR |
| THESIS SUPERVISOR: | Dr. Jeffrey Shawn Henderson, Ph.D. |
| COMMITTEE CHAIR: | Dr. Norman Madarasz, Ph.D. |
| THIRD READER: | Dr. Christos Antoniou, Ph.D. |

FINAL COPY FOR SUBMISSION TO THE THESIS COMMITTEE
MAY 2010

# ACCEPTANCE

The Thesis Committee hereby accepts this thesis for evaluation by Donald Oxford York in fulfillment of the requirements for the Degree of Master of Philosophy

The Respiratory Therapist:
A Study of Followership Within Critical Care Environments

Dr. Norman Madarasz, Ph.D. — Date
Chair of The Thesis Committee
UGSM-Monarch Business School, and
Chair of Philosophy Studies
Universidade Gama Filho

Dr. Jeffrey Shawn Henderson, Ph.D. — Date
Thesis Supervisor
Director of Studies
UGSM-Monarch Business School

Dr. Christos Antoniou, Ph.D. — Date
Professor of Management
Member of the Academic Board
UGSM-Monarch Business School, and
Fellow in International Business
University of Leeds

# PERMISSION

Title: The Respiratory Therapist: A Study of Followership Within Critical Care Environments

Program: Master of Philosophy in Business Research

Degree: Master of Philosophy in Business Research

I, Donald Oxford York, agree that Monarch Business School shall make copies of this thesis available for scholarly purposes. Use of any material presented in this thesis shall result in due credit to the author and the University.

Mr. Donald Oxford York, BA, RRT, ECC INST-TR _____ Date

# PURPOSES AND ATTESTATION

This document is prepared as a thesis submission to UGSM-Monarch Business School, in partial fulfillment of the degree of:

Master of Philosophy in Business Research

The author hereby attests that the work herein provided in fulfillment of the above degree requirements is wholly of his own effort and hand. Further, the author attests that this document constitutes the entire submission of the thesis/dissertation component.

Dissertation Committee Members:

| | |
|---|---|
| Thesis Chair | Dr. Norman Madarasz, Ph.D<br>Chief Academic Officer and<br>Member of the Academic Council<br>UGSM-Monarch Business School, and<br>Chair of Philosophy Studies<br>Universidade Gama Filho |
| Thesis Supervisor | Dr. Jeffrey Shawn Henderson, Ph.D.<br>Director of Business Studies and<br>Member of the Academic Council<br>UGSM-Monarch Business School |
| Thesis Committee Member | Dr. Christos Antoniou, Ph.D.<br>Professor of Management and<br>Member of the Academic Council<br>UGSM-Monarch Business School, and<br>Fellow in International Business<br>University of Leeds |

Mr. Donald Oxford York, BA, RRT, ECC INST-TR — Date
May 31st, 2010

# ACKNOWLEDGEMENTS

I would like to take this opportunity to thank Dr. Jeffrey Shawn Henderson, Ph.D., Director of Studies at UGSM-Monarch Business School, for his guidance, mentorship and sponsorship throughout the duration of this project. His professional guidance and insight into Business Research Design are greatly appreciated and have proven to be an integral part of the process.

Secondly, many thanks to my academic reader, Dr. Norman Madarasz, Ph.D., Chief Academic Officer at UGSM-Monarch Business School and Program Director of Philosophy Studies at Universidade Gama Filho, for his patience, support, commentary and diligence in overseeing the entire process. I have great appreciation for his thoughts and comments concerning the material and form of the thesis.

I would also like to thank Dr. Christos Antoniou, Ph.D., Member of the Academic Board of UGSM-Monarch Business School and Fellow of International Business at the University of Leeds, U.K. for accepting to be the third reader on the Thesis Committee.

Further, a special thanks is also given to Dr. Robert Saggers, Ph.D. Professor of Instructional Psychology at McGill University for all his continual help, support and guidance throughout both my leadership studies at McGill University and during the present work while at UGSM-Monarch Business School.

Likewise, I would like to acknowledge both Dr. Lloyd Williams, Ph.D, D.Min., Associate Professor at U21 Global and Dr. Mark Esposito, Ph.D., Professor of Management at the Grenoble Graduate School of Business for their practical thoughts and insight during my initial phase.

Lastly, special thanks are given to the many professionals who were interviewed and took part within my study. Their time and effort is greatly appreciated and was instrumental in making this thesis successful.

# TABLE OF CONTENTS

# TABLE OF FIGURES

# LIST OF ABBREVIATIONS

| | |
|---|---|
| ER | Emergency Room |
| ICU | Intensive Care Unit |
| JGH | Jewish General Hospital |
| MET | Medical Emergency Team |
| MGH | Montreal General Hospital |
| MUHC | McGill University Health Center |
| OR | Operating Room |
| RAT | Respiratory And Anastasia Technologist |
| RT | Respiratory Therapist |
| RVH | Royal Victoria Hospital |
| SMH | St. Mary's Hospital |

# NOTE ON TERMNOLOGY

Within the thesis the terminology of the words "Respiratory Therapist" and "Respiratory and Anastasia Technologist" are used frequently. It should be noted that the usage of these words should be taken to be gender neutral. Further, the male pronouns: he, his, him, himself should also be read with the female gender in mind.

# CHAPTER ONE

# INTRODUCTION

# CHAPTER ONE- INTRODUCTION

## 1.1 BACKGROUND

In recent years, the role of “followers” within organizations has become an important theme in theoretical, applied and empirical research within leadership/management studies (Kellerman, 2008; Kelley, 1988; Hughes, Ginnett, & Curphy, 2006). According to Barbara Kellerman, “Times are changing. Followers are becoming more influential and leaders less”, (Kellerman, 2008, p. 2). The primary focus on “the leader” has created a negative connotation in the meaning of being a “follower” and has lead to leader-centrism (Kellerman, 2007). Also, most of the leadership theories have a unidirectional perspective on how a leader should relate to a follower (Howell & Shamir, 2005). As Townsend & Gebhardt state, “Virtually no one leads all of the time. Leaders also function as followers; everyone spends a portion of their day following and another portion leading”,  (1997, para. 2).

Followership appears to be an integral component to effective leadership (Latour & Rast, 2004). The traditional leader-follower roles appear to be revolutionized having effective followership as a pre-requisite for effective leadership. Within the army, there is an inseparable duality amongst the two concepts (Latour & Rast, 2004). A leader appears to be nothing without followership and at times even a leader must follow (Latour & Rast, 2004).

Leadership can be defined as “a social process in which interacting individuals coordinate their actions to achieve shared goals” (Vugt, 2006, p. 355). Leadership is each person’s responsibility and duty (Hughes, Ginnett, & Curphy, 2006). Leadership cannot be studied without examining the needs of and desires of the follower (Vugt, 2006). More so, there are followers who support the status quo and then there are others who create/lead change (Kellerman, 2007).

Leadership and followership within the profession of medicine is a critical issue that can often mean the difference between life and death. Within the field of medicine as a profession the second half of the nineteenth century saw the development of specialized services (Lega & DePietro, 2005). By the early tweentieth century, specialties grew forming diffferent divisions within the organzational structure; which in turn, gave rise to clinical units and processing of medical care specializations (Lega & DePietro, 2005). The creation of hospitals, stemming from community based medicine, brought forth more areas of specialization (Lega & DePietro, 2005).

In an article by Lega & DePietro (2005), Henry Mintzbrg termed health care organizations as professional bureaucracies due to their organizing around the skills and knowledge of professionals. The professionals are in charge of categorizing, diagnosing, executing and applying regimens to suit client needs (Lega & DePietro, 2005). The jobs created within such an organization are highly

specialized not formalized and tend to be oriented towards stability rather than change (Dickinson & Ham, 2008). The distribution of medical work and the way doctors plan influences or is influenced by other specialized professionals. These factors have created a shift within the physicians dominating role in decision making (Lega & DePietro, 2005).

Multiple professionals, not simply doctors, play key leadership roles within healthcare thereby making leadership dispersed and distributed within departments and specializations. This makes collective decision making an important issue (Dickinson & Ham, 2008). However, it appears that subordinate positions are not thoroughly examined for expertise or skill sets in order to better understand key leadership roles in critical care settings. By tradition, the physican took all the critical decisions and often pursued goals critical to their status as professionals (Lega & DePietro, 2005). That is, in all critical care settings the leader “appears” to be the physician who imposes the necessary procedures.

The background of the problem appears to be a lack of study and clarification between leader and follower roles, typology and the interchange that exists between professionals in an effort to better serve the patient. Instead, there seems to exist multiple levels of expertise: the specialist, the technicians and/or therapists and the nursing staff. Hence, the resulting gap in the literature due to an over-reliance on leader-centrism creates an opportunity to further study the important and critical issue of followership.

In a 2008 study, Dickinson & Ham stated that it is important to have collective decision-making in leaders from professional backgrounds within healthcare that can help to bring forth change. Hospitals are characterized as having strong horizontal linkages and therefore change should be initiated from the bottom-up (followers or subordinates) rather than just from the top down as in a formal authority model (Dickinson & Ham, 2008). Thus, the study of followership within a critical care environment can possibly also prove to be a research environment for developing leadership skills amongst health care professionals in a general context.

Moreover, studying leadership/followership is important as developing a new generation of competent medical leaders can eliminate hospital inefficiency (Dowton, 2004). The hospital is far from being a stable environment and can quickly become even more unstable when a crisis occurs. Therefore, establishing and developing effective leader-follower relations is fundamental to patient care and altruism (Cruess, Johnston, & Cruess, 2002). There is a great deal of autonomy granted to professionals, therefore examining effective followership would be an essential step in leadership studies within the healthcare field.

Often, it is considered that a leader should at times follow and at other times take on the lead role in order for teamwork to be effective (Bennis, 2010). Good

leaders know how and when to follow and they set examples in order to permit others to develop (Kelley, 1988). Moreover, one can suggest that within the health care field the roles of leader and follower are often reversed in order to ensure patient safety, as leadership in healthcare is dispersed on a professional level of expertise/specialty as previously discussed (Leitko & Szczerbacki, 1987). With the above in mind, it is understood that followership remains a somewhat overlooked and understudied phenomena, especially in terms of its importance to patient care.

## 1.2 STATEMENT OF THE PROBLEM

In a 2008 study James Marosis stated that: “leadership is a partnership in reciprocal following”, (Maroosis, 2008, p. 17). And as Adair has stated:

> “followership and leadership can be viewed as two sides of the same coin. The issue is that we have not developed great leaders one follower at a time.” (Adair, 2008)

It appears that followership is in need of leadership as those who follow are not being recognized for their leadership ability.

Within critical care settings the respiratory therapist plays a key role with respect to leadership due to their expertise in cardio-pulmonary and renal care (CSRT,

2010) (Appendix A & B). Their specialized body of knowledge should allow them to transition into more developed leadership roles. In support of a more developed role the Canadian Society of Respiratory Therapy (CSRT) (2010) advocates:

1. A Respiratory and Anesthesia Therapist ("RAT") should be included in every Medical Emergency Team ("MET") due to their critical care knowledge and expertise (CSRT, 2010);

2. Historically, Respiratory Therapists have played a crucial role in critical care delivery within their regular obligations. Moreover, they are knowledgeable in performing this role both within or external to an Intensive Care Unit ("ICU");

3. Respiratory Therapists should be considered as exceptional candidates in providing training to METs as well as to take on leadership roles (CSRT, 2010).

The profession of respiratory care, in which Respiratory and Anesthesia Technologist "RATs" belong, can seemly add insight to followership and fill in existing gaps within the scholarship of healthcare leadership. Most technical health care programs appear to be designed to prepare the student for working as a "subordinate" or "follower" to the leader (read: physician) placing a limitation on their expectations and their perceptions as leaders. It seems that in these positions the characteristics of the follower are the catalyst that enable a transitioning into leadership positions to occur in the first place. As earlier discussed, another factor may be attributed to the hospital being a professional

bureaucracy that by its nature creates power struggles and conflict amongst professionals thus potentially making follower-to-leader transitions difficult.

The respiratory therapist (RAT) is an ideal candidate for leadership roles (CSRT, 2010). However, there appears to be a discrepancy between the RATs suggested role during their studies and the actual role they perform within the organizational setting. Moreover, understanding the RATs self-concept, role recognition and position within the team dynamics may help reveal underlying reasons or precursors for the lack of leadership functions that seems to exist.

The literature on leadership studies has focused mainly on the “physician-leader” (Dowton, 2004). Since followership is a relatively new phenomenon within the academic literature it has been hereto understudied and remains somewhat unknown to most health care professionals. In short, followership is an overlooked and understudied phenomenon, especially in terms of its importance to patient care. The premise of this study is to further develop an understanding of what it means for the respiratory therapist “RAT” to be an effective follower and/or leader within critical care environments.

## 1.3 THE PURPOSE STATEMENT

The relevance of this thesis is to discover to what extent a Respiratory and Anesthesia Technologist ("RAT"), whose position is typically associated as a follower, subscribe to a shared set of beliefs about their general role within critical care environments as considered both by their own cohort group as well as by colleagues who typically assume a leadership role in the group. Research of this type is important to add to the general knowledge in this currently underdeveloped sphere. Further, the study will examine the critical issue that at times a follower may bypass or circumnavigate their leader(s) to reshape a situation under their own considerations.

As reflected within the academic literature it is believed that within critical care environments followers should play a vital role in the leadership process and at times may need to lead the process whereby the person fills the role of leader thus influencing others to achieve common goals (Baker & Gerlowski, 2007). The "others" are followers and their active participation is essential to the process (Baker & Gerlowski, 2007).

## 1.4 THE RESEARCH QUESTION

The aim of the research is to bring increased attention and study to the reciprocal relationship existing between the leader and the follower within the literature. As

mentioned, it is believed that the relationship that exists between followership and leadership is an overlooked and understudied phenomenon especially in terms of its importance to patient care within critical care environments. Thus, the main research question of the thesis has been developed and defined as:

> **The Research Question:**
>
> "What are the constructs, attitudes and beliefs held by Respiratory and Anesthesiologist Therapists (RATs), with respect to their operational, functional and temporal roles in assuming the position of leader or follower within the group dynamics of high stress critical care environments as understood by both their own cohort group as well as colleagues who typically assume a leadership role in the larger group."

## 1.5 THE RESEARCH METHODOLOGY

The thesis research methodology is qualitative by way of a phenomenological research approach in order to be able to isolate the main aspects and influences on followership. The phenomenological methodology is considered most appropriate in order to capture subtle meanings and personally held beliefs and to avoid imposing external thought complexes on participants (Sommer & Simmer, 1991). Study participants are chosen from the field of respiratory

therapy specifically located within the main teaching hospitals and affiliates of the McGill University Health Centers (MUHC), in Montreal, Quebec, Canada, being: The Jewish General Hospital, The Montreal General Hospital, Royal Victoria Hospital and St. Mary's Hospital. The research methodology relies on two separate study methods, namely:

1. Survey Method: Study participants are surveyed on their demographic backgrounds and basic understanding of follower/leader concepts. A sample questionnaire list is provided in Appendix E.

2. Interviews: Study participants undergo a follow-up interview process where underlying concepts and personally held beliefs concerning follower/leadership are unmasked and uncovered. The general strategy for the interviews is to follow a qualitative approach using a semi-structured methodology where broad questions are asked permitting free-flowing responses by interviewees (Sommer & Simmer, 1991).

## 1.6 THE SIGNIFICANCE OF STUDY

The significance of the thesis is to update previous research and development in an attempt to generate the foundational knowledge and understanding for a future working model of followership within the healthcare field.

A successful leader must be a follower at times and must learn to work with others with similar leadership and followership styles(Campbell & Kinion, 1993). This statement is relevant within the present study as healthcare structures require other professionals to work together with similar skills and styles yet differing points of view. Interestingly, within the healthcare field the domain of Nursing appears to have more developmental workshops on leadership and followership than other healthcare domains (Guidera & Gilmore, 1988).

Further, research of this type is important because it will contribute to the continuing legitimization of the respiratory therapy field (RT) and the role and responsibilities of the RAT within leader-follower relations. One of the principal aims of the thesis it to contribute to a better consideration of the RAT's understanding with regards to:

1. The empowerment for them to further explore their talents;
2. The shifting of responsibilities and roles within their expertise;
3. The improvement of their decision-making ability;
4. The promotion of their independent critical thinking, and finally;
5. The level of respect that the profession offers for both new and existing members.

Moreover, carrying out research within health care can advance general leadership research in terms of: its position or place in professional

organizations; gender constraints in leadership; and how professionals interact as leaders and followers. As Gilmartin and D'Aunno state;

> "Health and healthcare are so important in the modern world that advancing knowledge about effective leadership [and followership] in this sector is worthwhile in and of itself." (2007, p. 389)

## 1.7 THEORECTICAL FRAMEWORK

As previously mentioned, the aim of the thesis will be to develop a base understanding of leader-follower exchange, followership style, influences and behaviors within the field of respiratory therapy. The theoretical framework is categorically separated into five paradigms in order to determine specific follower types and examine leader-follower relations:

1. Role Orientation: The research of Jon Howell and Maria Mendez (2008) clarifies the different roles followers play in organizations. Their work will be used to examine how the RAT conceptualizes their role orientation (Figure 2.3.1A). The principle influences behind role orientation are based upon expected work competencies, the communication process and self-expectations.

2. Dimensions: The research of Rodger Adair (2008) distinguishes the types of existing followers found within organizations. Adair's work will be used in identifying the RAT's perceptions of their organization using what is called the 4-D Followership Model (Figure 2.3.2A). Adair's model attempts to link emotional content about current job position along with how the follower expresses particular behaviors within their organization.

3. Empowerment: The research of Ira Chaleff (2009) brings forth new insight as to the role followers can assume in relation to the organization. Chaleff developed a matrix comprised of four styles based on empowering the follower to support and challenge leader behaviors and polices (Figure 2.3.3A). Chaleff's work will be used to examine how empowered the RAT feels in critical care environments and the model will explore the various elements that may deter them from being or becoming empowered.

4. Followership Styles: The research of Robert Kelley (1988) explains follower behavioral characteristics that may be found within the organization. Kelley's work explores the different styles of followership to examine whether followers may be considered dependent or independent thinkers as well as examining their level of contribution to the organization.

5. IFM-The Interactional Framework Model: Rich Hughes et al (2006) is credited with designing the IFM-Interactional Framework Model for

analyzing leadership (Figure 2.3.6A). Hughes et al explore the importance followers have within the leader-follower relationships with respect to the situation at hand. This will be used to study the RAT's work relations to other followers and those who hold leadership positions. Though the Interactional Framework Model permits an examination of varying situations the thesis research will keep the situational variable constant, namely: critical care environments.

## 1.8 NATURE OF RESEARCH

The overall goal of the research is to profile followership in respiratory therapy by examining characteristics, behaviors and types working in critical care settings. The aim is to examine how leadership or followership roles, styles, influences and behaviors in critical care environments are important in enabling respiratory therapists to perform their roles. This thesis aims to be instrumental in understanding how to develop effective followership and enable role assumption to shift from leader to follower. As well, the essential factors that influence respiratory therapist articulation and effectiveness to achieve optimal staff performance and patient care outcomes will be examined.

## 1.9 DEFINITIONS

The author has provided definitions of the key terminology used throughout the thesis to ensure a general framework for clarification.

**Leader:** a role in which a person assumes primary authority, guides, commands, directs and supports the activities of another or other, who are commonly called followers, to achieve goals held in common with the leaders or organization (Baker & Gerlowski, 2007).

**Leadership:** is a process, not a person and is also a property. The property is a set of characteristics attributed to those who are perceived to use such influence successfully (Baker & Gerlowski, 2007).

**Follower:** An active participative role in which a person supports the teachings or views of a leader and consciously and deliberately works towards goals held in common with the leader or organization (Baker & Gerlowski, 2007).

**Followership:** a process by which a person fills the role of follower, supporting the view of a leader and consciously and deliberately working toward a common goal shared with the leader or organization (Baker & Gerlowski, 2007).

## 1.10 LIMITATIONS AND DELIMITATIONS OF THE STUDY

There are many factors that influence the leadership process and its elements. This may be the reason behind why broad generalizations about leadership are so problematic. Time constraints with respect to fieldwork may disrupt the data collection process. The shortage in staff by the selected target population may present some difficulties in data collection. Participants' schedules are not flexible and participants are often called to perform overtime or to remain on duty on an ad hoc basis. This may result in rescheduling and prolongation of the study. Based on the participants work week and levels of fatigue there are bound to be aspects of leadership practice, organizational culture and team communication that will not be revealed during the questionnaire. Moreover, study-group members may feel the need to be guarded in their conversations and actions, especially when participating in the initial stages of the research.

**Delimitations:** Choosing to observe multiple team members will allow more depth of understanding. Additionally, structured interviews will be used in order to minimize the obtrusiveness and influence of the researcher on the team members as well as to eliminate the researcher bias resulting from having worked many years within this field.

## 1.11 ASSUMPTIONS

There are two main assumptions that shape the conduct of this research:

A. Effective followership is a basis for leadership. Effective followers should be able to fulfill particular leadership roles based on “readiness”, capabilities and particular crossover in competencies. Following is equivalently important to leading as we spent most of our time following rather than leading. At times, we must follow before leading particular tasks in our given specializations. This should be done to bring forth balance between individual strengths and weaknesses.

B. Leadership is related to followership. Leadership can be taught to those who follow thereby increasing leadership abilities; followership is essentially a learning function of leadership. Rather, than constantly differentiating between the two concepts they should be viewed as parallel phenomenon. Followership should complement and support the leadership process and vice versa.

## 1.12 SUMMARY OF CHAPTER ONE

As illustrated thus far, the study of followership is an underdeveloped area of research. Further, based on a thorough investigation of the literature and to the knowledge of the author, such a study has not been conducted within subordinate roles such as respiratory therapy. In general, unlike leadership, there has not been extensive research in followership and its link to subordinate positions. The nature of the study is to explore followership within a critical care environment by examining the role that the respiratory therapist plays. It should be noted that there still exists a great deal of uncertainty in the study of followership and its importance within the healthcare setting. This study highlights the aspects or forces that are inherent in the subordinate position of Respiratory Therapy and sheds further light on the new scholarship of followership as it pertains to critical care.

The study aims to build an understanding that can be used for future frameworks to investigate current knowledge and to develop the mind-set for leader-follower relations. Furthermore, it explores whether other subordinates can view a subordinate colleague as a leader. Lastly, a supplemental aim of the thesis is to develop a content dictionary of key terms with respect to follower/leadership used by the participants and their applications within critical care settings.

The thesis achieves the above through a careful analysis and linking of both praxis and theory. Practical application of the seminal theories as observed in a critical care operational setting is obtained through the fieldwork analysis as presented in Chapters Three and Four. However, before doing so major seminal authors are studied in order to evaluate the state of the art of follower/leadership theory. These authors are covered in detail within the Literature Review of Chapter Two. The findings of the field work analysis and the application of the seminal theories covered within the Literature Review will be compared and contrasted within Chapter Five to provide a synthesis of insight with respect to responding to the research question as earlier identified.

# CHAPTER TWO

# LITERATURE REVIEW

# CHAPTER TWO - LITERATURE REVIEW

## 2.1 OVERVIEW

The aim of the thesis is to develop a foundation of leader-follower exchange, followership style, influences and behaviors within the field of respiratory therapy. The thesis is grounded in the scholarly literature of the seminal writers within the discipline of “followership” and “leadership” studies. The literature review section presents a general overview of what the literature of the domain reveals with respects to elucidating the research question. General themes covered within the seminal literature revolve around the topics of:

1. The historical component to leadership theory;
2. The interaction between Leaders and Followers;
3. The question as to what constitutes followership;
4. The four common followership paradigms and related typologies;
5. The changing role of followers within organizations.

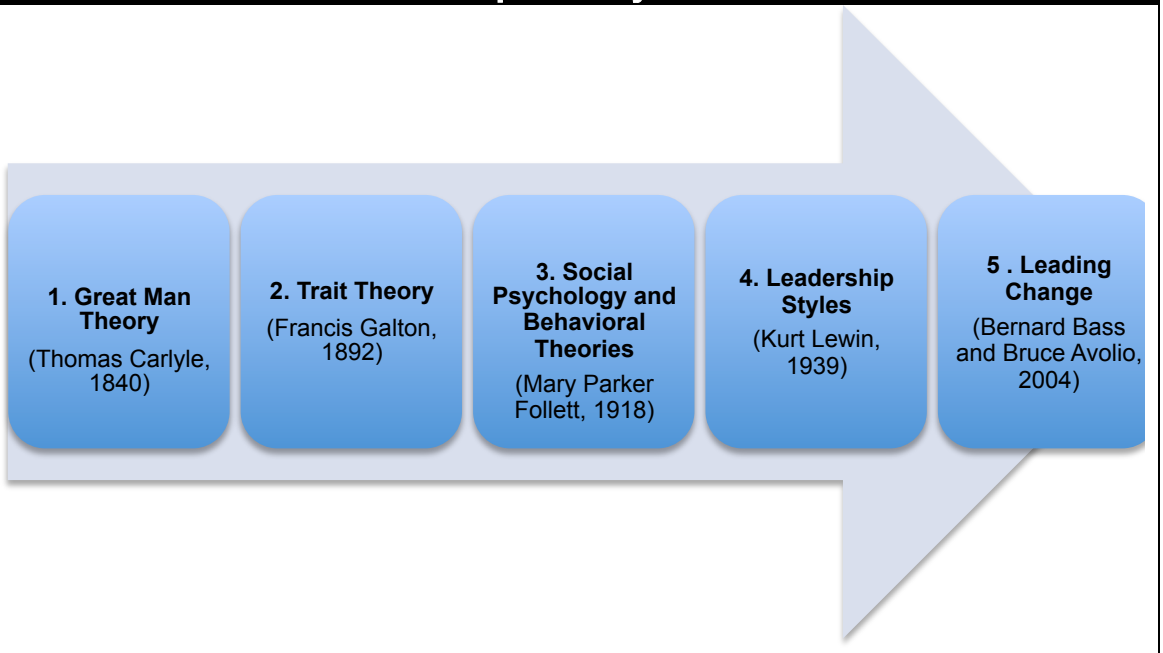
Important authors that are routinely referenced within the above themes include: Thomas Carlyle, Francis Galton, Mary Parker Follett, Rich Hughes, Fred Fielder, Kenneth Blanchard, Paul Hershey, Robert House, Terance Mitchell, Victor Vroom, Phillips Yetton, Ira Chaleff and Robert Kelley. The work of these authors and others will be instrumental in providing an extensive examination of the

above-mentioned themes while defining the process and role of the leader or follower within the position of Respiratory Therapist.

## 2.1.1 LEADERSHIP TIMELINE

Over one hundred years have been devoted to the study of leaders and leadership theory. The Leadership Theory Timeline (Table 2.1.1A) is a portrayal of the evolution of leadership theory and practice. More so, it recognizes the essential theorists who have made a significant contribution in shaping modern leadership thought and concepts.

**Table 2.1.1 A**
**Leadership Theory Timeline**




Source: Donald Oxford York, 2010

## 2.2 LEADERSHIP STUDIES

Researchers have for decades investigated leadership skills and its acquisition from a variety of perspectives. The sections that follow will provide a review of leadership from the following perspectives: historical, social-psychological, behavioral theories, leadership styles as well as the main theoretical models most often referenced.

### 2.2.1 HISTORICAL PERSPECTIVE

The origins of leadership theories began with the great person or great man theory. The theory suggested that leaders were born not made (Alcock, Carment, Sadava, Collins, & Green, 1997). It was believed that great leaders would arise when there was a great need. In 1840, Thomas Carlyle lectured on the theories of great men in leadership. In his book “On Heroes, Hero-worship and the Heroic in History”, he studied leadership characteristics within aristocratic society and those in positions of authority to generate characteristics of leaders (Carlyle, 1840). Great man theory was based on the notions that leaders are born not made (Alcock, Carment, Sadava, Collins, & Green, 1997). The great man theory states that leaders are born with specific characteristics that account for their ability to lead. During periods of crisis a great man (a leader) would emerge to solve the issues at hand (Carlyle, 1840).

Carlyle viewed Heroes as great men who assumed positions of leadership (Carlyle, 1840). Carlyle's work classified theses great men into four categories of distinction from regular men:

1. Divinity
2. Kings
3. Priests, and
4. Men of Letters (Intellectuals).

Carlyle writes that it is always profitable to be within the presence of great men as their knowledge and work ethic is of valuable experience. He viewed heroes as divine individuals who have an internal luminance about their character that can brighten the most grimace times (Carlyle, 1840). Leaders (heroes) possessed the following characteristics:

**Table 2.2.1A**
**Carlyle Great Man Leader Characteristics**
**(Circa 1840)**

| | | |
|---|---|---|
| Heroic Nobleness | Nobleness | Loyalty |
| Charisma | Strong Faith | Truthfulness |
| Sincerity | Great Appreciation For Existence | |

Source: (Carlyle, 1840)

A hero was also in positions of authority, attracted others through speech, worshipped in their fellowmen and they used power to influence and make history. A leader's ability to think as well as their education came about from life

experiences (Carlyle, 1840). Moreover, the study of great men was essential to developing one's own inner hero.

Francis Galton shifted the research towards genetics and hereditary factors involved in leadership (Alcock, Carment, Sadava, Collins, & Green, 1997). Galton's work attempted to explain that all leadership abilities are derived from inheritance (Alcock, Carment, Sadava, Collins, & Green, 1997). Galton's was one of the first to place a statistical analysis on great men thereby embracing many aspects of human variation in leaders (Galton, 1892). His work compared the various traits shown below.

**Table 2.2.1 B**
**Galton Trait Theory Analysis Factors**
**(Circa 1892)**

| | | |
|---|---|---|
| Race | Intelligence | Age |
| Personality | Self-Confidence | Height |
| Weight | Fingerprint Patterns | Talkativeness |

Source: (Galton, 1892)

Galton discovered as well that great men have remarkable mothers and that they are largely indebted to maternal influences (Galton, 1892). Hence, the generation of the nature versus nurtures contextual application to leadership development

(Galton, 1892). Great men were seen to have high morals and have an affectionate character.

### 2.2.2 SOCIAL PSYCHOLOGY AND BEHAVIORAL THEORIES OF LEADERSHIP

The twentieth century brought forth a social psychology perspective to leadership studies. Mary Parker Follett's (1918) manuscript on "The New State" merged various theories found in social psychology to examine qualities of effective leaders. Follett's theories showed leadership was a reciprocal process between leading and following. Follett's work emphasized group psychodynamics. A leader must guide their group (followers) and the group must guide their leaders (Follett, 1918). Follett classified three types of leaders:

1. Actual Leader
2. Official Leaders, and
3. Genuine (or real) Leaders.

An actual leader was one who occupied positions as boss, official leaders were servants of the people (Follett, 1918). Both were considered to be wrong types. A genuine (real) leader is chosen by the people to lead freedom and equality (Follett, 1918). Follett's philosophy was based on the idea that leadership cannot be studied nor could accurate statements be made unless group psychology was explored. The understanding that social psychology is instrumental in understanding the interaction of groups and power within leadership studies was crucial in her work. Mary Parker Follet's influence with group psychology

continued in the work of James Alcock who focused attention on the use of power.

According to James Alcock et al (1997) a group is two or more people who influence each other, share common goals, an ongoing relationship and who believe they belong to the group. Within each group there is a distribution of power and selected members may have more than others (Alcock, Carment, Sadava, Collins, & Green, 1997). Power creates the ability to influence groups to comply or follow. A person in power or a powerful person may use more than one of these to influence others. Table 2.2A reviews the different types of power that Alcock et al focused upon:

| **Table 2.2.2 A<br>Alcock et al.<br>Types of Power in Group Dynamics** | |
|---|---|
| **Reward Power** | Compliance carried forth due to reward |
| **Coercive Power** | Compliance influenced by threat |
| **Legitimate Power** | Authority figures exercising their duties backed by coercive power |
| **Expert Power** | Individuals with specialized and important knowledge |
| **Informational Power** | Those who provide or withhold information |
| **Referent Power** | Obedience fulfilled due to the fact people wish to be like those holding power |
| **Reciprocal Power** | Based on the personal desire to gain or return support |
| Source: (Alcock, Carment, Sadava, Collins, & Green, 1997) | |

The leader is associated with being the most influential and powerful. Follett coined the term “vital leadership” as being structured when a man steps into the position. The one who emerges as leader has vision, perseverance and power to guide and elicit group action (Follett, 1918). The designated leader must also have the ability to trace the causal effect of each problem but more so to see the relative value to each of his followers (Follett, 1918). In other words, the leader must take note of how their vision will aid the needs of the followers as well as the situation. A leader must assess the situation and draw out all the varying needs of the followers’ experiences then relate it within the treatment of the problem (Follett, 1918).

A skillful leader should not have an authoritative style but stimulate what is best in their followers and empower them (Follett, 1918). The role of the leader must be to keep them working towards the vision and to guide and reshape aspects of the problem as time moves forward (Follett, 1918). A leader must continually maintain follower motivation. The power of interaction and the feeling of interconnectedness equals the power of leadership, as it solidifies group dynamics (Follett, 1918). Follett (1918) early within her research realized the importance of emotional intelligence within leadership and the dynamics existing between the leader, the follower and the situation. A crowd leader dominates through formulating vague generalizations and uses the power of suggestion to manipulate the followers. Follett was strong in her belief that society will bring

out leadership through group organization then the emergence of heroes and leaders will arise (Follett, 1918).

### 2.2.3 LEADERSHIP STYLES AND THEORECTICAL MODELS

In 1939, Kurt Lewin conducted experiments and came up with three styles of leadership:

1. Autocratic (Authoritative)
2. Democratic (Participative)
3. Laissez-faire.

An autocratic leadership style increased productivity during high stress situations where the leader takes all of the decisions (Alcock, Carment, Sadava, Collins, & Green, 1997). Whereas a democratic leadership style explored self-satisfaction of the group members as they were all involved in the decision making process (Alcock, Carment, Sadava, Collins, & Green, 1997). In the Laissez-faire style, the leader allows others to decide on the decisions to be taken. Research concluded shows that no one leadership style is likely to be effective in all situations thereby highlighting the importance of the situational theories as a key factor in style (Alcock, Carment, Sadava, Collins, & Green, 1997).

In the 1960's and 1970's, contingency theory or approach emphasized that the leader's reaction depends on the nature of the task and the environment (Anaconca, Kochan, Scully, Maanen, & Westney, 2005). The four contingency theories are:

1. Contingency Model
2. Normative Decision Model (NDM)
3. Situational Leadership Theory (SLT)
4. Path-Goal Theory (PGT)

Fred Fiedler is one of the leading researchers who assisted in shifting leadership studies towards leadership style and behaviors. Contingency theory emphasized that leadership style must be matched to a particular group situation in order for leadership to be successful (Alcock, Carment, Sadava, Collins, & Green, 1997). The Fielder contingency model suggested that leader effectiveness depended on both style and favorability of the situation (Hughes, Ginnett, & Curphy, 2006). In other words, a leader may be better in one context but less effective in another.

Fiedler designed an instrument called the Least-Preferred-Coworker scale (LPC) to identify leadership style based on attitudes expressed about a coworker. The score specified something about the leader and not whom the leader evaluated. In his theory there exists two categories of leaders:

- Task Oriented Leader (Low-LPC leaders)
- Socio Emotional Leader (High-LPC).

The low-LPC leader motivation refers to getting the task done while often ignoring the needs of the followers (Alcock, Carment, Sadava, Collins, & Green, 1997). The high-LPC leader are motivated by relationship they have with their followers rather than maximizing efficiency (Alcock, Carment, Sadava, Collins, &

Green, 1997). Fielder stated that the style of leadership is based on situational control. The level of control a leader can exert depends on the level of trust, how structured the task is and the amount of power the leader possesses. His model assumes that the effectiveness of either of these styles is contingent upon the requirements of the given situation.

In 1973, research by Victor Vroom and Philip W. Yetton designed the normative decision model to improve some aspects of leadership effectiveness (Vroom & Yetton, 1973). The model explored how the interaction between the leader, follower and situation influenced the subordinate's participation in the decision-making process and group performance (Vroom & Yetton, 1973). They examined the theory of the leader's decision-making process within-group settings.

Decision-making involved three processes:

- Autocratic Process (A1, A2)
- Consultative Process (C1, C2)
- Group Process (G2) (Table 2).

The levels of participation in the normative decision making model were as follows (Hughes, Ginnett, & Curphy, 2006):

| Table 2.2.3A<br>Vroom & Yetton (1973)<br>Levels of Participation<br>Normative Decision Making Model | |
|---|---|
| A1 | Leader uses all known information and then makes decision alone. |
| A2 | Leader gathers all information from followers, and then makes decision alone. |
| C1 | Leader shares problem with relevant followers individually, listens to ideas and then decides alone not necessarily reflecting the followers' influences. |
| C2 | Leader shares problem with followers as a group, listens to ideas and then decides alone not necessarily reflecting the followers' influences. |
| G2 | Leader shares problems with followers as a group and then together generates and accepts consensus agreement. |
| Source: (Hughes, Ginnett, & Curphy, 2006) | |

In the normative decision making process leader effectiveness is difficult to measure due to the fact that the model does not address the values, attitudes, personality or motivations of the leaders, which all have an influence upon their decision-making. The leader must be skilled within all five decision-making processes in order to use all the procedures and be adaptable to the situation (Vroom & Yetton, 1973). Making good decisions is not enough to be considered an effective leader. In the decision making process the situation and to a large extent the follower's information is influential (Hughes, Ginnett, & Curphy, 2006).

In the late 1960's through the 1970's, the situational approach concluded that different situations create or call for different types of leaders (Anaconca, Kochan, Scully, Maanen, & Westney, 2005). Studies by Kenneth Blanchard and Paul Hershey (1968) were essential to the structure of this theory. The situational leadership theory states that a leader who is more effective bases their behavior on their follower's development (Blanchard & Hershey, 1968). The two leadership categories of leader behaviors are task and relationship. They are described below:

**Table 2.2.3 B**
**Situational Leadership Theory**
**Leadership Categories**

| | |
|---|---|
| Task Behavior | Involves the leader solely dictating the responsibilities (what, how, when and who does it) of the group. |
| Relationship Behavior | Involves two-way communication with their followers: listening, encouraging, being supportive, clarifying, elucidating importance, facilitating and giving support. |

Source: (Blanchard & Hershey, 1968) and (Hughes, Ginnett, & Curphy, 2006)

The situational approach appeared to be more superior to the other theories that assume one leader would be good for in all situations (Hughes, Ginnett, & Curphy, 2006). However, it was limited in that it excluded such variables as: style of leadership that may be related to personal traits; and the reactions of followers (Hughes, Ginnett, & Curphy, 2006). Leaders influence their followers but followers also influence their leaders. To be successful an individual leader must

be in tune with the expectations and needs of the followers. Thus, being successful in leadership is a combination of the right leader and right situation.

As well the theory does not take into account that situations and different traits alone did not accurately predict leadership effectiveness. Thus, researchers shifted to personal behavior theories (Anaconca, Kochan, Scully, Maanen, & Westney, 2005). This shift moved the focus to what a leader really does. Leadership effectiveness is influenced by how readily a follower may complete a task. Robert Hughes terms this “follower readiness”, which refers to a follower’s ability and willingness to complete a particular task. Follower readiness is the key contingency factor (Hughes, Ginnett, & Curphy, 2006).

Robert House and Terence Mitchell (1971) gave rise to the PGT-Path Goal Theory. Path Goal Theory aims to study how the leader supports and motivates their followers to achieve goals. The leader’s approach depends on the particular situation faced, the follower’s motivation, the difficulty of the task and the capability of the follower. House and Mitchell describe four leadership styles shown below.

The path goal theory had two follower variables, one based on satisfaction and the other on the view of their own abilities. A follower would support a leader’s behavior based on their level of satisfaction or on their willingness to also take a

leading role in order to see if would be accepted (Hughes, Ginnett, & Curphy, 2006).

| Table 2.2.3 C<br>House & Michell - Path Goal Theory (1971)<br>Leadership Styles | |
|---|---|
| Supportive Leadership | Is similar to relationship behaviors in situation leadership theory. |
| Directive Leadership | Is similar to task behaviors from situational leadership theory. |
| Participative Leadership | Is based on advice giving and involvement of the group within the decision-making process. The level of participation will depend on the type of decision to be made. |
| Achievement Oriented Leadership | Is based on carrying forth demands and being supportive with their followers. The leader sets very high goals or challenges for the followers then provides continual support to empower and maintain confidence in the task. |
| Source: (House & Mitchell, 1971) | |

Thus, leader directives would not motivate a follower especially if they felt confident in their abilities and skills of performing the task. Within the Path Goal Theory it shows how situational and follower characteristics can impact the leader's attitudes and behaviors but also shows that the follower and situational variables can affect each other. By using Path Goal Theory the situation can be

examined to assess the appropriate leadership behavior to meet the demands at hand (Hughes, Ginnett, & Curphy, 2006).

## 2.3 LEADING CHANGE

Leadership research over the past 30 years has helped develop the understanding of the concept of the "leader-follower" as well as the importance of the situation. In the 1980's and 1990's, leadership research placed emphasis on leading change as many new challenges were being addressed due to technology, globalization, and shifts in the economy (Jung & Avolio, 1999). Hence, this shifted development towards charismatic, transactional and transformational leadership. An example of a charismatic leader who was popular during this time of economic change was Lee Iacocca the maverick that turned around the ailing Chrysler corporation and subsequently developed his own leadership theory called the 9 C's of leadership[1]. His vision and personal charisma was at the heart of both his personal success and the resultant success of the company.

### 2.3.1 THE CHARISMATIC LEADER

Max Weber defines charismatic leadership as:

[1] The 9 C's of Leadership by Lee Iacocca include: Curiosity, Creativity, Communication, Character, Courage, Conviction, Charisma, Competence and Common Sense. Source: http://www.leeiacocca.net/scorecard/scorecard.pdf

> "resting on devotion to the exceptional sanctity, heroism or exemplary character of an individual person and of the normative patterns or order revealed or ordained by him" (Weber, 1920, para.1).

The charismatic leader is likely to emerge during periods of crisis or uncertainty. This thought contains reflections of the great man theory of leaders (Anaconca, Kochan, Scully, Maanen, & Westney, 2005). Charisma is an exceptional gift and quality within an individual that allows them to attract a considerable number of followers (Alcock, Carment, Sadava, Collins, & Green, 1997).

**Table 2.3.1A**
**Conger (1989)**
**Four Step Approach To Leadership**

| | |
|---|---|
| 1. Assessment | Continual assessment of the environment and formulating a vision. |
| 2. Communication | Communicating a vision, using motivational and persuasive arguments. |
| 3. Trust | Building trust and commitment. Subordinates must desire and support the goals of the leader and this is likely to be accomplished by more than coercion; rather the leader builds trust in the leader and the viability of the goals; this is likely to be done through personal risk taking, unconventional expertise, and self-sacrifice. |
| 4. Vision | Achieving the vision. Using role modeling, empowerment, and unconventional tasks. |

Source: (Conger, 1989)

The charismatic leader demonstrates a high level of self-confidence, is influential, has a compelling vision, original, communicates well, creates change within the status quo, is able to captivate followers and ignites emotions (Alcock, Carment, Sadava, Collins, & Green, 1997). The charismatic leadership is characterized by a strong interpersonal relationship among leaders and followers (Howell & Shamir, 2005). The follower is enthused to conformity, allegiance, commitment and devotion (Alcock, Carment, Sadava, Collins, & Green, 1997). Jay Conger (1989) established four steps within the charismatic leadership process as shown above in Table 2.3.1 A.

The research of Bernard Bass and Bruce Avolio (2004) focused on what was called the full range leadership styles. Their research focused on two categories of leaders: the “transactional” leader and “transformational” leader.

## 2.3.2 THE TRANSACTIONAL LEADER

The transactional leader reaches desired outcomes by recognizing the roles, tasks and needs of the follower (Bass & Avolio, 2004). Transactional leaders “display behaviors associated with constructive and corrective transaction”, (Bass & Avolio, 2003, p. 6). The transactional leader builds confidence, motivates, stimulates desire, specifying the compensation and rewards, that will lead the satisfied follower to expend the energy required by the tasks (Bass & Avolio, 2004).

Transactional leadership in its active or passive form focuses in on identification of mistakes; in its constructive form such a leader works closely with the follower setting up and defining agreements, discovering an individual's abilities and capabilities and specifying the compensation and rewards that will be granted for successful completion of the tasks.

**Table 2.3.2A**
**Bass & Avolio (2004)**
**Transactional Leadership Behaviors**

| | |
|---|---|
| Contingent Reward | CR is based on offering recognition when goals and objectives have been meet.<br><br>Provide others with assistance in exchange for efforts, specific about who is responsible for achieving performance targets, clarifies the rewards when goals are achieved. And expresses satisfaction when expectations are meet. |
| Management By Exception (Active) | MBE is based on specifying the standards for compliance and closely monitoring deviance. Focuses all attention on irregularities, deviation, exceptions and keeps track of mistakes and directs attention to failure to meet standards. |
| (Passive/ Avoidant) | Passive–avoidant behavior from the leader is similar to "no leadership" or laissez-faire leadership style.<br><br>a. **Management-by-Exception: Passive (MBEP)-**interferes only when problems are deemed as serious, when things are wrong only then action is taken and waits for problems to become chronic.<br>b. **Laissez-Faire (LF)-**avoids getting involved for important issues, absent when needed, avoids decision-making, delayed response when dealing with urgent questions**.** |

Source: (Bass & Avolio, 2003).

Form closely monitors for occurrences in mistakes, in its passive form waiting for mistakes to occur before taking action. In its corrective form, it focuses on actively setting standards (Bass & Avolio, 2004). Transactional leadership is associated with two core behaviors as shown in Table 2.3.2A.

## 2.3.3 THE TRANSFORMATIONAL LEADER

The Transformational Leader influences their followers and associate's awareness during a change process to better see themselves, the new opportunities and challenges (Bass & Avolio, 2003).

> "A 'transformational leader' articulates a shared vision of the future, intellectually stimulates subordinates, provides a great deal of support …[,] recognizes individual differences and sets high expectations", (Kirkman, Chen, Farh, Chen, & Lowe, 2009, pp. 744-745).

The transformational leader aims to optimize followers, groups and organizational development and innovation (Bass & Avolio, 2003). Also, transformational leaders are proactive and increase the amount of potential, morals and ethical standards within their followers. Transformational leaders tend to be trusted, admired, respected and wish to be emulated by their followers. The leader's credibility is established based on their considerate behavior of attending to the follower's needs instead of their own. Also, they share risks with followers and

consistently promote values, ethics and principles. Their idealized influence falls into five main categories, as shown below.

| Table 2.3.3A<br>Bass & Avolio (2003)<br>Transformational Leadership<br>Idealized Influence - Attributes and Behaviors | |
|---|---|
| IA - Idealized Attributes | Instill pride, goes beyond self-interest, builds respect and displays a sense of power and confidence. |
| IB - Idealized Behaviors | Values, beliefs, importance of having a strong sense of purpose, moral and ethical consequences of decisions and emphasizes the importance of the collective mission. |
| IM - Inspirational Motivation | Optimistic about the future, compelling vision of future, confidence in achieving goals and very enthusiastic about accomplished goals. |
| IS - Intellectual Stimulation | Getting others to look at problems from a different angle, seeking different perspectives when solving problems, re-examine critical assumptions to test appropriateness. |
| IC - Individual Consideration | Spends time coaching, developing other's strength and teaching; treats people as individuals having different needs, abilities and aspirations. |
| Source: (Bass & Avolio, 2003) | |

## 2.4 CRITIQUE OF LEADERSHIP THEORY

The field of leadership theory has generally failed to show an unambiguous distinction in character between those who follow versus those who lead. In reference to Joesph Rost, “Many scholars have studied leaders and leadership over the years, but there still is no clear idea of what 'leadership' is or who leaders are”, (1993, p. 13). Over the last 100 years, leadership research has not produced a comprehensible theory to explain why the separation exists between the concepts of leadership and followership. (Rost, 1993).

Craig Pearce and Jay Conger state, “ [Leadership theory] lags seriously behind…[due to its]…singular focus on the conception of an individual leader to the neglect of distributed forms of leadership”, (Pearce & Conger, 2003). Thus far, leadership research has shown that leaders are designated authority figures selected through hierarchy (Pearce & Conger, 2003). The subsequent section critiques leadership theories and highlights the gaps within the current literature (Table 2.4 A).

**Figure 2.4A**
**Leadership Theory Wheel**


Source: Donald Oxford York, 2010

A. Great Man Theory Critique:

This theory is biased due to the fact that only those who are in positions of leadership or authority are examined for their abilities. Leader centrism is created instantaneously as there is no consideration for those in subordinate positions nor is there consideration of their ability to lead. Moreover, another bias within great man theory is that during this scholarship era only the educated and aristocratic were considered to have leadership abilities.

Hence, nineteenth century social scientist, Hebert Spencer, refuted the great man theories of Thomas Carlyle. Spencer claimed that it lacked scientific evidence, was only hearsay and was too generalized (Spencer, 1896). According to Spencer, Carlyle focused too much on the actions of great men (Spencer, 1896). This in turn did not lead to specification of leader characteristics nor the meaning behind the theory (Spencer, 1896).

The Great Man theory did not address gender issues or leadership process and development (Alcock, Carment, Sadava, Collins, & Green, 1997). Also, it focused mainly on men who were already in positions of leadership thereby narrowing its views (Alcock, Carment, Sadava, Collins, & Green, 1997). In addition, The Great Man theory does not make inquiries on those who rose to leadership positions from lower socioeconomic status. Furthermore, the concept of followership is missing from great man theory. Every leader has a particular journey or experience prior to filling a leading role. One can postulate that leaders are not born this way but are prepared for the role they play. Leaders can be born into power positions that put them next in line to lead but that in and of itself does not clearly state or create their effectiveness.

B. Trait Theory Critique:

Trait theories suggest that leaders can be made through a combination of genetics and hereditary factors. Every living entity is biologically made up of

particular genes based on heredity which in turn implies that leadership ability exists not only in leaders. Once more, those individuals studied were already within positions of authority. Trait theory is not specific only to leaders. Instead, it is a generalization that is related to all persons. Society and groups may prefer individuals with particular traits to assume leadership positions however one can argue that they most likely cannot be found through an investigation into genes and heredity. Conversely, we can make a case that personal characteristics are most likely also to some extent learned and shaped by environmental and cultural imperatives as well as the psychological state of the actor intermingled with the surrounding group. Therefore, we arrive at the premise or viewpoint that leadership cannot be solely based on traits alone. Unfortunately, a thorough discussion of the above revolves around the timeless argument of nature versus nurture and the ability to thoroughly examine this issue would go far beyond the scope of the present thesis and is therefore left for further analysis for later research.

Moreover, it appears that those in subordinate positions were not given the chance to disprove trait theory. Galton's trait theory applied to great men who were in positions of authority or royalty (Alcock, Carment, Sadava, Collins, & Green, 1997). Trait theory has failed to isolate qualities that are specific to those who lead. The extensive list of traits can be both found in those who lead and follow suggesting that leadership can be done by anyone. Trait theory does not

explain why some individuals might possess similar traits yet not all be placed in positions of leadership.

Trait theory has identified a number of endless potentially significant traits but has not established which of these traits best predicts how effective a leader would be (Anaconca, Kochan, Scully, Maanen, & Westney, 2005). Another issue with trait theory is based on the fact that it does not take into account how different situations effect leadership and the resultant type of leader that is needed (Hughes, Ginnett, & Curphy, 2006).

C. Social Psychology and Behavioral Theory Critique:

Social psychology theories present the importance of group dynamics and individual's influence in selecting a leader. Social theories bring forth the existing reciprocity between the leader and follower. During periods of crisis a leader may emerge from the group but that does not mean by definition that they can carry forth or attend to the needs of the people. Leadership has come to be presented as an interchangeable process and is controlled through groups. The social theories, such as: group psychodynamics (Mary Parker Follett) and social psychology theories of power (Jim Alcock), show that groups are attracted to a particular leadership type or style and that followers play a key role in the leadership process.

Leadership behavioral theories are seen to focus only upon the leader's actions and not their personality, internal state or mentality. Behavioral theories seem to miss answers to the following:

- How does society and the environment affect leader behavior and style?
- How did the follower influence the leader's behavior and vice versa?

Behavioral theories do not address the performance of those who follow or the possible styles that may exist within their own leadership abilities.

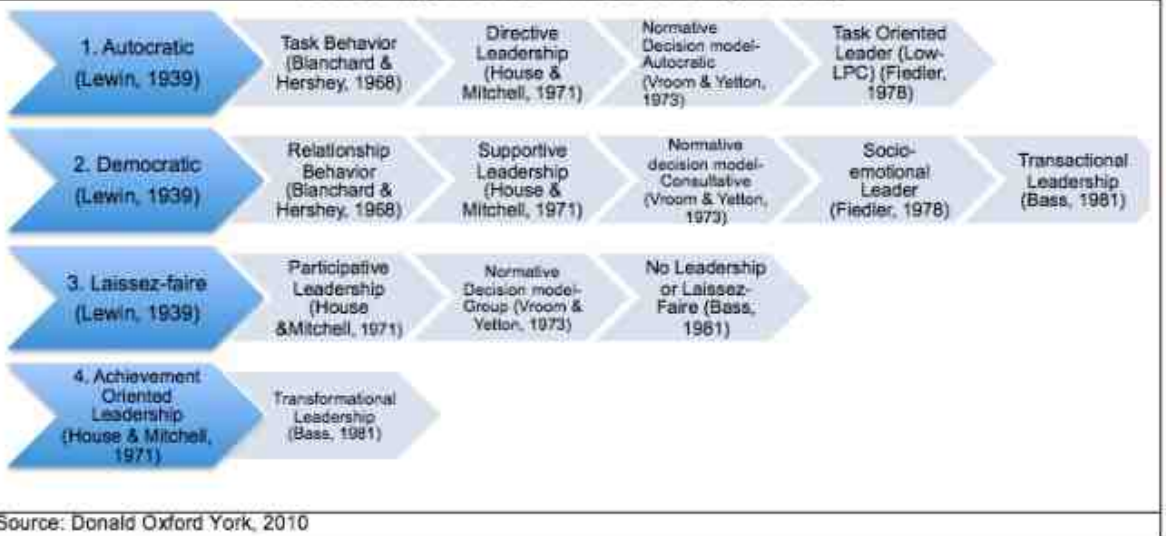
The concept of behaviorism is rooted within behavioral theories of leadership. Behaviorism positions itself on the belief that all behaviors are acquired through conditioning influenced by environmental interactions (William, 2004). Science has shown that behaviors can be created, shaped and learned. This fact suggests that those who follow can lead when placed into the correct condition and situation.

D. Leadership Style Critique:

Leadership styles are perhaps the most ample area of research but are greatly repetitive. The domain of leadership styles has generally failed to generate new or unique theory but instead is seen to have regurgitated and relabeled old

themes. Table 2.4 B displays the reoccurring themes in leadership style and the presentation of their new label across time.

**Figure 2.4B**
**Revolving Themes in Leadership Theory**




Source: Donald Oxford York, 2010

After a considered analysis of leadership style it can be shown that there are four main or principal approaches as shown below. Leadership styles lack research in the areas of internal and external factors (personal and organizational) influencing the leadership environment.

| TABLE 2.4C<br>Principal Leadership Styles | |
|---|---|
| Autocratic | The leader is the final decision maker and does not take input from their group or subordinates. |
| Democratic | The leader gets input from group then makes the final decision on their own. |
| Laissez-Faire | The leader presents issue(s) and a collective agreement is made on how to resolve the task. |
| Achievement Oriented Leadership | The leader achieves the group's goals or prepares members for change by using techniques of empowerment, motivation and support. |
| Source: Donald Oxford York, 2010 | |

E. Leading Change Critique:

The premises of such theories may need to be reevaluated as they assume that the leader is correct about their vision and need for change. More so, if the follower believes the leader to be right, it does not mean the leader is actually right.

Transformational and transactional leadership assume that people will follow those who inspire them but in actual fact people may have their own agendas

and work against the leader in some covert manner. The underlying focus within the literature that leaders have a vision and passion to achieve great things may undermine the coinciding fact that followers may also possess the same focus and characteristics. Followers may be the ones: leading change, being creative, having visions and being essential to the leadership process. Followers may be looked upon as change strategists and implementers in their own right and thereby demonstrate their own ability to lead or put forth their own agendas.

The outcome of transformational leadership should transform the follower due to the nature of the process however there seems to be a lack of research on the reverse mechanism, namely: how the follower transforms the leader. Anecdotally, one can say that transformational leaders are not always successful and do not always achieve greatness. Otherwise said, for every Lee Iacoca of Chrysler fame there are a host of unsuccessful transformational leaders. Examples of leaders who could not transform their company include:

1. In 2009, Akio Toyoda, Toyota president, undermined the serious safety risks, product issues and problems involved within their vehicles. This lead to “disingenuous quasi-apologies and disjointed plans” for resolving the crisis (George, 2010). To control the firestorm, unknown mid-level managers were laid off (George, 2010). According to William George, “Toyota can only regain it’s footing by transforming itself from top to bottom to deliver the highest quality automobiles” (2010, para. 3).

2. In 2001, Jeffrey Skilling became CEO of Enron's new trading operations. Before 1997, Enron was a highly profitable player in the natural gas industry (Lagace, 2008). Skilling encouraged Enron to make a number of risky gambles with high-expected return. Skilling's voracious appetite for cash led to Enron's financial decline and naturally its profitability. An article written by Martha Lagace states:

> " At Enron there were many opportunities for enormous personal gain that distracted top executives from the essential tasks of maintaining institutional integrity and building stable relationships with shareholders and employees. Similarly, Enron's leaders perpetuated a kind of utopianism that ended up distracting them from hard choices by a flight to abstractions", (Lagace, 2008, para.20).

Moreover, the role of a transformational leader is meaningless when there is nothing to transform and often effective leadership may be more about incremental change management than reinventing the firm.

Transformational, charismatic and transactional leaders are great for generating ideas and putting forth propositions but are not necessarily attuned to the fine

details that are required during the implementation process that often originates from the followers.

Transactional leadership is considered to be insufficient and limited by its reward-punishment approach. From an overall organizational perspective it is not considered very productive if “Followers” take the all the blame for a failed strategy or program, nor is it considered prudent or fair for rewards to be allocated based solely on the successful completion of the leader’s demands. The style tends to oppress and categorizes the follower as a person whose primary purpose is solely to adhere to the leader’s orders thereby being typified as lacking a mind of their own, goals or initiative. In reality, followers may have many more skills or a variety of skill-sets that set them apart from the leader in unique and valuable ways and these skills may be critical in providing a possible substitute leader in times of need or change.

Charismatic leadership has similarity to great man theory in that it is a divine gift used to attract followers; such a leader is typically presented as infallible. Interestingly, the research does not examine if there is such a thing as charismatic followership. After all, it is known that there exist informal networks within organizations where an employee may have more input, power and/or influence on a group than their manager or leader.

The historical and modern leadership theories do not present any clean-cut distinctions on why the terms leader and follower are needed in professional bureaucracies. Neither do the theories necessitate and place emphasis on the interchangeability amongst the two concepts.

Followers who are not transitioned into leadership positions may simply remain in their follower position due to fear of the organization or leader. Such fear may cause the follower to lose voice and limit the use of their talent. In many grassroots initiatives it is the person at the bottom of the hierarchy or the one who holds less or little power within the organizational dynamic that creates both the environment and impetus behind the change process. For instance, this has come to be apparent within the nascent domain of corporate sustainability. These individuals may be ready to lead but the opportunity and requisite level of organizational trust has to be made available to them so that they feel personal and profession assurance to assume such a leadership position. If the power structure and dynamic or the rigidity of the hierarchy prevents such an opportunity from manifesting then inherent value in the form of human resource talent that lie within the organization will not be captured or exploited and the benefit of potential financial, strategic or operational gain will be lost.

## 2.5 FOLLOWERSHIP STUDIES

Leadership theories tend to focus on leader behaviors, the importance of support from followers, structuring tasks or goals and including followers in decision-making process. Although there are several theoretical models that help explain differences regarding what constitutes effective leadership and interactions between leaders and followers there is now a shift in leadership research towards followership as an important constituent and revolving aspect to understand what creates effective leadership.

As is shown in the literature, the term “follower” often takes on a negative connotation. Being a follower is associated with ‘being passive”, “blindly obedient subordinates”, “lacking drive and ambition”, “inferior” or “lacking the right stuff” (Baker & Gerlowski, 2007). However, the research shows a shift in the understanding that an overly centric preoccupation with leadership theory prevents the field from discussing the importance of followership (Kellerman, 2007). Susan Baker and David Gerlowski’s (2007) research has shown that:

> “[t]he view of followers has shifted from one that saw followers as passive, blindly obedient subordinates who unquestionably obeyed the directives of their superiors to one that recognizes followers as active and collaborative participants in the leader-follower relationship” (p. 17).

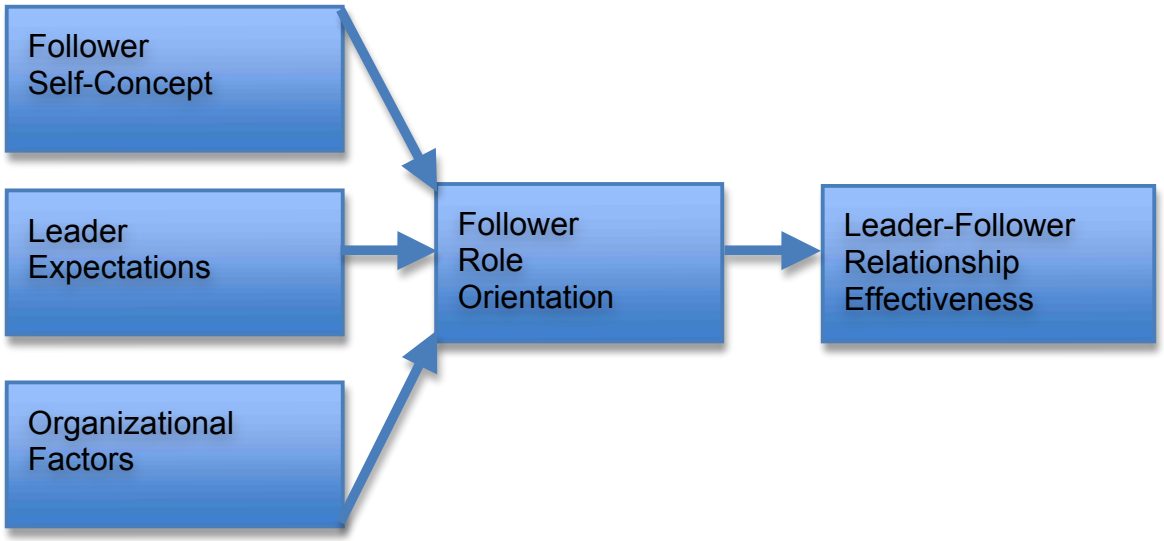
It is believed that all successful leaders need good followers and the combinations of leaders who listen to followers are unbeatable (Cavell, 2007). Within the study of followership there are five paradigms that categorize followers, as shown below.

| Table 2.5A<br>Followership Paradigms<br>Cavell, 2007 | |
|---|---|
| Role Orientation | Clarifies the different roles followers' play within their organization by studying the external and internal influences governing their behavior. |
| Dimensions | Distinguishes the types of followers found within organizations. The model attempts to create a link between the follower's emotional attachment to their current job and how it effects their motivation in the work place. |
| Empowerment | Brings forth new insight to the role followers can assume in relation to the organization. The theory is based on ways on detecting an empowered follower, the elements to support the empowered follower and challenges to leader behaviors and policies. |
| Followership Styles | Explains the follower's behavioral characteristics that may be found within the organization. The theory explores the different styles involved in followership in an attempt to examine if those who follow can be critical thinkers. Furthermore, the theory explains the different ways a follower contributes to the organization. |
| IFM-The Interactional Framework Model | Analyzes the leadership interaction and existing relationships between the leader, follower and situation. |
| Source: (Cavell, 2007) | |

## 2.5.1. ROLE ORIENTATION

Research by Jon P. Howell and Maria J. Mendez (2008) describe how followers conceptualize their role, duties and responsibilities within the organization (See Figure 2.3.1A below). This leads to an in-depth analysis of effectiveness in followership (Howell & Medez, 2008). There are three antecedents as shown.

**Figure 2.5.1A**
**Antecedents and Outcomes of Follower Role Orientation**
**Howell & Mendez, 2008**




| | |
|---|---|
| Follower Self-Concept | Refers to how followers view themselves. |
| Leader Expectations | Are based on ways they shape the follower-role behaviors. |
| Organizational Factors | Is the constraints or encouragement given to the behavior of followers on a structural and interpersonal level? |

Source: (Howell & Medez, 2008)

According to Howell and Mendez (2008), follower role orientation can be categorized as: interactive, independent and shifting, as discussed below.

- Interactive Role: is equivalent to leadership in terms of fulfillment of goals set by the group and organization (Howell & Medez, 2008). The follower finds importance in achieving goals when they are working with the leader. According to Howell and Shamir, "[followers] active role in [sic] constructing the leadership relationship, empowering the leader and influencing his or her behavior, and ultimately determining the consequences of the leadership relationship", (2005, p. 4) is critical to the reinforcement of the leader- follower dynamic. Such interaction is a reflection of cooperation and mutual influence not compliance. Both the leader and follower use their power for the benefit of their relationship, group and organization. The antecedents of such behavior implies that the follower sees themselves acting out roles in relation to significant others, their self worth is dependent on these behaviors.

- Independent Role: is a trend based on making followers more self-determined and self-managing in their work (Howell & Medez, 2008). The intention is to create more leadership substitutes in order to delegate particular tasks to allow the leader to focus on others. Such results are achieved from increasing the amount of education and training of the follower. The antecedent of an

independent role orientation is based on an individualized self-concept. Followers of this type make significant changes in personal characteristics that differentiate them from other followers or the leader. This type of role orientation permits the follower to enact leadership substitutes that contribute or detract from the organization (Howell & Medez, 2008).

- Shifting Role: is based on the necessity to shift from leader to follower, which is common, and is challenging in team based work structures (Howell & Medez, 2008). Followers of this type of role orientation usually are professionals and have complementary knowledge to those who are leading. The follower must have a high tolerance for ambiguity to be suited to accept leadership from different leaders and enact effectively within the role. Establishing clearly defined roles and extensive communication appears essential for transitioning into this role orientation. The antecedents of a shifting orientation are those who set aside their own goals for others or the group and acceptance of the leadership or followership role is based on what the group desires or requests of them. This type of follower views himself or herself as dynamic and flexible, which allows for a shifting role to take place (Howell & Medez, 2008).

Howell and Mendez describe seven behaviors that constitute effective followership as shown below. (Howell & Medez, 2008).

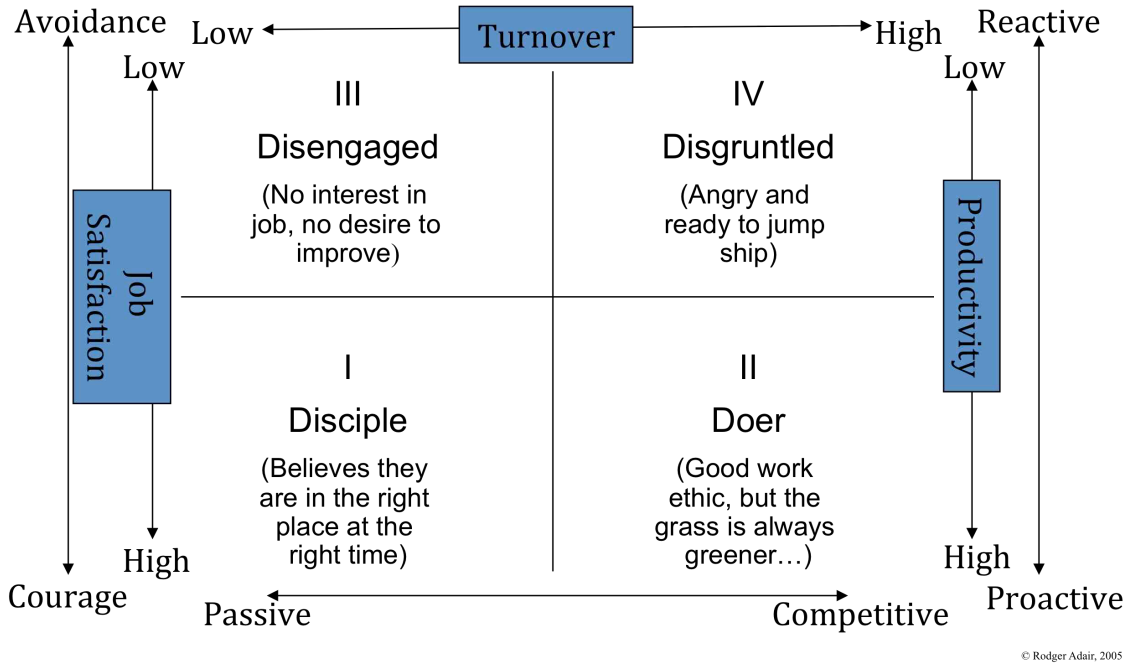
| Table 2.5.1 B<br>Effective Followership Behaviors<br>Howell & Medez, 2008 | |
|---|---|
| Competency & Knowledge | Competency in job knowledge and work tasks. |
| Collaborative Relationships | Building a sportive and collaborative within relationships between the leader and coworkers. |
| Support | Defense and support of the leader. |
| Mistake Avoidance | Helping the leader to avoid making costly mistakes. |
| Comportment | Representing appropriate comportment for the organization. |
| Concern | Demonstrating a concern about performance and maintaining an affable environment. |
| Participation | Participates in changes occurring in the organization. |
| Source: (Howell & Medez, 2008) | |

The work of Howell and Mendez will be instrumental in determining the RAT's, Respiratory and Anesthesia Technologist's, role orientation and self / leader expectations within critical care environments.

## 2.5.2 DIMENSIONS

Rodger Adair (2008) describes followership in the following manner, "A follower shares an influence relationship among leaders and followers with the intent to support leaders who reflect their mutual purpose", (p. 139). He states that leadership and followership are two sides of the same coin (Adair, 2008). He represents the above in his 4-D Followership Model shown below.

**Figure 2.5.2A**
**4D Followership Model**
**Rodger Adair (2008)**




Source: (Adair, 2008)

The 4-D followership model visually represents how a follower views himself or herself within the workforce and expresses the appropriate behaviors for their position (Adair, 2008).

- Quadrant I-Disciple: These followers are engaged, highly productive, content about their jobs and plan to be with the organization for a long time. The disciple's primary focus is based on serving others. One issue with such

behavioral characteristics is that being so heavily team focused may inhibit their individual growth or acceleration.

- Quadrant II-Doer: Their primary interest is in serving their own needs. They are characterized as being motivated, a team player, highly productive but often tend to change careers for advancement.

- Quadrant III-Disengaged: These followers do the minimum, only enough to maintain their job position. They are not too concerned about the organization's purpose or mission, only the value of keeping their own job. Their individual growth is hindered by these mentioned factors. They seem to have a passive reaction to stress.

- Quadrant IV-Disgruntled: These followers feel as if their values aren't met within the organization nor do they add any value to the organization. They tend to be affronted by actual or perceived events and have active reactions to stress (Adair, 2008).

### 2.5.3 EMPOWERMENT

Ira Chaleff states, "If [followers] are to be effective partners with leaders, it is important to remember …followers...possess [their] own power, quite apart from the reflected power of the leader", (Chaleff, 2009, p. 19). Chaleff believes that

within every organization, vested power is shared amongst the leader and follower. That is, a democratic hierarchy may allow for power to be distributed amongst the leader and the follower. In an autocratic hierarchy, the follower can reclaim their power when the leader steps down. There still exists an imbalance in formal power amongst leaders and followers, despite this fact a follower must learn to connect with their power and learn how to use it. The research from Ira Chaleff will be instrumental in studying the RAT's level of the empowerment.

In 1995, Chaleff (2009) focused on empowerment of followers and came up with four different degrees in which followers supported their leaders. He defined the separate groups as:

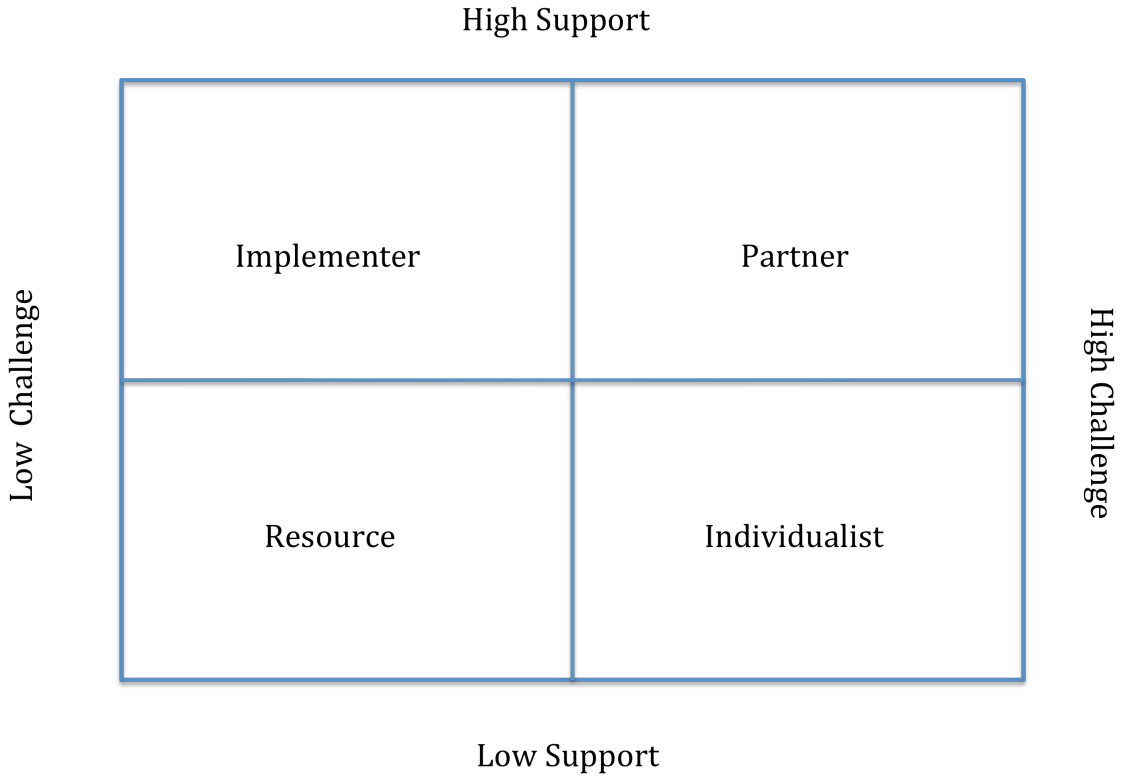
- Implementers: reinforce the leader's perspectives, they are team oriented, respectful of authority, supportive, dependable, and compliant.

- Partners: complement the leader's perspective and are based on peer relations with authority, focus is on strength and growth, they confront sensitive issues, they are mission oriented and purpose driven.

- Resource Types: avoid the attention of authority, they make complaints to third parties, execute minimum requirements, their primary interests lie elsewhere, they are uncommitted, they bring forth a set of specific skills and are available and present.

- Individualists: are not intimidated by authority, they are self margnalizing, rebellious, irreverent, reality checker, independent thinkers, self-assured, forthright, and confrontational.

**Figure 2.5.3 A**
**Styles of Followership**
**Ira Chaleff (2009)**




Source: (Chaleff, 2009)

## 2.5.4 FOLLOWERSHIP STYLES

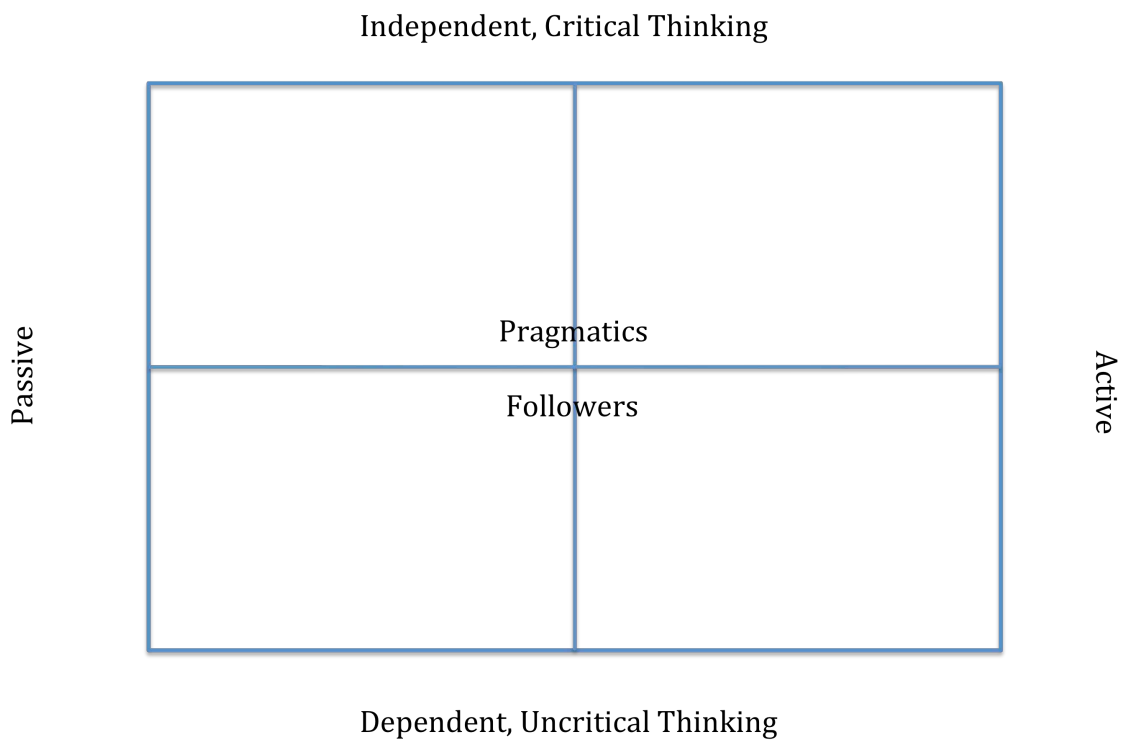
Robert Kelley

Robert Kelley is credited as being one of the first researchers to give voice to the follower and his research is fundamental to categorizing the possible typologies and follower styles of respiratory therapist found later in this thesis. His research produced positive correlations between the follower and their importance to leadership (Hughes, Ginnett, & Curphy, 2006). Kelley brought forth the notion that most individuals more often follow than lead and subordinates should be considered as supervisors and superiors (Kelley, 1988).

Kelley (1988) distinguished five different followership styles based on their level of motivation and behavior as shown below. (Kelley, 1988; Kelley, In Praise of Followers, 1988):

- The Alienated: is an independent and critical thinker.
- The Passive: does not think for themselves.
- The Conformist: lacks independence and critical thinking.
- The Exemplary: is a constant critical thinker and is active within the organization.
- The Pragmatic: walks the middle road and does not ask too many questions.

**Figure 2.5.4A**
**Styles of Followership**
**Robert Kelley (2008)**




Source: (Kelley, 2008)

## 2.5.5. THE INTERACTIONAL FRAMEWORK MODEL FOR ANALYZING LEADERSHIP

Rich Hughes et al (2006) IFM-Interactional Framework Model depicts leadership as a function of three elements not simply as a function of one person. These elements are (Hughes, Ginnett, & Curphy, 2006):

- The Leader
- The Follower
- The Situation.

The framework allows for leadership scenarios to be separately examined on each level of analysis. The model allows for the exploration of the interactions among the independent elements and their overlapping areas of convergence.

**Figure 2.5.5A**
**IFM- Interactional Framework Model For Analyzing Leadership**
**Richard Hughes et al (2008)**


Source: (Hughes, Ginnett, & Curphy, 2006)

Using this model, the leadership process can be better understood by not only looking at the leader-follower relationship but also by considering how they affect each other and how they are affected by the situational dynamics surrounding leadership (Hughes, Ginnett, & Curphy, 2006). Similarly, the follower and situation may be examined in parallel. Due to the flexible and highly descriptive nature of this model, it will be used to guide the principal part of the research on follower-situation, follower-leader and follower-follower interactions.

### 2.5.6 FOLLOWERSHIP AND LEADERSHIP THEORY CRITIQUE

Leadership is defined as a social influence process shared among all members of a group (Hughes, Ginnett, & Curphy, 2006). Susan Baker defines followership as “a process by which a person fills the role of follower, supporting the views of a leader and consciously and thoughtfully working toward shared goals of the leader or group” (Baker & Gerlowski, 2007, p. 15).

In comparing followership to leadership, there are no clear distinctions amongst the two concepts. Instead, leadership and followership are two points along a continuum, in which the people pass from “active followership” to “Small-L” leadership (people who lead) (Townsend & Gebhardt, 1997). The concept of “Big-L” leadership is based on those who are in positions of authority and authorized to lead (Turmel, 2007).

What clearly defines following from leading is individual skills and talents, experience, readiness and abilities. The type of situation is the determining factor for having one transition from follower to leader. What appears to define a leader from a follower is:

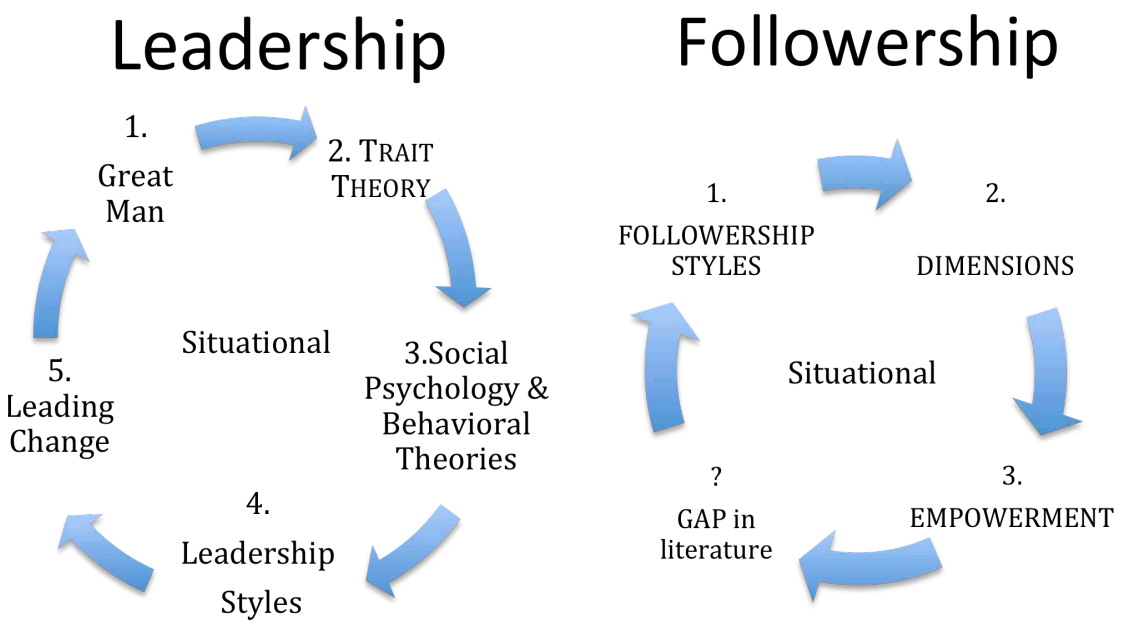
| | |
|---|---|
| 1. Values | Represent the individuals value system in line with organizational goals and purpose. |
| 2. Trust | Is the individual a trustworthy, credible and believed in. |
| 3. Power | The level of the employee within the hierarchy and how they utilize their authority to complete the task at hand. |
| 4. Vision | Strategy, goals for the group or organization and leading towards a better solution. |

Robert Kelley discusses that followers can influence “the upward” as they are often at the bottom where the problems occur, which may cause them to become more skilled (Kelley, 1988). The transition from leader to follower is within the situation and realization that there are different levels of leaders. The confidence of the organization and their understanding of the subordinate’s skill sets and the many crossovers in competencies should be further examined in order to effectively transition followers to leaders. The examination of an organization’s willingness to empower subordinate positions and allow for better understanding of how followers have an opportunity to transition into leadership roles is a key determinant of the success of the transitioning.

The existing gap in the followership literature is based on lack of developmental aspects for followers transitioning into leaders. Naturally, following precedes

leading and we can postulate that most people do more following than leading throughout the day. It does not appear to be possible to lead without learning to follow. Learning to follow includes many essential steps required to lead effectively. Figure 2.5.6A displays the evolution of both theories:

**Figure 2.5.6 A**
**Leadership and Followership Theoretical Summary**




Source: Donald Oxford York, 2010

## 2.6 THE SIX THINKING HATS- EDWARD DE BONO

Edward De Bono (1999) constructed the “Six Thinking Hats ” (STH) model (thinking styles) to thoroughly examine the various possibilities within a complex situation or challenge (Bono, 1999). Edward De Bono describes thinking as the

ultimate human resource used to separate emotion from logic, creativity from information (Bono, 1999). The STH's approach is intended to be constructive, creative and multifaceted alternative to the argumentative approach which tends to be one-sided (Bono, 1999). One of the many strengths of using the STH model comes from "Parallel Thinking". Parallel thinking is based on exploring a subject or situation from all angles (Bono, 1999). The STH model and its use of parallel thinking can be understood from the following example:

> "There is a large and beautiful country house. One person standing in the front of the house. One person is standing behind the house. Two other people standing on each side of the house. All four have different views of the house. All four are arguing (by intercom) that the view each is seeing is the correct view of the house. Using parallel thinking they all walk around the house and look at the front. Then they all walk around to the side, then the back, and finally the remaining side. So at each moment each person is looking in parallel from the same point of view" (Bono, 1999, p. 4).

The STH model does not deliberately take an opposite view, which is seen in argumentative, confrontational or adversarial thinking (Bono, 1999). In other words, the intention of the STH model is to be able to see all sides of a problem or situation after thorough examination.

The work of Edward De Bono does not consist of any direct relationship to followership or leadership studies but can be utilized to determine possible causal factors involved in the subject manner. The six thinking hats theory allows for important decisions to be looked at from different perspectives and forces the subject to move outside of a habitual thinking process (Mind Tools, 2010).

The “Six Thinking Hats” different approach of assessment are explained below:

**Table 2.6**
**Edward de Bono - 1999**
**The Six Thinking Hats**

| | |
|---|---|
| White Hat | Focuses on obtaining the existing facts and information about the situation or challenge. |
| Red Hat | Explores the emotional and intuitive aspects for justification of the present views. |
| Black Hat | Is the judgmental, critical and analytical aspect of the search for what is by using logical negative view. |
| Yellow Hat | Uses a positive logical view for searching for the benefits and what is good. |
| Green Hat | Places emphasis on creative thinking and generation of new ideas. |
| Blue Hat | Takes control of the process and the steps involved: it is “thinking of thinking”. |

Source: Bono (1999)

## 2.7 SUMMARY OF CHAPTER TWO

As reviewed in this chapter, early research focused on the leader and paid very little attention to the importance of the follower within the leadership paradigm. Present day research on followership is attempting to eliminate leader centrism and to shift the focus upon collaboration, motivation and cooperation between the leader and follower. In addition, the literature on leadership is shifting towards power sharing and decentralization of authority (Hughes, Ginnett, & Curphy, 2006).

After a review of the literature there appears to be no formal study or theory that links followership styles, orientation and personal perspective specifically to the critical care environment within the health care field.

The study of followership explores style, psychological dimensions and empowerment. Leadership theory is lacking research within the former areas when attempting to explain what constitutes a leader. In addition, followership and leadership are presented as such that it appears that an effective follower is equivalent to an effective leader. The literature review would suggest that leading is not specialized and that it can be taught, learned and practiced by anyone willing to follow. The former statement may prove to be critical for understanding the Respiratory Therapist's followership-leadership exchange within critical care environments.

Taking into consideration the preceding review of leadership and followership this thesis sets out to develop an understanding of the respiratory therapist role orientation, typologies and influences on leader-follower relations within critical care environments. The following section on research methodology will further examine followership within the respiratory therapy field as it was reflected within the present study fieldwork.

# CHAPTER THREE

# RESEARCH METHODOLOGY

# CHAPTER THREE- RESEARCH METHODOLOGY

## 3.1 OVERVIEW

The research methodology of the thesis is qualitative by way of a phenomenological research approach in order to be able to isolate the main aspects and influences on followership. This study aims to build a framework to further investigate the current trends emerging in the study of followership design and interrelations; as well as study the main consequences on critical care environments. The analysis is derived from an extensive literature review covering 40 years of scholarship that shows a lack of study on followership especially as linked to critical care environments.

## 3.2 APPRIOPRIATENESS

Historically, the scholarly work generated within leadership studies used quantitative methods to justify their existing theories of the subject manner and to differentiate between leaders and followers. For example, Thomas Carlyle's (1840) work was grounded within the quantitative approach leading to the tabulation of individual characteristics that were used for differentiating "Great Men". In addition, the work of Francis Galton used applied statistical analysis to study human variations (traits) within leaders (Galton, 1892).

Conversely, research has shown that the quantitative approach may prove to be insufficient for understanding complex relationships involved within leadership. The research of Timothy Judge et al (2002) has shown that the quantitative approach can be meet with great difficulty as it potentially masks the relationship of the subject manner and the criteria in broad subjects such as personality and leadership (Judge, Ilies, Bono, & Gerhardt, 2002).

According to Karin Klenke, “the history of [leadership] research has…relied heavily [and] at times exclusively on…quantitative methodology to help us identfiy and understand leadership problems and develop solutions that can be scientifically tested, verified, and replicated.” (2008, p. 3). In recent times, the quantitative approach is scrutinized in leadership studies which in turn has lead to other methods of inquiry such as the qualitative approach (Klenke, 2008).

The present research has selected a qualitative research methodology in order to become more experienced with the phenomenon of followership within critical care environments. The qualitative approach should allow for further knowledge and exploration between the existing followership-leadership literature and the limited linkage to critical care environments. Qualitative research allows for developing a deeper understanding of existing problems within the phenomenon and allows the researcher to formulate and converge new ideas with old (Trochim, 2006).

Qualitative research is eminent for investigating complex and sensitive issues (Trochim, 2006). For example, with respect to the Respiratory Therapist's role as a follower in leadership positions would prove to be difficult to develop a quantitative methodology that would emphasize or elaborate upon key positions on the issue of followership in critical care environments. Qualitative research allows for analysis of how people think and generates in-depth information about specific topics (Trochim, 2006). Quantitative analysis is not considered to be well suited in the present research as it is viewed to be of little value to collect numeric data with the possibility of a resultant undifferentiated data dump. In selecting a qualitative methodology to study followership, the research allows for describing the challenges, functions and roles of a Respiratory Therapist through their own language and in eminent detail.

An open-ended questionnaire is most appropriate for the methodology of the study in so far that it permits a wide array of possible responses to the research question and should allow the participants to free associate prior to data analysis (Zikmund, 2003; Sommer & Simmer, 1991). Furthermore, the questionnaire methodology is most advantageous as the researcher cannot know all the possible questions within this understudied domain. It is almost certain that the available answers are so multifaceted that the questions will not be suited to a multiple-choice format. Moreover, such a study should avoid the possibility of suggesting answers to the participants or responder. In summary, this survey method was selected in order to ensure that respondents answer in their own voice.

## 3.3 RESEARCH DESIGN

The research methodology is split in two sections, being:

1. Preliminary Survey Questionnaire
2. Semi-Structured Follow Up Interviews

The preliminary survey method is used to uncover the attitudes held by respiratory therapists with respect to leader and follower roles. Subsequently, semi-structured follow-up interviews are carried out for clarification on the received survey responses.

The preliminary survey questionnaire design contains two sections:

1. Participant Profile: to give credence to cultural aspects, the influence of age, years of experience and postgraduate educational effects that may possibly influence the responses of participants to follower-leader exchanges is monitored. The profile is used to determine participates' organizational culture, their own cultural backgrounds and years of experience working in this area.

2. Leader-follower Questionnaire: To develop this profile questions that pertain to leadership and followership topics are asked of the respondents.

The main questions pertain to: motivation, self-concept, typology, decision-making, control and communication.

The resultant design utilizes an original ten-item questionnaire; create by the author to explore followership within respiratory therapy (Appendix E). The questionnaire was constructed, pretested, revised and distributed to ten-registered respiratory therapists working within the McGill University Health Centers or affiliated teaching hospitals. The selected design uses open-ended questions that bring forth salience of the issues in leadership and followership. The reason for utilizing the open-ended format is that it allows for respondents to reply in their own words and helps to determine the salience and import of opinions and positions. Moreover, in using this methodology the attitudes of participants towards the subject manner can be meticulously analyzed. This approach is the main methodological strategy employed in this study to fully develop a thorough understanding of followership and leadership in respiratory care environments.

The intent of the research methodology is to measure several factors, including:

1. The dynamics of leader and follower behavior
2. The extent of leader-follower relations
3. Group decisions making methods within respiratory therapist critical care environments.

The sum of these responses should indicate which of the general followership styles and types are most descriptive within the organization and the relations involved.

The second part of the research design involves a semi-structured interview, where all of the participants are asked the same questions but with a few modifications to the wording or sentence structure to better suit the particular respondent and their unique situation. This methodology is considered most suitable for obtaining more in-depth information concerning particular questions, as well as providing adaptation to fit the respondents' age and level of experience (Sommer & Simmer, 1991). The general strategy for the interviews is to follow a qualitative approach using the semi-structured methodology where broad questions are posed permitting free-flowing responses by interviewees. This methodology is considered most appropriate in order to capture subtle meanings and personally held beliefs and to avoid imposing external thought complexes on participants (Zikmund, 2003). Moreover, subsequent follow-up semi structured interviews are completed to give the participants an opportunity to discuss extraneous findings, receive feedback and to further clarify inter-relationships among the leader–follower variables of interest.

These two methods were used to generate a large quantity of information related to the pressing questions involved in followership and leadership studies within

critical care settings and should yield important insights to present theories of leadership.

## 3.4 VALIDITY AND RELIABILITY

Selection of the survey method was ideal in identifying and measuring the behavioral characteristics involved in the leader-follower exchange and meeting the research objectives. The survey method can also provide external validity, as well in providing alternative explanations for the behaviors that follow in the study (Sommer & Simmer, 1991). Expectantly, the research results and findings may extend beyond the critical care setting when using this methodology in examining followership.

The questions used were verified for clarity and organization during a small sample pretesting phase of the study. This in turn, allowed for the top ten questions to be formulated in bringing forth a balance within the subject matter of the questions, proper placement to help establish a good relationship with the participant and to pave the way for more difficult or controversial questioning during the follow-up interview in an organized and culturally sensitive way.

The research discovered within this thesis may lead to future replication of the findings. The same instruments and methodology used may produce the same results when applied to similar target populations working in other critical care

environments. The reliably of the thesis findings add an important contribution to its research validity.

## 3.5 SAMPLING METHOD

The respiratory therapist was selected as the target population by way of purposive sampling. This method was selected in so far that the respiratory therapist is the most important and relevant actor involved in critical care environments with respect to followership and leadership theory and praxis. Due to the difficulty of accessing respiratory therapists with respect to their hectic schedules snowball sampling occurred by way of the researcher asking for other potential follow-up respondents to contact. Via email participants received an introductory letter (Appendix F) and a consent form (Appendix D). The process of sampling:

1. Target Population: comprised of registered respiratory therapist within various McGill University Health Centers ("MUHC") and affiliated centers. Target population members volunteered their time in participation of the study and include: registered healthcare professionals working in the McGill University Health Centers such as Neonatal Intensive Care Unit (NICU), Intensive Care Unit (ICU) and Operating Room (OR) or affiliated McGill teaching centers. Each member had to be a Registered Respiratory therapists working in teams identified by their level of expertise.

2. Sample size and units: The sample included ten full-time employed respiratory therapists. A self-administered survey was distributed during the last week of March 2010 returned to the researcher either personally or by e-mail within a week after agreement to participate in the study. Participation was voluntary and no individual identification was collected on the questionnaire only general profiling categories such as: years of service, areas of specialty, cultural background/ religious or philosophical beliefs.

## 3.6 DATA COLLECTION

The survey method was used and the data collected was received by direct participation of the respiratory therapist during the process. Each participant received the survey by email and had initially seven days to respond or else they were eliminated from the process due to time constraints. Each respiratory therapist participated in the survey by filling out the followership questionnaire. In addition, half of the participants required a follow up interview.

Prior to collecting data from the target population, the questionnaire was used during a pretesting phase involving four nurses in order to assist in determining whether or not the data collection plan would be appropriate for the main phase of the research. This allowed a minimization of errors in the formulation of the

questionnaire by re-wording particular questions, checking for clarity and verifying whether the general survey design would be sufficient and appropriate. The data tabulated from the small sample pretest provided a more thorough format for the eventual collection of relevant information and subsequent knowledge within the larger main survey.

## 3.7 DATA ANALYSIS

The ten-item questionnaire was designed to reflect the influences, attitudes and behaviors associated with follower or leader roles for respiratory therapists working in critical care environments. Content analysis was the approach to quantifying the responses within the questionnaire, in order to make the study systematic and replicable. The important issues and special content provided within the interviews were transcribed then proofread by the researcher and returned to the participants via email in order to verify their intended meaning. If there existed any discrepancies between the transcribed text and the intended meaning of the respondent the transcripts would be modified by the researcher and finally approved by the respondent as necessary. Coding categories were then developed with associated content by analyzing the questionnaire segments along with the interview segments thereby creating a coding dictionary with continual testing and revising until no new categories emerged.

Over a two-month period twenty-five questionnaires were distributed and ten were returned, resulting in a response rate of 40%. Seven participants were female (seven RT's =70% of population) and three (RT's =30% of population) were male. All the participants had work experience in respiratory care areas such as: Intensive Care Units (ICU), Emergency Department and Wards. Fifty percent of the RT's had experience working both within Operating Room and Respiratory Care. The average age of the participants was 31 years with an average tenure in their current organization of seven years.

## 3.8 SUMMARY OF CHAPTER THREE

A total of ten registered respiratory therapist working within various centers of the McGill University Health Centers or affiliated teaching hospitals partook in the present study. Seventy percent of the participants were male and thirty percent were female. Each respondent had working experiencing in respiratory therapy while only forty percent of the respondents had both operating experience and respiratory care experience. The study employed an original ten-item questionnaire consisting of a two sections: 1. Profile and experience, and 2. Open-ended questionnaire. The qualitative methodology utilized for this research allowed for the placing of a more detailed personal description on leader-follower exchange within respiratory care and allowed the testing of respondent's self-concept, role orientation, interaction with leaders and other team member.

The responses where then analyzed, coded and categorized in order to develop a further understating of the attitudes and understandings of the respiratory therapist working within critical settings environments. The subsequent chapter will delve in to more extensive detail.

# CHAPTER FOUR

# PRESENTATION OF THE DATA

# CHAPTER FOUR- PRESENTATION OF THE DATA

## 4.1 PURPOSE STATEMENT

As previously mentioned, the purpose of this thesis is to discover to what extent a Respiratory and Anesthesia Technologist, ("R. A.T."), whose position is typically associated as a follower, subscribe to a shared set of beliefs about their general role within critical care as considered and understood by those assuming a leadership role in the group.

## 4.2 RESEARCH METHOD

The methodology used within this research study is qualitative by way of a phenomenological research approach in order to be able to isolate the main aspects and influences on followership. Study participants are chosen from the field of respiratory therapy specifically located within the main teaching hospitals of the MUHC, McGill University Health Center, in Montreal, Quebec.

## 4.3 DATA COLLECTION

The survey method was utilized for studying followership within respiratory therapy. Data is collected by direct participation of the respiratory therapist within the study. Each participant received the survey by email and had seven days to respond or else they would be eliminated from the process due to time constraints. Each Respiratory Therapist participated by filling out the two-part questionnaire (Appendix E). Each Respiratory therapist was given initially five working days to complete the questionnaire which was sent by email. Completed surveys were ultimately received within a 15-day period.

Due to unfamiliarity with the concepts in followership some participants had issues in responding to the questions and therefore took longer than the allotted 90-minute completion time. The consensus concerning the questionnaire was that it forced the respondents to think deeply about their role as a respiratory therapist. The majority of the respondents (6 out of 10) required two-to-three hours to complete the questionnaire.

## 4.4 DATA DISTILLATION

This section will provide a detailed explanation of the resulting information collected from the previously stated instrument and method used in this study. The ten respiratory therapist's participating responses allowed the researcher to transcribe the collected information in the two sections:

1. Within the first part of the survey Therapists were coded into their respective demographic areas (RT 1 to 10):

- Gender
- Age
- Years of experience
- Areas of specialty
- Professional position
- Place of birth, and
- Religious / cultural background

**Table 4.4A**
**Respiratory Therapist (RT) Profile**

| | RT 1 | RT 2 | RT 3 | RT 4 | RT 5 | RT 6 | RT 7 | RT 8 | RT 9 | RT 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Gender | F | F | F | M | M | F | F | M | F | F |
| Age | 28 | 42 | 32 | 25 | 30 | 51 | 49 | 28 | 21 | 31 |
| Title | RRT | AC | TC | RRT | CC | RRT | RRT | RRT | RRT | CI |
| Other Areas | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Yrs of Exp. (RC) | 8 | 16 | 6 | 4 | 3 | 12 | 15 | 7 | 1 | 9 |
| Yrs of Exp. (OR) | 1 | 0 | 2 | 0 | 5 | 0 | 0 | 0 | 0 | 2 |
| Higher Education | UG | 0 | UG | 0 | UG | 0 | 0 | 0 | 0 | UG |
| Place of Birth | E | E | C | C | C | E | C | C | CB | A |
| Religion/ Philosophy | CO | CO | AT | BD | J | J | CO | J | CO | CO |
| Centers | MUHC | ATH | ATH | MUHC | ATH | ATH | MUHC | ATH | ATH | MUHC |

**LEGEND**

Participants Positions:
Assistant chief – AC
Technical Coordinator-TC
Registered Respiratory therapist- RRT
Clinical coordinator-CC
Clinical instructor- CI

Respiratory Care (RC)=
Neonatal Intensive Care Unit (NICU)
Intensive Care Unit (ICU),
Emergency Room (ER), Wards (W)

Anesthesia (A)= Operating Room (OR) and Post Anesthesia Care Unit (PACU)

Higher Education Areas=
Undergraduate Degree (UG)
Master's Degree (M)

Working centers:
McGill University Health center (MUHC)
McGill University affiliated teaching hospitals (ATH)

Place of Birth:
Canada (C)
Caribbean (CB)
Europe (E)
Asia (A)

Religion/ Philosophy:
Christian Orthodox (CO)
Atheist (AT)
Jewish (J)
Buddhism (BD)

Source: Donald Oxford York, 2010

The second part of the survey leads to classification of data categories influencing or affecting both self-concepts of followership and leadership interrelations. Upon completion of content analysis of the data collected, similarities where brought out and formulated into common themes or thought processes (Table 4.4A to 4.4I).

| Table 4.4B<br>Compilation of Key Terms<br>From a Respiratory Therapist Perspective | |
|---|---|
| Leadership | An ability of one or more individuals to lead other people into accomplishing a goal or a common goals; an ability to control or influence the actions of someone else. The way of leading followers. |
| Followership | The willingness to follow a leader, the process of learning to follow a leader or be a supportive. A way of learning to be good followers. 60% not answered due to the fact they did not know that such a word exist or left it blank. |
| Leader | A person possessing certain characteristics such as intelligence, charisma, talks up for themselves, challenges group or others to think, flexibility which are integrated into a daily function while dealing with different situations, people and accomplishing something great. |
| Follower | a person who follows, adheres to a suggestion or command. A person who doesn't question decisions made by superiors or designated leader, doesn't take initiative on their own, doesn't like change or change at all; one who says yes to everything and doesn't have motivation to lead. |
| Source: Donald Oxford York, 2010 | |

In table 4.4B we see a compilation of key terms and their definitions from a respiratory therapist perspective. The respiratory therapists were asked to define: leadership, followership, leader and follower from their own perspective

and experiences. The responses where then categorized and coded to formulate the presented definitions.

In table 4.4C we see the determinants of leaders and followers in respiratory care. The respiratory therapists' responses were categorized under three areas: characteristics, personal views of positions that typically lead or follow and departmental influences. The research indicated that a leaders characteristic was based on level of education, years of experience, their self-perception of job role and included those who recently graduated from the discipline. The research also indicated that followers characteristics were based on various situational factors and self-perceptions of their work role.

| Table 4.4C<br>Determinants of Leaders and Followers<br>in Respiratory Care | |
|---|---|
| Leaders | **Characteristics:** Seniority, accomplishes tasks or learned skills well, dedication to the job, bachelor or masters or other higher levels of education, New graduates due having the latest information.<br><br>**Views of positions:** Head Nurses, Doctors, Anesthetist, Nurse Clinicians.<br><br>**Departmental:** superiors lack of interest in an area thereby having the particular role given to whom ever wants it or searching outside for external sources rather than working with who they have. |
| Followers | **Characteristics:** depending on the particular situation or crisis (cardiac arrest, ventilator setup, patient assessment, emergency Room, Operating room)<br><br>**Views of Positions:** Respiratory Therapy. Head Nurses, Nurse Clinicians and Doctors. (Some may have to lead and others follow temporarily) |
| Source: Donald Oxford York, 2010 | |

In table 4.4D we see that the Respiratory Therapists *self-concept* is divided into four types:

- The Empowered: Those who are empowered by their autonomy and skill-set who receive departmental support;
- The Restricted: Those who view themselves as leaders but are restricted by departmental policies and procedures;
- The Majority: The majority who tend to simply follow what ever is accepted of them.
- The Mixed Limited: Those who are empowered and supported within one area, they may view themselves as leaders but limited in another based on organizational or departmental policies.

| Table 4.4D<br>Self-Concept of Being a Leader or Follower<br>In Current Position | |
|---|---|
| Leaders<br>(2 RT's) | • **Self-Concept**: I am a leader, I am outside, I run my own enterprise, I went to university, I teach and educate.<br>• **Organizational/Departmental**: allows for RT to shine in their area of expertise. Leading others or orienting others.<br>• **Position:** More autonomy working in OR settings or ER, NICU<br>• **Tasks:** oxygen therapy, respiratory hygiene. |
| Followers<br>(4 RT's) | • **Self-Concept:** We follow what is asked of us, just doing our job and adhering to doctor's orders.<br>• **Organizational/Departmental:** we are not depended upon to lead just to follow new policies and procedures with little input. Lack of respect for what we can actually do. Favoritism.<br>• **Areas:** ICU, Wards<br>• **Position:** RT follow doctors and nurses orders. An autonomous job with little autonomy. |
| Both<br>(4 RT's) | • **Self-Concept:** I am prepared to lead at any moment or always ready to lead if given the opportunity to be the designated leader or assigned leader. A leading role does not take place frequently due to my position, not appreciated at times due to conflict with other disciplines, and isn't expected of me due to the hierarchical order of typical positions that lead (i.e. nursing and physicians). Leadership role is external to hospital setting or rotational based on the situation.<br>• **Organizational/Departmental:** restricted to lead due to policies even though there are crossovers in skills. Lead in some areas and follow more in others due to policies but same skills can be utilized.<br>• **Areas:** RC and Anesthesia<br>• **Position:** RT is a position based on following. RT is positing of leading in their area of expertise like airway management, Cardio Respiratory drugs, ACLS, Basic Life Support and mechanical ventilation. |
| Source: Donald Oxford York, 2010 | |

In table 4.4E we see the determinants of leadership transferability within the field of respiratory therapy. The following data responses where then categorized and coded to formulate the following definitions. The research indicated that seven RT's felt that leadership is transferable based on following factors: replacement positions, years of experience and higher education. In addition, the research

has shown that three of the respondents felt that there is no transferability of leadership but instead leadership is a collective effort.

| Table 4.4E<br>Transferability of Leadership<br>In Respiratory Care | |
|---|---|
| Yes (70% of RT's) | **Departmental/Organizational:** Mainly situational such as Vacation, sick leave, maternity leave or paternity leave. When the leader fails. Administrative work of Assistant chief or Chief can't be transferable or attained unless there is higher education involved.<br><br>**Characteristics/Traits**: seniority, experience in an area, likeability, go getter personality, accomplishing what the leader can't do |
| No (30% of RT's) | **Departmental/Organizational:** we are all working together nurses, doctors and us to achieve the same goal of patient care. |
| Source: Donald Oxford York, 2010 | |

In table 4.4F we see the influential factors either enhancing or deterring the leadership process of the respiratory therapist.

| Table 4.4F<br>Influences Effecting The Leadership Process | |
|---|---|
| Departmental/ Organizational Level | 8 participants responded: Nurses are running the show, get what they want equipment, materials, education seminars etc. and everything is given to them. Nurses manage the Operating Room; overtime gets cut for RT's before Nurses.<br><br>4 participants responded: Lack of respect for the profession only viewing for mediocre work not for expertise in cardio-respiratory care. No awareness of abilities and expertise being one profession that works mainly in high critical care areas. |
| Note: The number of responses outweighs the total number of respondents as some respondents offered more than one unique explanation to the question at hand. | |
| Source: Donald Oxford York, 2010 | |

In table 4.4G is a compilation of essential elements to be effective from a respiratory therapists perspective.

| Table 4.4G<br>Characteristics To Be Effective | |
|---|---|
| **Departmental / Organizational level** | Identifying who in the department can carry forth particular tasks, making time for practice. |
| **Personal Characteristics/Traits** | good organizational skills, knowledgeable, asking for help, good RT skills, clear speaker, unemotional, assertive, openness to suggestion ready to act, emotional stability, ready for change, updates regularly |
| Source: Donald Oxford York, 2010 | |

Table 4.4H is divided in two parts:

1. Admirable Characteristics in Those Who Lead: discusses the key elements that a respiratory therapist idealizes those who lead. The responses are not specific to themselves but from a general perspective of others working in critical care environments.
2. Initiation of Leadership During Crisis Situations: categorizes the typical positions in order of those who lead during crisis situations, such as: cardiac arrest or other patient related issues.

| **Table 4.4H**<br>**Admirable Characteristics In Those Who Lead** | |
|---|---|
| RT's Perspective | Fairness, organizational skills, decision-making ability, knowing when to ask for help. Knowledgeable, effective listening, being non-judgmental, ability to critique without criticizing, giving positive feedback when necessary, knowing when to step back and let someone else lead. |
| **Initiation of Leadership During Crisis** | |
| | 1. Doctors (ER,NICU or ICU)<br>2. Anesthetist<br>3. Nurses<br>4. Respiratory Therapists |
| Source: Donald Oxford York, 2010 | |

Table 4.4l is divided in two parts:

1. Leader's Power on Followers Within Critical Care Environments: discusses the effects the leader has on the follower during crisis situations. In addition, to the work relationship between leader and follower.

2. Followers Influence on Leader's Behavior and Attitudes: categorizes both the positive and negative influences a follower can have on leaders behavior and attitudes working in critical care environments.

| **Table 4.4l<br>Leader's Power on Followers<br>Within Critical Care Environments** | |
|---|---|
| RT Views | 1. Must obey orders, no questions can be or should be asked,<br>2. If power is not respected it will have no effect on the leader, they will simply try to it themselves,<br>3. If respected all will be adhered to and the RT can relax. |
| **Followers Influence on Leader's Behavior and Attitudes** | |
| RT Views | • **Positively:** ability to take over a task where there is cross over in skills, success of skills, working together, by showing gratitude and appreciation of leader. Stimulating and supporting leader decisions.<br>• **Negatively:** ability to take over a task where there is cross over in skills (leaders ego may appear). When a leader fails a particular task attention is shifted to RT, no followership would mean no leadership (we need each other). May be disregarded towards negative decisions taken. Not supporting leader's decisions due to lack of respect for them. |
| Source: Donald Oxford York, 2010 | |

## 4.5 IDENTIFICATION OF FINDINGS

This thesis attempted to answer the following specific research question:

> "What are the constructs, attitudes and beliefs held by Respiratory and Anesthesiologist Therapists (RATs), with respect to their operational, functional and temporal roles in assuming the position of leader or follower within the group dynamics of high stress critical care environments as understood by both their own cohort group as well as colleagues who typically assume a leadership role in the larger group."

The determinants of "Leaders versus Followers" in working as a respiratory therapist (Table 4.4C) were based on three dimensions: characteristics, position and departmental.

- Characteristics: include seniority, levels of education, dedication to the job, and how well skills were learned.
- Positions: tended to be head nurses, doctors, anesthesiologists and nurse clinicians.
- Departmental: influences were based on searching for leaders externally of the Hospital and not exploring talents internally.

Followers were characterized depending on the circumstances and area of work, for example: during cardiac arrest, patient assessment, emergency room attending, operating room attending. Positions that tended to be considered followers were: respiratory therapist, head nurses, nurse clinician and doctors. Interestingly, positions of following appear to be viewed as rotational or collaborative meaning that some must lead and follow simultaneously depending on the circumstance.

Transferability of leadership in respiratory care (Table 4.4D) showed that seven RT's wrote that leadership was transferable based on two dimensions: departmental and characteristic and/or traits. Departmental level leadership was transferable based on leave of absence, holidays, seniority, employee illness, when current leaders fail a substitute is needed. Characteristics or trait was based on years of experience, likeability, doing what leader can't do, in charge for the day and higher education determine leadership transferability. Three RT's stated leadership isn't transferable because we all contribute together to achieve the same goal of patient care. This is an interesting statement as it shows team dynamics are imbedded within leadership and followership towards collaboration of skills.

Factors believed by the respiratory therapist to influence the leadership process

where mainly departmental/organizational. Eight of the RT's responded, "Nurses are running the show" (Table 4.4F). Four of the RT's responses included on an organizational level that there is a general lack of respect for the profession and a resultant lack of clarity on the abilities and expertise of a respiratory therapist.

Table 4.4G and 4.4H reveals RT's views on what is required to be effective and what is admirable in those who lead.

- Being Effective: was shown to include good organizational skills, knowledgeable, asking for help, good RT skills, clear speaker, unemotional, assertive, openness to suggestion ready to act, emotional stability, ready for change, updates regularly.

- Personal Characteristics or Traits for Those Who Lead: were shown to be: fairness, organizational skills, decision-making ability, knowing when to ask for help, knowledgeable, effective listening, being non-judgmental, ability to critique without criticizing, giving positive feedback when necessary, knowing when to step back and let someone else lead.

According to James Maroosis (2008), "It is the situation that calls for action, by dictating the need for leadership and it is a partnership of reciprocal following that enacts a response" (p. 18). The situational aspect in critical care focuses on the

individual who initiates leadership during a crisis. The responses were in the following order:

1. Doctors
2. Anesthetist
3. Nurses
4. Respiratory Therapist (Table 4.4H).

There is a reciprocal following as each of these team members should collaborate during a crisis moment, as it appears that these are the key members for patient crisis management.

## 4.6 SUMMARY OF CHAPTER FOUR

The respiratory therapist responses were analyzed, coded and categorized into result tables to generate fundamental elements involved in leadership or followership within their position. This chapter showed the impact of role and context to further develop understanding of the respiratory therapists: personal definition of key concepts found within the leadership and followership literature, the effect self-concept has on role orientation, the view on leaders and followers in critical care and the determinants encouraging, supporting or preventing the transition from follower to leader or vices versa. The subsequent chapter will go into more extensive detail on the synthesis and integration of the research findings.

# CHAPTER FIVE

# SYNTHESIS AND INTEGRATION

# CHAPTER FIVE – SYNTHESIS AND INTEGRATION

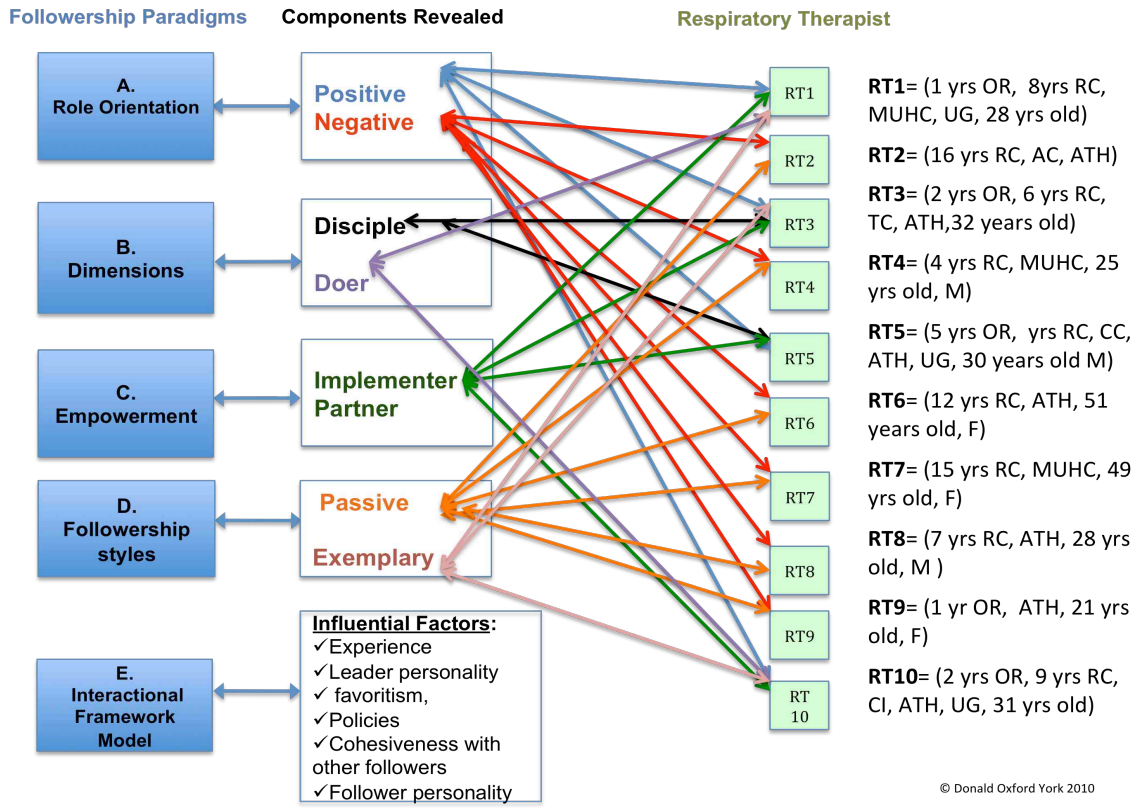
## 5.1 OVERVIEW

The present research was conducted throughout the MUHC and affiliated centers using ten health care professionals within the field of respiratory therapy. The survey method was used to collect and generate a set of variables relating to the issues or effectiveness of followership. The subsequent subsections will synthesize and integrate the nature of these findings.

## 5.2 ANALYSIS OF FOLLOWER PARADIGMS

Table 5.2 A is a qualitative analysis of followership paradigms and their components found within the results of the present research.

**Figure 5.2 A**
**Graphical Analysis of Follower Paradigms**




Source: Donald Oxford York, 2010

A. Role Orientation: indicates that followers should act more independently of their leader (Howell & Medez, 2008). The respiratory therapist is restricted by multiple factors impeding his progress. The amount of support, policies and procedures at the organizational/departmental level are not

standardized for consistency. There is an obvious lack of clarity in the RT's role and expected competencies within all areas of the hospital.

The respiratory therapists have particular skill sets that are similar to physicians and nurses but are unknown at an interdepartmental level. This fact may discourage or silence the respiratory therapist from improving himself (negative role orientation). The respiratory therapists role orientation increases positively as their level of education or training is enhanced. Furthermore, the respiratory therapists having experience working in both respiratory care and the operating room (anesthesia) are more confidence about their skills and have a stronger positive self-concept. This is due to the fact that the RT working in anesthesia works very closely with the Anesthetist who empowers and supports their actions.

Howell and Mendez (2008) view of followership as a *shifting role* is based on the necessity to shift from leader to follower. This statement was clear to the respiratory therapist who had experience working in anesthesia. Both the RT and Anesthetist rotate between leading and following during OR cases and are substitutes for one another. This seems to be common occurrence due to having complementary knowledge to the leader (anesthetist).

The */eader expectations* were not clear but it appears that the RT working in

respiratory care experiences more challenges and limitations within their duties. This problem seems to be caused by certain departmental and organizational polices; such barriers limit what is expected of the RT and has created tension amongst some of the same team members, i.e.: nurses and physicians. The RT working within anesthesia is clearly empowered and is granted more independence in carrying forth tasks without guidance. The RT and the anesthetist seem to collaborate more in their leadership efforts and are supported by the department.

Therapists who worked in both respiratory care and OR had a positive self-concept, role orientation and appeared ready to lead. Once again, it appears that polices and procedures allow the RT to perform certain skills in some areas but restricted them in others. For example, RTs working in anesthesia were not allowed to touch mechanical ventilators in an ICU setting despite having the same background training. Those therapists who simply took orders from nurses or physicians had a negative self-concept and role orientation. Many of the therapists within this grouping felt that it was hopeless for them to excel because “nurses were in charge” or “nurses always get what they want”. Other important factors include: discouragement from department heads towards taking on more of a leading role, lack of respect towards the profession, favoritism towards some workers over others causing tension and restricting personal growth.

B. Dimensions: Rodger Adair (2008) dimensions represent how a follower views themselves, within the workforce and expresses the appropriate behaviors in their position and organization (Figure 2.3.2A). The present study did not capture the full extent of Adair's theory due to the small sample size. However, for the participants within the study what was found was a mix of *doer* (quadrant II) and *disgruntled* (quadrant IV) types. In the analysis of tables 4.4A, 4.4C, 4.4D, 4.4E and 4.4F, *doers* seem to be the ones who:

A. Are in a younger age category
B. Have more experience due to either having an undergraduate degree or degrees in other disciples
C. Are working in both anesthesia (OR) and respiratory care.

The *doers* feel empowered by their leaders and are ready to lead or follow based on the situation. *Doers* do not place limitations on themselves regardless of the restraints created by policies, procedures or other staff members. *Doers* are often selected by department heads to orient new staff members and appear to have other leading roles outside of the hospital in educating others.

The *disgruntled* RT felt as if their values were not being met. In some instances, the RT felt that their department heads were not supportive and did not care enough to help them better themselves. Many have felt that

nurses were “running the show” and that their role was simply based on following doctor’s orders. Others have felt they had very little input in decision-making despite their extensive level of expertise. The RTs who were labeled as *disgruntled* seem to be heading towards becoming *disengaged*. However, further research would be needed to confirm this statement as being significant as it is presently an general observation from the field work.

D. Empowerment: Ira Challeff (2009) created four different degrees in which followers supported their leaders: *Implementers, partners, resources* and *individualists.*

The present study found that respiratory therapist who worked in both respiratory care and anesthesia or those that have a higher education appeared to fit the *implementers* category. Recent graduates had a better understanding of the latest technological trends, carried forth departmental change and were placed in positions to educate coworkers. An empowered RT’s work thus became more effective, was encouraged and respected throughout other areas of the hospital.

*Partners* tended to be RT’s who worked in both respiratory care and anesthesia (OR). They were empowered by their leader (Anesthetist) respected and trusted. For example, what was discussed by participants

who worked in both combined positions stated “the Anesthetist allows the RT to continue delivering anesthetic gases and drugs while they were not present in the OR theater”. Leadership is clearly transferable in this setting as the RT is expected and is granted the right to lead.

The *Individualist* may be found in some instances where the RT feels empowered and is viewed as effective in their assigned tasks. They can change the status quo, lead and educate other followers or leaders. They challenge the leading doctors, departmental procedures and policies or nurses as far as possible either to win by becoming a leader or loose by being forced to follow orders.

E. Followership Styles: Robert Kelley (1988) distinguished five different followership styles based on their level of motivation and behavior: *the alienated follower, passive follower, the conformist, exemplary and pragmatic.*

The *passive* follower style can be found in the RT study group based on their self-concepts and departmental influences. This is evident in statements such as: “We follow what is asked of us...”, “… just doing our job and adhering to doctor’s orders..”; “ …lack of respect for what we do”, “…we are not depended upon to lead just to follow…” (Table 4.4D). This attitude and self-concept may translate to the conformist level of motivation and

behavior, creating a lack of independence and critical thinking (Kelley, 1988). The *exemplary follower* is similar to the *implementers* being that they are the ones who worked in both respiratory care and anesthesia or apparently have higher education.

F. Interactional framework: Rich Hughes et al (2006) interactional framework model depicts leadership as a function of three elements: *the leader, the follower and the situation*.

This study presented diverse responses from the respiratory therapist about the leader and follower interactions. In table 4.4B, the respiratory therapists were asked to define key terms from their own perspective. *Leadership* was defined as individuals who lead others in accomplishing a task, a way of leading followers (Table 4.4B). *Followership* was defined as a willingness or process of following a leader or learning to be a good follower. Only four participants responded to this due to the fact they had little knowledge that the word “followership” existed. A *leader was* defined as someone having particular characteristics as intelligence, charisma, sets challenge, stands up for himself or herself, is flexible and adaptable to people, situations and goals. The *follower is* someone who follows commands or suggestions without questioning and doesn’t take initiative, is not flexible, and is one who says ”Yes” to “doesn’t care about leading”.

## 5.3 RESULTING FOLLOWER TYPOLOGIES

After analysis of the data collected within the fieldwork it can be shown that there exist four types of followers within respiratory therapy:

- The Empowered: Those who are autonomous and highly skilled as well as receiving departmental support;
- The Restricted: Those who view themselves as leaders but are restricted by departmental policies and procedures;
- The Majority: those who tend to simply follow what ever is expected of them;
- The Mixed Limited: Those who are empowered and supported within one area, they may view themselves as leaders, but are limited in another based on organizational or departmental policies.

Table 5.3 A provides a categorical summary of the four different typologies found in respiratory therapy.

**Table 5.3 A**
**Categorical Results of Respiratory Therapist Typology**

**RT1**= (1 yrs OR, 8yrs RC, MUHC, UG, 28 yrs old)

**RT2**= (16 yrs RC, AC, ATH)

**RT3**= (2 yrs OR, 6 yrs RC, TC, ATH,32 years old)

**RT4**= (4 yrs RC, MUHC, 25 yrs old, M)

**RT5**= (5 yrs OR, yrs RC, CC, ATH, UG, 30 years old M)

**RT6**= (12 yrs RC, ATH, 51 years old, F)

**RT7**= (15 yrs RC, MUHC, 49 yrs old, F)

**RT8**= (7 yrs RC, ATH, 28 yrs old, M )

**RT9**= (1 yr OR, ATH, 21 yrs old, F)

**RT10**= (2 yrs OR, 9 yrs RC, CI, ATH, UG, 31 yrs old)

| Resulting Categories | Respiratory Therapist (Types) |
|---|---|
| **Majority (6 out of 10)** | The majority who tend to simply follow what ever is expected of them. (RT2, 4, 6, 7, 8, 9) |
| **Restricted (2 out of 10)** | Those who view themselves as leaders but are restricted by departmental policies and procedures. (RT3 & 5) |
| **Empowered (4 out 10)** | Those who are empowered by their autonomy and skill set who receive departmental support. (RT1, 3, 5, 10) |
| **Mixed Limited (empowered but restricted) (2 out of 10 )** | Those who are empowered in one setting but restricted in the other settings based on policies. (RT3 & RT5) |

Note: The number of responses outweighs the total number of respondents as some respondents offered more than one unique explanation to the question at hand.

Source: Donald Oxford York, 2010

*The empowered* respiratory therapists tended to be the ones working who consistently received support from their leader and who in turn expected them to be autonomous, professional and to acquire assistance when necessary.

*The restricted* respiratory therapist had the ability and readiness in both respiratory care and anesthesia (four participants). The RT appeared to play the

role of leader external to the hospital settings through other external achievements or secondary careers. They are supported and encouraged by their department to lead in their specialized tasks. The restriction placed on the therapist was based on having more autonomy in particular areas of the hospital (i.e. Intensive Care Unit versus Emergency Department).

*The majority* of respiratory therapists felt that their career was based on following or adhering to orders given by doctors and nurses. They felt limited due to departmental and organizational policies or procedures. Furthermore, the majority felt as if their profession wasn't being respected due to not being involved in decision-making or from a lack of support and/or favoritism stemming from the organizational level (i.e Nursing). The majority in general considered the field of respiratory therapy as being an autonomous field, however they also felt that in reality there was very little autonomy being practiced. This paradox was seen as being the primary factor that lead to feelings of frustration for this group of participants.

*The Mix Limited* is a combination of those who are autonomous in their tasks within one area but are limited in their tasks in another area not due to skill level but instead due to departmental or organizational restrictions and policies. These individuals are empowered, have leading roles and are supported within certain areas of the hospital but remain limited elsewhere.

## 5.4 THE NATURE OF FOLLOWERSHIP RESEARCH

The nature of followership research presents conflict within our common understanding of leadership thereby forcing the reader to a cognitive reconstruct. As introduced earlier in Chapter 2, Edward De Bono (1999) designed the *Six Thinking Hats* (thinking styles) model in order to examine the various possibilities within a complex situation or challenge (Bono, 1999). The colors of the Six Thinking Hats (STH) worn are: *White, Red, Black, Yellow, Green and Blue* (Bono, 1999). The "Six Thinking Hats" approach of assessment will be reexamined from Chapter 2, Table 2.6:

**Table 2.6**
**Edward de Bono - 1999**
**The Six Thinking Hats**

| | |
|---|---|
| White Hat | Focuses on obtaining the existing facts and information about the situation or challenge. |
| Red Hat | Explores the emotional and intuitive aspects for justification of the present views. |
| Black Hat | Is the judgmental, critical and analytical aspect of the search for what is by using logical negative view. |
| Yellow Hat | Uses a positive logical view for searching for the benefits and what is good. |
| Green Hat | Places emphasis on creative thinking and generation of new ideas. |
| Blue Hat | Takes control of the process and the steps involved: it is "thinking of thinking". |

Source: Bono (1999)

Taking the basic premise of De Bono's Six Hat Theory and applying it to the study of followership–leadership one can see that changes in the situational dynamic and environmental constraints presented to follower-leaders may necessitate the adoption and recognition of the wearing of different hats. This in turn helps to illuminate the multifaceted nature of the followership-leadership paradigm. The adoption of this theory to followership-leadership helps to underscore the complex nature of the field and the reality that a future and complete theory needs to reflect this reality. What follows is a short discourse on the Six Hat Theory and how it can be specifically applied to the field of followership-leadership studies.

Putting on a White Hat to examine the phenomenon of followership should reveal that leaders need followers to help them follow what they themselves are following. This relationship takes the form of shared response-ability to a shared calling. Both the leader and follower find each other in true fellowship to create and produce responsibly. In accordance with de Bono's theory, James Maroosis states: "Leadership teaches the way by sharing and co-creating a path for both to follow" (Maroosis, 2008, p. 23).

While wearing a Red Hat, the study of followership presents a very sensitive, rational, emotional and very insightful aspect to the leadership process. Leadership is known as being both rational and emotional (Hughes, Ginnett, &

Curphy, 2006). In the research, followership just as leadership consists of actions and influences based on passion, inspiration, logic and reasoning. The apparent difference between follower and leader becomes critical during the situations such as a crisis. Conflict may arise for the follower if they perceive there to be issues between their goals, ethics, and those of the leader. The list of variables that influence the development of a follower into a leader (and vice versa) is:

- Their self-concept
- Level of trust and respect
- The situation
- Their personal strengths
- The organizational policies
- The follower's emotions can affect the leader negatively, positively, constructively or destructively.

The Black Hat reveals that within follower styles there exist individuals who would rather wait for occurrences to take place. This can affect the leader's goals, attitudes and behaviors. At the same time, there are followers who have developed learned-helplessness due to their lack of support from the department or organization. Therefore, the negative stereotypes associated with being a follower are confirmed as true concerning their behavior and attitude. In turn, these aspects deem followers as ineffective and being of little contribution or consequence to the leader, organization or departmental goals.

The Yellow Hat reveals the view that is based on organizations and departments who empower their followers due to acceptance and acknowledgement of their skill sets. These empowered followers' crossover in skill sets allows them to lead within the given area of expertise or alternatively when the leader fails. In these instances, a follower's effectiveness can be looked upon as acts of leadership. Being a leader should not be about organizational ranking and power but a set of personal abilities, skill readiness and abilities that can be learned if the desire and motivation is present. Leadership should be assessable to everyone once there is the development of trust and respect.

Switching to the Green Hat*,* one sees that leadership becomes a collaborative process intertwined amongst the leader, follower and the situation. Good leaders know how to follow and they set an example for others in the group (Kelley, 1990). Instead of distinguishing between the concepts of leader and follower, it should be looked upon as a reciprocal and collaborative leadership effort within team dynamics. In this approach, both parties are looked upon as one unit aiming to achieve the same goals and allowing the other to shine. Keep in mind that both concepts of leader and follower cannot exist without the other, having more opportunities to collaborate, relate, educate and construct seems to be the more important constituents of the leadership process. Lastly, collaboration between the leader and follower should not be interpreted as a threat or of being a competitive or individualistic effort.

According to the Blue Hat, the present study reveals two important components effecting the development of follower effectiveness:

1. Departmental and Organizational Structure: There is a need for more passion and care from the employer for their employee's development and growth. Instead of seeking and investing in external talent searches the organization looks internally to fill roles from the diversified team members. This should make the employees feel more assured within their positions and roles and can help to prove that followers can be fostered into the leadership process. According to Barbara Kellerman," followers can be agents of change…[and] form a large group of great potential power. Followers can sidestep leaders…[and at the same time] have an obligation to support good leadership and thwart bad leadership" (Kellerman, 2008). The structure dictates the follower's form and the way they interact with the internal or external leader as well as with other followers. Developing cohesiveness among structure and toward the leaders should increase participation, cooperation and communication.

2. The Designated Leaders: should attempt to educate their group members to improve themselves and their worth. Furthermore, the designated leader should allow for delegation to take place creating a shift in attention to other tasks and to generate effective leader substitutes. Part of a

leader's duty should entail enhancing group members' decision-making abilities, skills and increasing overall motivation. This will make the group feel more part of the process. In addition, the leader can learn from the follower, therefore the sharing of knowledge is taken as being essential to being an effective leader or follower.

### 5.4.1 DEVELOPING FOLLOWERS INTO LEADERS

The work of Robert Kelley provides many of the important aspects in developing an effective follower into a leader. In Kelley's article, "In Praise of the Follower" effective followers share a number of essential qualities to those of leaders, they are: (1988, p. 144):

- Self-managed;
- Committed to organizational goals and to a purpose principle or person outside themselves;
- Competency builders and focus their efforts for maximum impact;
- Courageous, honest and credible.

The above is important in so far as it shows that ineffective followers acquiesce into the chain of command and largely see themselves as subservient. Their sense of powerlessness is based on fear that may transform into a self-fulfilling prophecy. One must keep in mind that, not all leaders or organizations appreciate

having effective followers and would simply prefer having sheep or “yes” people (Kelley, 1988).

## 5.5 POWER STRUGGLES IN CRITICAL CARE SETTINGS

Part of the problem in leader-follower exchange within critical care settings is based on power struggles between nursing, respiratory therapists and physicians. All three members possess “expert power” being that they all have specific specialization and essential knowledge in working in high stress environments. Expert Power also creates conflict were there are crossovers in skill as do barriers created by bureaucratic policies and procedures. The latter creates conflict by creating the possibility that follower’s decisions are not supported.

At times “legitimate power” from either physician or departmental heads may be backed by “coercive power”, thereby limiting effective followership (Table 2.2A-Types of Power). The results of the present research show that the personal definitions of the respiratory therapists concerning the term follower (Table 4.4B) fit all the existing negative connotations. The evidence would suggest that it is unknown to the therapists that followers can be looked upon as effective within the dynamic of the follower-leader construct. Interestingly, six RT’s did not know of the word “followership”.

Leadership is the product of the effort of effective followers multiplied by the effort of effective leaders. The transition from follower to leader in respiratory therapy can be very difficult as seen in the research based on factors such as departmental or organizational issues, self-concept and referent power and ego. The present research reveals that leading is possible as a follower but there needs to be intrinsic motivation and the opportunity.

The field of respiratory therapy is a fairly new profession, having existanced for only five decades (Weilacher, 2010). Developed orginally for administering medical gases to patients, advanced life support, post-opertive care, neonatal resusucitaion and much more (Weilacher, 2010). It is not suprising that the positon may be to some extent still searching for respect and a place in terms of taking on a leadership position within the larger environment of critical care. Though the present research did not extend beyond the setting of the critical care environments of the identified hospitals, with related analysis at the practitioner level, there seems to be anecdotal evidence that the profession itself, at an organizational level, has not focused on effective followership in order to revolutionize the field and place it in a more competitive position for the future.

This study has shown that the respiratory therapist meets great challenges in executing their duties within a professional and bureaucratic organzation known as a hospital. This is not necessarily the case in other areas such as sky service (nurse and RT collaborating with no physician in the environment of airplane

services) or being an advance life support and prehospital trauma educator. Higher academic degrees and continuing education beyond what is presently the norm is essential in developing effective followers who can lead when leader substitions are neeeded as well to allow them to diversifiy their professional role.

## 5.6 SUMMARY OF CHAPTER FIVE

The survey method was used to generate a set of variables relating to the issues or effectiveness of followership. After a comprehensive analysis of the research findings, the results have revealed that effective followers have leadership qualities that are similar or different from those who are placed within positions of leading. Some of the influential factors limiting the follower's ability to lead include:

1. The level of departmental or organizational support and their willingness to develop followers into leaders;
2. The organizations policies and procedures in respect to the role they wish their followers to play regardless of skill levels;
3. The leader's willingness and ability to transfer their knowledge in order to develop effectiveness and trust within their followers;
4. Lastly, the follower's attitude, behavior and perception about their job responsibility and roles they play may be self-limiting, empowering or allow for advancement in leadership positions.

The following chapter will review concepts of followership-leadership and explore the conclusive nature of the findings to provide recommendations for future research.

# CHAPTER SIX

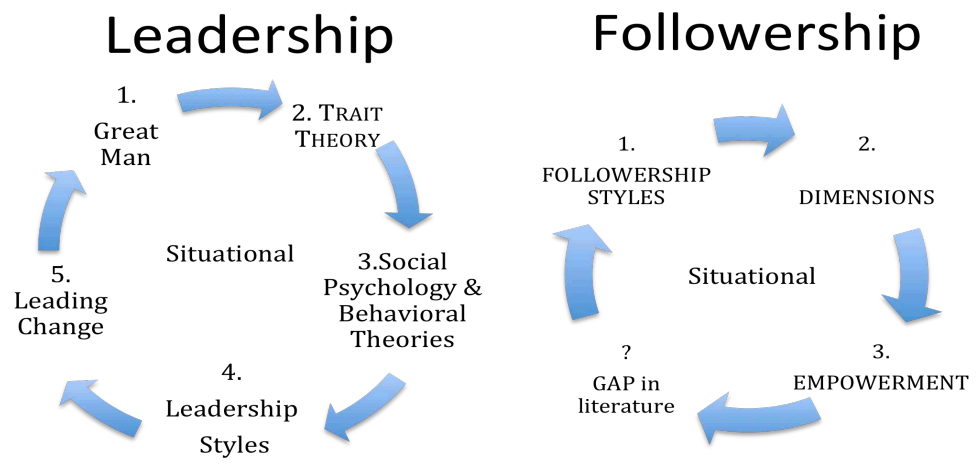
# CONCLUSIONS AND RECOMMENDATIONS

# CHAPTER SIX-CONCLUSIONS AND RECOMENDATIONS

## 6.1 REVIEW OF LEADERSHIP AND FOLLOWERSHIP

Over the last century, leadership theories have focused mainly upon the leader utilizing top-down models and bureaucratic paradigms. This thesis has broadly investigated the theoretical and empirical developments within the leadership and followership literature. As previously illustrated in Figure 2.5.6A, a schematic of the evolution of leadership and followership theories is presented again for summary purposes.

**Figure 2.56A**
**Leadership and Followership Theoretical Summary**




SOURCE: Donald Oxford York, 2010

Historically, the seminal literature has shown that leadership theories have progressed from great man to trait theories only to discover that no single trait can completely explain a leader's ability. Subsequent leadership research shifted towards a social psychology and behavioral perspective that lead into leadership styles. Modern day research continues to focus upon leadership styles in attempt to find out what constitutes effectiveness in leading change.

As presented throughout this thesis, the study of followership is creating another shift in paradigmatic thought by placing emphasis on the follower. The study of followership has begun to dissipate leader centrism and has shifted thoughts towards collaborative efforts between leader and follower. Historically, the study of followership began with follower styles. This area of study has shown that not all followers enjoy being dominated or told what to do but instead can be also dominant and effective. Moreover, followership styles have shown that followers can be relied upon and be placed into positions of leadership.

The theoretical framework for studying follower dimensions has introduced a new concept that has not yet existed in studying leaders. The importance of understanding the individual's self-concept, role orientation and their leader's effectiveness are key concepts in understanding what constitutes and differentiates leading from following.

Finally, the research explored follower empowerment. The empowerment role is fundamental in understanding the extent to which an individual views himself as someone who wants to be empowered within a particular profession (Zhang & Bartol, 2010). The empowered follower can be given the authority to lead a group based on their skill set, readiness and willingness. These factors should influence the follower's intrinsic motivation and create a process of engagement within a higher level of performance. Empowerment should moderate the link between empowering leadership (sharing of power) and leading. The key to empowerment is based on the leader's readiness, wiliness, trust and ability to delegate important tasks to those who are in a subordinate position.

For summary purposes the research question is repeated below:

**The Research Question:**

"What are the constructs, attitudes and beliefs held by Respiratory and Anesthesiologist Therapists (RATs), with respect to their operational, functional and temporal roles in assuming the position of leader or follower within the group dynamics of high stress critical care environments as understood by both their own cohort group as well as colleagues who typically assume a leadership role in the larger group."

The results of studying respiratory therapists working in critical care environments has shown to have corresponding research findings found within the literature review. However, many of theoretical paradigms found in the seminal literature on followership were not directly applicable to a professional health care environment. Nevertheless, the present research compared and contrasted the perception that established leadership theories has evoked new concepts and issues that can be further utilized within the study of followership. In addition, the present findings have provided important information that may further shape the influences of leading versus following. The following section further explores some of these newly revealed insights with respect to the above-mentioned research question.

## 6.2 CRITICAL REMARKS

This research attempted to address the situation of followership from respiratory therapists' perspectives working in critical care environments. Results of the selected methodology have shed light on the need for further research in these areas. To conclude the research has made three critical remarks concerning followership in the Respiratory Therapist working in critical care environments:

1. Lack of Respect For RT's Competency Level : There is a general lack of respect for RT's competency level and training stemming from the traditionally viewed leaders (Doctor's and Nurses) and from the departmental/organizational level.The former factors influence the level of

performance , colloboration and effectiveness of the Respiartory Therapist.

2. Lack of Self in Perfomance of Job Duties: Due the above mentioned point there has devepled on the part of the RT a lack of confidence and self-awreness that needs to be improved or reversed in order to facilitated the adoption of followership.

3. Lack of Appropriate Terminology: The lack of appropriate terminology has created a barrier to further development within the field of followership and has led to an observed separation of duties and positions. Lack of terminology does hinder the development of a specifically designed followership-leadership theory for healthcare. Therefore, what is required is a replacement of the terms “leader” and “follower” for the term terms “Collaborative” or “Reciprocal” leadership processes. Collaboration or reciprocation is the basis for effective leadership dynamics and should be used in healthcare as it is a collective effect based on accordance of situation.

New terminology needs to explore a more democratic and less hierarchical implementation of the roles and responsibilities within the workflow. This will in turn enable a greater respect for the position of RTs within skilled work groups. Thereby, having positive reinforcement of their

self-confidence, self-esteem and self-perception. With this in place, a new definition and appropriate theory of followership-leadership can begin to be developed. This represents the critical and salient issues obtained from the research study that should be the focus of future investigation.

## 6.3 RECOMMENDATIONS

Future research on followership in healthcare should focus on:

1. Culture: the cross-cultural aspects of followership may have an affect on beliefs systems, behaviors and norms. The important questions as to whether followership is something of importance or carries forth major differences if one is considering group dynamics in Africa, Greece or Japan? When exploring the difference in religion or philosophical beliefs of these particular cultures are they likely to produce a different approach to followership study that in turn can contribute to a further understanding of the varying facets the concept. Furthermore, one can ask the important question as to which factors found within cultures affect followership behaviors the most? On an organizational or departmental level one could investigate the cultural aspects affecting categorizations, styles and behaviors.

The study of followership carries forth many cultural variables. Understanding how culture fits into these theories can boost the understanding of the workings of effective leadership and followership. (Deresky, 2006).

2. Gender Differences: With regards to issues of gender one can ask the important question as to whether or not there exists gender differences in transitioning from followership to leadership positions? Are there gender differences in followership with respect to both follower behavior and follower effectiveness? The investigation of gender roles within healthcare would appear to be a very fruitful domain and beneficial to followership studies in particular. Health care tends to be a female dominated domain and would allow for further analysis with regards to the role that gender plays within the application of the prevailing theories.

3. Followership Pathway To Leading: More research should be dedicated towards examining the empowerment that the leader's role initiates in follower development in healthcare. This would be an interesting study for considering how many followers end-up shifting in to leadership roles in healthcare.

Another investigation that would prove to be beneficial would be an analysis of the interaction between followership, leadership and team

effectiveness in critical care settings. On an organizational and departmental level what should be examined is the level of confidence of participants and their understanding of the subordinate's skill sets and crossover in competencies important for the internal generation of leaders.

The study of followership in healthcare may fill the gap between the leader-follower exchanges, as the health sector must deal with professionals of all types with crossover in skill sets. The follower is becoming an integral part of the leadership dynamics and should be focused upon in a more detailed manner within the subject matter.

4. Dynamic Followership In Healthcare Team: The study of followership within health care should further examine dynamics of followership in carrying-out leadership acts. This factor should prove important when dealing with multidisciplinary teams. Followership appears to be the defining aspect in leadership acts and may prove to be a premise for analyzing the transitional phases of interaction amongst team members and the trust existing within the players in critical care environments.

5. Multi-Level Analysis Of Followership And Leadership Development: Future research should investigate leadership and followership by analyzing the perspective and influences from multiple levels of the health care system.

This will assist in advancing knowledge on leadership and followership processes, development, funding and other influences (Table 6.3 A).

**Table 6.3 A**
**Followership-Leadership**
**Levels of Analysis**

| Level | Area | Focus |
|---|---|---|
| Meta | Governmental Regulators<br>Non-Profit Standard Orgs. | Public Security and Safety |
| Meso | Departmental<br>Organizational<br>Hospital | Systems, Department Heads, Budget Allocations, Policies and Procedures |
| Micro | Individual | Doctors, Nurses, Respiratory Therapists |

Source: Donald Oxford York, 2010

The present research focused upon the "Micro level" which was based on the leadership-followership paradigm within the area of the individual (Respiratory Therapists). On a multiple-level of analysis of Followership-Leadership we see:

A. Micro Level - the research is concerned with developing a basic understanding of belief and values, human aspirations and purpose with an organization. The goal is to define what is important and worth pursuing to the individual. The micro level can be and often

is viewed as the starting point of analysis. However, the thought of the primacy of the Micro-level as being the most important departure point of analysis in and of itself needs to be further researched. Though, the individual actor in followership-leadership studies is considered critical other actors at the organizational and societal levels as well as higher-level organizational constraints and imperatives may prove to be more of a determining factor in the adoption of any specific followership-leadership paradigm or theory.

B. Meso Level -the research should determine whether or not the micro level discoveries within leadership and followership paradigm are feasible, are real and meet objectivity in the presented judgments. The Meso level should allow for further analysis of the challenges, obstacles and the possible barriers at the departmental level that may prevent followers from transitioning into leaders. Through the Meso level of analysis specific tools can be generated to search for resources, study the current support systems and the potential factors that ameliorate leadership within health cares systems.

C. Meta Level-the research should transform the results from Micro and Meso level into further understanding the needs, budget allocations of intergovernmental agencies and concern about

collaborative leadership and followership in healthcare systems. In addition, the Meta level will give insight to studying the readiness, willingness and concern of government and non-profit organizations in the allocation of funds and industry standards to developing acceptable industry wide followership-leadership practices.

Future studies need to focus on the “Meso and Meta level” to provide a deeper understanding of the rationality, reality and barriers in the implementation of developing followership and leadership in healthcare. Furthermore, other actions and behaviors from upper level management and organizational goals can themselves be determined.

## 6.4 RECOMMENDATIONS FOR FOLLOWERSHIP DEVELOPMENT PROGRAMS

The present research investigated the norms and assumptions behind followership and leadership within the critical care environments of the leading hospitals of the MUHC in Montreal, Canada. The study compared and contrasted the actual applied, on-the-ground practices of critical care practitioners as evidenced in the field-work through existing models based on the seminal literature. The models were described in detail along with their applicability to observed behavior as fitting within their existing frameworks. In some observational instances exclusions as per the “fit” within the constructs of the

models were mentioned. However, the present research stopped short of creating new frameworks or models when it was shown that essential elements were lacking or new evidence pushed the boundaries of existing models. This critical and important analysis and next step should be taken in follow up studies by other researchers, or at a higher level of study.

In pursuing this next step and developing a model for effective followership to become effective collaboration and in some instances leader substitutes future researchers would be wise to include the following six elements based on the evidence uncovered during the current research:

1. Redefinition Of Terms: More educational programs and support of team member's skills and abilities are needed. At the organizational level and departmental level, there must be a redefinition of terms. Following precedes leading and is the basis for leadership positions. One cannot learn to lead without following and vice versa. The terms leader and follower are interchangeable within health care. Contrary to popular belief, it is not possible for any healthcare professional to lead at all times. Therefore, a generally accepted definition of "followership" should be further defined and may possibly take the form of something similar to the following:

> "the process of developing essential elements to reciprocate, collaborate or substitute a leading role. It is based on individuals' readiness, ability and willingness to lead others and themselves towards accomplishing a particular goal".

A generally accepted definition of the term "Leadership" should be further refined along the lines of:

> "the interchange between leading and following based on situational context".

Leadership rotates between leading and following based on an area of expertise. Leadership should be viewed as being dispersed throughout an organization not only based upon one person or type. The terms "leader" and "follower" should not exist in healthcare as each team member is part of the leadership process and is critical in terms of patient safety. As a replacement for these terms "Collaborative" or "Reciprocal" leadership should be implemented. The words collaboration or reciprocation are the heart of effective team dynamics and should be used as all health care professionals work in tandem according to the situation. Final decision-making should be a collaborative process as no one professional can get through all the areas of expertise alone. However, it is recognized that

there most likely exist real challenges to effectively introduce new terminology into the professional lexicon.

2. Educating On Followership And Leadership Theories: Those who possess the willingness, readiness and ability should be taught about existing leader and follower theoretical models, styles and the factors responsible for effective collaborative leadership. The goal will be for the learner to develop flexibility in styles of leading and following as there is no one best way, but instead should be able to transition through different conduct based on situational contexts. The learner will have the ability to make informed strategic decisions on a personal and group level. In addition, each learner would possess a broad knowledge that is relational to his or her particular skill set and domain. The research indicates that one of the major differences between subordinates and leaders appears to be their level of education. What the area of followership needs is greater dissemination of the knowledge on how to become part of the leadership process. Thus, further research may also look at the programs and policies needed to further reinforce institutional support for followership-leadership education within the organization of the hospital setting that can be made easily accessible to practitioners.

3. Developing Followership Into Leadership: Researchers may also study the effect that greater or lesser emphasis on hiring external consultants to fill

vacant roles has on the effectiveness of existing followership-leadership adoption within the healthcare environment. There is a wealth of cultural and foundational knowledge as well as experiences internal to an organization, especially in a large modern hospital. Internally, there exist a diverse and dispersed talent pool that simply needs to be further developed. It is believed by the author that effective leadership cannot be put into practice unless followership skills are developed internally. Moreover, there is the possibility for the organization to reap potential gains in savings in human resource recruitment costs if they are able to become more efficient and effective at developing internal resources.

The first stage of developing these skills come from self-awareness through training programs to develop independent critical thinking, self-management, and an understanding of the similarities and differences between leadership and followership roles. The goal is to develop strength, learn delegation, substitution, role orientation, effectiveness and balance through a process of self-discovery. Further study can aid in developing these programs.

The second stage requires the organization or department to have evaluations (self and small group) and feedback on performance, including feedback for employees on both leadership and followership roles. Future

studies can help in providing a roadmap to help determine the best fit for procedures to address the above.

The third stage would involve the role of leadership training and development into personal and organizational effectiveness. This should be achieved through assessment and development of personal leadership skills suitable to meet organizational goals. With regards to this level of analysis future studies can provide a wealth of potential informational content on leadership training with regards to form and function.

4. Preparation of Change and Crisis: In healthcare, crises are unavoidable and one must constantly prepare for change. Developing skills for leading and managing the process of change during critical times is crucial. This will include generating team effectiveness through collaborative efforts to become balanced change agents (when to lead and follow), strategist and implementers. The learner will need to study the various existing models of change and change management. Furthermore, the participant should learn to utilize various methods in collaboration to stimulate group participation, gain commitment and minimize reluctance or resistance to change. Thus, a whole area of study devoted to the practice of change management as it relates to the followership-leadership dynamic can take place to further assist in developing a more cohesive work place environment.

5. Peer Transfer of Leadership Experience: It would seem likely that those who are in leadership positions are obliged to develop and educate with the aim of developing expertise within other members of the team. The intention behind this thought is two fold: the first path is to enhance team members' role status in preparing to lead through empowerment. The second is to strengthen individual's talents to improve organization and patient safety. This can be accomplished by any of three methods: *peer education, mentoring and coaching*.

   The intent will be to allow each professional to learn how to work with one another, assist each other and to understand and acknowledge where substitution can take place through similarities in skill sets. This most likely should be an obligation of the empowered leader to create organizational performance and self-managed groups, establish respect for workers' talents and strengths, formulate shared responsibilities amongst same departments and others, and removing unnecessary limitations through enhancing growth (individual and departmental). Further study should be implemented in order to determine the best method to enable the above.

6. Trans-Cultural Leadership Development: cultural diversity is complex and requires developing sensitivity. The importance of examining cultural aspects is based on learning how to collaborate effectively by drawing

upon the strengths that different cultures have to offer and thereby minimizing the cost of disruption and increase the potential for integration with the organization.

The first level aims to understand how diversity shapes individual behaviors through studying ethnicity, race, religion and national backgrounds. Level two would explain how these individuals are influenced or may be deterred by the standards, ideals, values, goals and experiences of the organization. The third level would study the effects of organizational culture. The above represents a potential of immense study for academics and professional practitioners and can prove to be a fertile ground for the development of efficient and effective policies and procedures.

## 6.5 CHAPTER SIX CONCLUDING THOUGHTS

According to Mary Guidera and Christine Gilmores “Effective followership not only serves to enhance leadership but is essential to a leader’s survival” (1988, p. 1017). Leaders cannot exist without followers; leading is not possible without learning to follow. The field of followership is still at an infancy stage yet is the central element to leadership. Followership research allows for opportunity in developing a new area of inquiry. The continual study of followership will make an impactful contribution in societal, organizational and individual behaviors and actions.

# APPENDICES

## APPENDIX A: CLINICAL HOURS

| RESPIRATORY AND ANESTHESIA TECHNOLOGY (R.A.T)<br>CLINICAL HOURS |
|---|
| http://www.vaniercollege.qc.ca/respiratory-anaesthesia/internships.html<br>(Vanier College, 2007) |
| Students enrolled in the Respiratory & Anesthesia Technology program also practice in hospitals mainly based in Montreal. |
| The amount of time spent as fieldwork is broken down as follows during our 3 year term: |
| 1st Semester: 10 hrs |
| 3rd and 4th Semester: 75 hrs |
| 5th and 6th Semester: 420 hrs |
| **Specialty areas where our students practice range from Operating Rooms, Intensive Care Units, Emergency Rooms, Cardiopulmonary Function Labs, Wards, Sleep clinics, Transport Services.** |

# APPENDIX B: CORE COURSES

| RESPIRATORY AND ANESTHESIA TECHNOLOGY CORE COURSES | | | |
|---|---|---|---|
| 101-HSD | Anatomy and Physiology I | 141-HSE-04 | Blood Gases |
| 101-HSE | Anatomy and Physiology II | | |
| 141-HAS | Intro To the Profession | 141-HSF-05 | PFT & Diagnostics |
| 350-HSB | Basic Instrumentation | 141-HSG-05 | Cardiovascular Diagnostics & monitoring |
| 141-HSC-06 | Psychology in Health care | 141-HSH-03 | Mechanical Ventilators |
| 141-HSD-VA | Respiratory Care | 141-HSJ-06 | Diseases & Disorders |
| 141-HSJ-06 | Clinical Respiratory Care I | 141-HSM-05 | Neonatal & Pediatric Respiratory Care |
| 141-HSK-05 | Artificial Pulmonary Ventilation | 141-HSN-06 | Clinical Respiratory Care II |
| 141-HSP-10 | Clinical Pulmonary Function Testing | 141-HSQ-18 | Clinical Critical Care |
| 141-HSR-18 | Clinical Anesthesia | 141-HSS-10 | Clinical Neonatal & Pediatric Respiratory Care |
| 141-HST-04 | Case Studies & Research | 141-HSU-VA | Clinical Application of Respiratory and Anesthesia Pharmacology |
| *Source:* (Vanier College, 2007) *http://www.vaniercollege.qc.ca/respiratory-anaesthesia/course-details.html* | | | |

RESPIRATORY CARE
PROFESSIONAL ADVOCACY

**If your hospital is implementing a MET, the CSRT encourages you to provide administrators with the following recommendations:**

- It is essential that effective internal communication and marketing strategies surrounding the implementation of the team be applied to raise awareness of the MET in order to maximize its potential.
- Respiratory therapists should be considered for a leadership position on the MET and should be involved in the education and training of the team as they have significant experience in the role of first responder to patients in critical decline.

**Important facts related to respiratory therapists' knowledge of critical care:**

- Respiratory therapists have expertise in:
  - Patient assessment (respiratory, cardiac, renal);
  - Oxygen therapy;
  - Respiratory medications and the delivery of aerosolized medications;
  - Blood gas procurement and analysis;
  - Airway management (both invasive and non-invasive);
  - Ventilation (both invasive and non-invasive);
  - Pulmonary hygiene; and
  - Anatomy, physiology and pathophysiology, with an emphasis on (but not limited to) the respiratory system.
- More than 50% of respiratory therapists are certified in ACLS
- Many respiratory therapists provide first response to patients that are experiencing a pre or post cardiac arrest medical emergency.
- Respiratory therapists have significant experience in applying critical care knowledge outside of the ICU setting.

*SOURCE: http://www.csrt.com/en/professional/advocacy.asp* (CSRT, 2010)

# APPENDIX C: STANDARDS OF PRACTICE

CANADIAN SOCIETY FOR RESPIRATORY THERAPY
**STANDARDS OF PRACTICE FOR RESPIRATORY THERAPISTS**
(CSRT, 2010)

## SPECIALIZED BODY OF KNOWLEDGE

- Respiratory therapists possess a specialized body of knowledge, and base the performance of their duties on respiratory therapy theory and practice.
- Respiratory therapists are essential members of the healthcare team, and assume a variety of roles in different areas of practice, such as clinical, education, health promotion, management, research, administration, and consulting.
- Respiratory therapists practice independently, interdependently, and collaboratively, and may practice within legislated professional regulations.

## SAFE PRACTICE AND APPLICATION OF KNOWLEDGE AND TECHNOLOGY

- Respiratory therapists safely and effectively apply their skills, knowledge, and judgment based on the needs of their patients.
- Respiratory therapists are committed to quality outcomes, and intervene so as to contribute to the best possible outcomes for their patients.
- Respiratory therapists who are involved with technical procedures must do so in accordance with any regional, provincial, or manufacturer standards or recommendations. These procedures must incorporate best practice standards, and should be research based.
- Respiratory therapists, in consultation with peers, relevant others, equipment manuals, and CSA guidelines shall select, operate and maintain equipment to provide safe, effective care.
- Respiratory therapists ensure that all equipment is appropriately cleaned, disinfected or sterilized, and is properly maintained and calibrated by trained personnel.
- Respiratory therapists will notify and discuss with the physician if he or she feels the ordered therapy/diagnostic procedure is inappropriate for the patient's condition. The respiratory therapist may refuse to perform such therapy/diagnostic procedure if they feel that it is detrimental to the patient. Such refusal must be made clear to the physician and be documented.

## COMMUNICATION AND COLLABORATION

- Respiratory therapists shall understand the objective of the ordered therapy/diagnostic procedure and will clarify with the physician if necessary.
- Respiratory therapists will inform the patient of the therapy/diagnostic procedure that will be performed, respecting the personal and legal rights of the patient including the right to informed consent and refusal of treatment.
- Respiratory therapists will maintain effective communication with members of the healthcare team regarding the patient's status and progress.
- Respiratory therapists will institute immediate supportive measures and notify relevant members of the healthcare team in the event of deterioration of the patient's condition.
- Respiratory therapists will document all information relevant to the provision of care as per organizational policies and procedures.

## ASSESSMENT

- Respiratory therapists will determine the initial clinical status of the patient, and ensure the ordered therapy/diagnostic procedure is consistent and correct for the patient's condition.
- Respiratory therapists will collect data from the patient, the patient's family, members of the healthcare team, health records and reference material to identify the patient's level of function as well as relevant risks affecting and factors contributing to the patient's health.

## PLANNING

- Respiratory therapists will develop and implement the plan of care in collaboration with members of the healthcare team.
- Respiratory therapists use evidence-based knowledge in selecting strategies and interventions.
- Respiratory therapists select strategies and interventions according to their effectiveness, efficiency and suitability in relation to the goals of the plan, and ensure that the goals of the plan are appropriate for each patient.
- Respiratory therapists will maintain, modify, or discontinue the plan in consultation with members of the healthcare team.

## EVALUATION

- Respiratory therapists will evaluate the effectiveness of strategies and interventions by comparing actual outcomes to anticipated outcomes.
- Respiratory therapists will use the results of the evaluation to improve

policies and procedures in respiratory therapy practice related to patient care.
- Respiratory therapists will evaluate his/her performance of individual procedures and overall practice

## PROFESSIONAL ACCOUNTABILITY AND RESPONSIBILITY

- Respiratory therapists are accountable for meeting the ethical and legal requirements of the profession of respiratory therapy.
- Respiratory therapists shall follow sound scientific procedures and promote ethical behavior in practice and in research.
- Respiratory therapists shall demonstrate behavior that reflects integrity and compassion, supports objectivity, and fosters trust in the profession and its professionals.
- Respiratory therapists shall report unsafe practice or professional misconduct of a peer or other healthcare worker to appropriate authorities.
- Respiratory therapists will provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.
- Respiratory therapists shall refrain from indiscriminate and unnecessary use of resources, both economic and natural, in their practice of the profession.
- Respiratory therapists promote disease prevention and wellness.
- Respiratory therapists promote the growth of the profession, and present a positive image of respiratory therapy to the community.

## CONTINUING EDUCATION AND COMPETENCE

- Respiratory therapists are committed to life-long learning to upgrade their knowledge and skills in order to keep their practice current.
- Respiratory therapists shall assume responsibility for maintaining competence in their practice of respiratory therapy, and shall seek opportunities for professional growth.
- Respiratory therapists shall acknowledge limitations in their knowledge, skills, or judgment, and will function within those limitations.
- Respiratory therapists strive for excellence in the profession by participating in, and promoting the use of self-assessment tools as well as obtaining feedback from appropriate others in order to determine and improve their knowledge, skills, and judgment.

*SOURCE: http://www.csrt.com/en/professional/standards_practice.asp*

# APPENDIX D: HUMAN SUBJECTS APPROVAL FORM


## Human Subjects Approval Form

1. Investigator: Mr. Donald Oxford York, RRT, BA
2. Title of Research: The Respiratory Therapist: A Study of Followership Within Critical Care Environments
3. Duration of Study: January 2009; concluded March, 2010
4. Location: Jewish General Hospital, St. Mary's Hospital and McGill University Health Centers (MUHC)
5. Subjects: Respiratory therapist working in critical care settings
6. Contact method: Email, Telephone and Departmental Notice.
7. Procedures: Questionnaire and follow-up semi-structured interviews
8. Purpose of Study: To study the respiratory therapist views on followership and leadership
9. Risks and Benefits: The questionnaires pose no potential risk to the subjects. After the session is finished, participants will receive a description of the objectives and procedures, and can request a copy of the data analysis. This experience should be of educational value to the field of Respiratory and Anesthesia technology and the study of leadership-followership in professional organizations. Identifying their professional goals as leaders or followers in the health profession and discuss ways of achieving these goals. It will encourage others to amass knowledge on this currently underdeveloped research sphere.
10. Informed consent: See attachment

# APPENDIX E: CONSENT TO PARTICPATE IN RESEARCH STUDY


**CONSENT TO PARTICIPATE IN RESEARCH STUDY**

TITLE OF RESEARCH: The Respiratory Therapist: A Study of Followership Within Critical Care Environments

INVESTIGATOR: Mr. Donald Oxford York, RRT, BA

PURPOSE OF STUDY
To study the respiratory therapist views on followership and leadership

PROCEDURES
Questionnaires and follow up semi-structured interviews

RISKS AND BENEFITS
The questionnaires pose no potential risk to the subjects. After the session is finished, students will receive a description of the objectives and procedures, and can request a copy of the data analysis. This experience should be of educational value to the field of Respiratory and Anesthesia Technology and to will be a positive contribution to the study of leadership-followership in professional organizations.

CONFIDENTIALITY
Original information will be destroyed.

RIGHT TO REFUSE
At any point in the study you may refuse to participate. You may quit or change your mind about being in the study after it has commenced.

QUESTIONS
At any point in time should you have questions please do not hesitate to ask. If at a later time any questions should arise. The principal investigator can be reached at 514-685-4330 or 514-330-9675. Also, by email dyork@oxfordyork.net . You will be given a copy of this form.

_____ _____

Date Signature of Participant

APPENDIX F: QUESTIONNAIRE


## QUESTIONAIRE

**(please provide responses by email within 5-7 business days to allow feedback and set appointment times to meet if necessary)**

### RESPIRATORY THERAPIST PROFILE

1. Email address:
2. Phone number: (if wished to be contacted)
3. Gender: Male or Female
4. Title and main units of work (can circle more than one): NICU, ICU, PACU, ER, OR, WARDS, Laboratory setting, Sky Service, Other_____
5. Other areas of specialty or study:
6. Years within the discipline:
7. Age Range: 20-25, 25-30, 30-35, 35-40, 40-45, 45-50, 50-55, 55-60, 60-65
8. Center(s) of practice: McGill University Health Center (MUHC), McGill Affiliated teaching hospital, Other_____
9. Place of Birth:
10. Cultural background:
11. Family Religious or philosophical upbringing:

# APPENDIX G: FOLLOWERS CHARACTERISTICS SURVEY

## FOLLOWERS CHARACTERISTICS SURVEY

**(Please be very critical and analytical with your responses)**

1. Define the following terms: Leadership, Leader, Follower and Followership?
2. What determines leaders and followers within your area of expertise?
3. Are you a leader, follower or both? How does your role identify with these concepts?
4. Is leadership something that is transferable within your position and/or in particular situations?
5. What are some of the departmental or organizational influences that effect or affect the leadership process?
6. What are key characteristics to be effective in critical care situation?
7. What do you admire in others who lead? What is your approach in a critical care setting?
8. Who leads changes when crisis occurs within a critical care setting? Who leads the situations when the leader is not available at the moment?
9. What type of influence does the leader's power have on the follower within critical care situations?
10. How do followers influence leader's behaviors and attitudes?

# APPENDIX H: EXAMPLE EMAIL

| | | | |
|---|---|---|---|
| **From:** | Donald Oxford York <dyork@oxfordyork.net> | **Sent:** | Mon 22/02/10 18:38 |
| **To:** | <RT1@yahoo.ca>, <RT2@hotmail.com>, <RT4angel@hotmail.com>, <RT5... | **Priority:** | Normal |
| **Cc:** | <RT7@gmail.com>, <RT8@hotmail.com>, <RT9@hotmail.com> | | |
| **Subject:** | The Respiratory Therapist: A Study of Followership Within Critical Care Environments | **Type:** | Attachments |
| **Attachments:** | The Respiratory therapist.doc 262 kb | | |

**The Respiratory Therapist: A Study of Followership in Critical Care Situations**

Dear fellow Respiratory Therapist,

As a graduate student in the department of Philosophy in Business Research, invite you to participate in a study based on followership conducted by Mr. Donald Oxford is required to conduct research as part of the requirements for a Master degree in Philosophy in Business research. It is being conducted under the supervision of Dr. Jeffrey Henderson, Ph.D.

You are invited to participate in a study entitled ***The Respiratory Therapist: a study in followership in critical care*** situations by Donald Oxford York.

It is being conducted under the supervision of Dr. Jeffery Henderson, affiliate professor of Grenoble School of Management and Director of Monarch Business school. The purpose of my research project is to discover to what extent RT's subscribe to a shared set of beliefs about their position and roles.

# BIBLIOGRAPHY


1. Adair, R. (2008). Developing Great Leaders, One Follower at a Time. In R. E. Rigio, I. Chaleff, & J. Liman-Blumen (Eds.), *The Art of Followership:How great followers create great leaders and organizations* (pp. 137-153). San Francisco, CA, USA: Jossey-Bass.
2. Alcock, J., Carment, D., Sadava, S., Collins, J., & Green, J. (1997). *A Textbook of Social Psychology* (3rd Edition ed.). Scarborough, Ontario, Canada: Prentice-Hall Canada.
3. Anaconca, D., Kochan, T., Scully, M., Maanen, J., & Westney, D. (2005). *Managing For The Future: Organizational Behavior and Processes.* Thomson South Western.
4. Avolio, B., Walumbwa, F., & Weber, T. (2009). Leadership: current theories, research and future directions. *The Annual Review of Psychology , 60*, pp. 421-449.
5. Baker, S., & Gerlowski, D. (2007). Team effectiveness and Leader-Follower Agreement: An empircal Study. *Journal of American Academy of Business , 12* (1).
6. Bass, B., & Avolio, B. (2004). Multifactor Leadership Questionnaire. *Multifactor Leadership Questionnaire: Manual and Sampler Set* (3). United staes of America: Mind Gardens Inc.
7. Bass, B., & Avolio, B. (2003). Multifactor leadership Questionnaire Feedback report. United Staes of America.
8. Bennis, W. (2010). Art of Followership. *Leadership Excellence , 27* (1), 3-4.
9. Bennis, W. (2008). *The Art of Followership: how great followers create great leaders and organizations.* (I. C.-B. Ronald E. Riggio, Ed.) San Francisco, CA, USA: Jossey-Bass.
10. Blanchard, K., & Hershey, P. (1968). *Situational Leadership (Blanchard-Hershey).* From 12manage.com: www.12manage.com/methods_blanchard_situational_leadership.html
11. Blanchard, K., & Hershey, P. (1968). *The Situational Leadership Model.* From 12Manage : The Executive Fast Track: www.12manage.com/methods_blanchard_situational_leadership.html
12. Bono, E. D. (1999). *Six Thinking Hats: Run better meetings make faster decisions.* England: Penguin Books.
13. Campbell, J., & Kinion, E. (1993). Teaching leadership/followership to RN to MSN. *Journal of Nursing Education , 32* (3), 138-140.
14. Carlyle, T. (1840 йил 5-May). *On Heroes, Hero-Worship , and the Heroic in history.* (R. Burkey, Ed.) Retrieved 2008 йил 26-July from www.fullbooks.com: www.fullbooks.com/Heroes-and-Hero-Worship1.html

15. Cavell, D. P. (2007). Leadership or Followership: one or both? *Healthcare Financial Management , 61* (11), 142-144.
16. Chaleff, I. (2009). *The Courageous Follower: Standing up to and for our leaders* (3rd Edition ed.). San Francisco, CA, USA: Berrett-Koehler Publisher.
17. Conger, J. (1989). *Charismatic Leadership (Weber)*. Retrieved 2010 йил 28-April from 12 manage: The executive fast track: www.12manage.com/methods_webers_charismatic_leadership.htm
18. Cruess, S., Johnston, S., & Cruess, R. (2002). Professionalism for medicine: opprotunities and obligations. *The Medical Journal of Australia , 177* (4), 208-211.
19. CSRT. (2010). *CSRT Professional Practice-Advocacy Tool Kit on Medical Emergency Teams*. Retrieved 2010 йил 10-March from The Canadian Society of Respiratory Therapy (CSRT): www.crst.com/en/professional/advocacy.asp
20. Deresky, H. (2006). *International Management: Managing across Borders and Cultures* (5th Edition ed.). (J. Shelstad, Ed.) Upper Saddle River, New Jersey, United States of America: Pearson: Prentice Hall.
21. Dickinson, H., & Ham, C. (2008 йил January). Engaging Doctors in Leadership: Review of the Litterature.
22. Dowton, B. (2004). Leadership in Medicine: where are the leaders? *Medical Journal of Australia , 181* (11), 652-654.
23. Emerald Group, p. (2010). The changing face of leadership:Different srtyles of leadership facilitate changing needs in heathcare, politics and industry. *Strategic Direction , 26* (1), pp. 21-23.
24. Follett, M. P. (1918). *The New State .* (V. Shreibman, Ed.) From www.sunsite.utke/FINS/Mary_Parker_Follett
25. Galton, F. (1892). *Hereditary Genius: an inquiry into its law and consequences.* (G. Tredoux, Ed.) From www.galton.org
26. George, W. (2010 йил 22-February). *Tradegy at Toyota: How Not to Lead in Crisis.* Retrieved 2010 йил 25-August from Havard Business School: www.hbswk.hbs.edu/item6381.html
27. Gilmartin, M. J., & D'Aunno, T. A. (2007). Leadership Research in Healthcare: A Review and Roadmap. In R. T. Group (Ed.), *INSEAD Healthcare Management initiative* (Vol. 1, pp. 387-483). The Academy of Managemet Annals.
28. Goleman, D., Boyatzis, R., & Mckee, A. (2002). *Leadership Styles Theory Goleman- Visionary, Coaching, Pace Setting and commanding: Creating Resonance*. From Value Based Management.net: www.valuebasedmanagement.net/methods_goleman_leadership_styles.html
29. Guidera, M., & Gilmore, C. (1988). In Defence of Followership. *American Journal of Nursing , 88* (7), 1017-1018.
30. House, R., & Mitchell, T. R. (1971). *The Path-Goal Theory.* From 12 manage : The Executive Fast Track: www.12manage.com/methods_path_goal_theory.html

31. Howell, J. P., & Medez, M. J. (2008). Three Perspectives on Followership. In R. E. Riggio, I. Chaleff, & J. Lipman-Blumen (Eds.), *The Art of Followership* (pp. 25-39). San Francisco, CA, USA: Jossey-Bass.
32. Howell, J., & Shamir, B. (2005). The Role of Followership in the Charismatic Leadership Process: relationahips and their consequences. *Academy of Management Review , 33* (1), 96-112.
33. Hughes, R., Ginnett, R., & Curphy, G. (2006). *Leadership: enchancing the lessons of experience.* New York, New York, USA: McGraw-Hill/ Irwin.
34. Irving, J. (1972). *Group Think (Janis)*. Retrieved 2010 йил 04-05 from 12 manage: The Executive Fast Track: www.12manage.com/methods_janis_grouthink.htm
35. Jones, H. R., & Johnson, M. (1972 йил June). LPC as a Modifier of eader-Follower Relationships. *Academy Journal of Management* , 185-196.
36. Judge, T., Ilies, R., Bono, J., & Gerhardt, M. (2002). Personality and Leadership: A Qualitative and Quantitative Review. *Journal of applied Psychology , 87* (4), 765-780.
37. Jung, D. I., & Avolio, B. J. (1999). Effcts of Leadership Style and Followers' Cultural Orientation on Performance in Groups and Individual Tasks Conditions. *Academy of Management , 42* (2), 208-218.
38. Kellerman, B. (2008). Followership: How Followers are Creating Change and Changing Leaders. 1-5. Havrd Busniess Publishing.
39. Kellerman, B. (2007 йил December). What Every Leader Needs to now About Followers. *Harvard Business Review* , 1-9.
40. Kelley, R. (1988 йил November-December). In Praise of Followers. *Harvard Business Review* , 142-148.
41. Kelley, R. (1990). Managing the New Workforce. *Machine Design , 62* (9), 109-113.
42. Kelley, R. (2008). Rethinking Followership. In R. E. Riggio, I. Chaleff, & J. Lipman-Blumen (Eds.), *The Art of Followership* (pp. 5-16). Hoboken, New Jersey, USA: Jossey-Bass.
43. Kirkman, B., Chen, G., Farh, J., Chen, Z. X., & Lowe, K. (2009). Individual Power Distance Orientation ad Follower Reactions to Transformational Leaders: A cross-level , cross-cultura examination. *Academy of Management Journal , 52* (4), 744-764.
44. Klenke, K. (2008). Qualitative Research As Paradigm. In K. Klenke, *Qualitative Research in The Study of Leadership* (pp. 3-29). Emerald Group Publishing Limited.
45. Koellner, S. G. (Ed.). (n.d.). The Goose Story. Technical Service Council.
46. Kotter, J. (1995 йил March-April). Leading Change: Why Transformation Efforts Fail. *Harvard Business Review* , 59-67.
47. Lagace, M. (2008 йил 7-July). *Innovation Corrupte: How Managers Can Avoid Another Enron.* Retrieved 2010 йил 25-August from Havard Business School : www.hbswk.hbs.edu/item/5950.html
48. Latour, S., & Rast, V. (2004). Dynamic Followership:The Prerequiste for Effective Leadership. *Air and Space Power Journal* (Winter), 102-109.

49. Lega, F., & DePietro, C. (2005). Converging patterns in hospital organizations beyond the professional bureacracy. . *Health Policy , 74*, 261-281.
50. Leitko, T., & Szczerbacki, D. (1987 йил 15). Why traditional OD fails in Porfessonal bureucracies. *Organizational Dynamics* , 52-65.
51. Maroosis, J. (2008). Leadershio: A Partnership in Reciprocal Following. In R. E. Riggio, I. Chaleff, & J. Lipman-Blumen (Eds.), *The Art of Followership* (pp. 17-24). San Francisco, California, USA: Jossey-Bass.
52. Mind Tools. (2010). *Mind Tools- Essential Skills For an Excellent Career*. (Mind Tools Ltd) Retrieved 2010 йил 19-05 from www.mindtools.com/pages/article/newTED_07.htm
53. Pearce, C., & Conger, J. (2003). *Shared Leadership: reframing the hows and whys of leadership.* Thousand Oaks, California, USA: Sage Publishing.
54. Rost, J. (1993). *Leadership For the Twenty-First Century.* West port, CT, USA: Praeger.
55. Serio, C., & Epperly, T. (2006). Physician Leadership: A New Model for a New Generation. *Family Practice Management , 13* (2), 51-54.
56. Sommer, B., & Simmer, R. (1991). *A Practical Guide to Behavioral Research: Tools and Techniques* (3rd Edition ed.). New York, New York, United States of America: Oxford University Press.
57. Spencer, H. (1896). *The Study of Sociology.* From Questia: Trusted Online Research: www.questia.com/read/92677756?title=The%20Study20%of20%Sociology
58. Townsend, P., & Gebhardt, J. (1997 йил December). *Followership: An Essential Element of Leadership.* From Quality Digest: www.qualitydigest.com/dec97/html/townsnd.html
59. Trochim, W. (2006 йил 20-10). *Qualitative Measures*. Retrieved 2010 йил 25-04 from Research Methods Knowledge Base: www.socialresearchmethods.net
60. Turmel, W. (2007 йил 25-June). *Leadership: Big "L"s and Little "l"*. Retrieved 2010 йил 30-May from Management Issues-The heart of a changing workpace: http://www.management-issues.com/2007/06/25/opinon/leadership-big-ls-and-littlels.asp
61. Vanier College. (2007). *Respiratory and Anesthesia Technology - Internships*. (V. C.-R. Technology, Producer) Retrieved 2010 йил 20-03 from www.vaniercolloege.qc.ca/respiratory-anaesthesia/internships.html
62. Vroom, V., & Yetton, P. W. (1973). *Vroom and Yetton's Normative Model .* From Changing Minds: www.changing minds.org/disciplines/leadership/theories/vroom_yetton.htm
63. Vugt, M. .. (2006). Evolutionary Origins of Leadership and Followership. *Personality and Social Psychology Review , 10* (4), 354-371.
64. Weber, M. (1920). *Charismatic Leadership (Weber)*. (1. Manage, Editor) Retrieved 2010 йил 28-April from 12 Manage: The executive fast track: www.12manage.com/methods_weber_charismatic_leadership.htm

65. Weilacher, R. (2010 йил 7-May). *AARC-50 Years of Service*. (AARC, Producer) From The History of the AARC: www.aarc.org/member_services/history.html
66. Welch, J., & Welch, S. (2006 йил 30-January). *The Leadership Mindset*. (J. a. Articles, Producer) From The Welch Way: www.welchway.com/About-You/Students/Finding-Success/The-Leadership-Mindset.aspx
67. William, B. (2004). *Understanding Behavioralism: Behavior , Culture and Evolution* (2nd Edition ed.). Black Well Publishing.
68. Yukl, G. (1999). An Evaluative Essay on Current Conceptions of Effective Leadership. *European Journal of Work and Orgnaizatinal Psychology , 8* (1), 33-48.
69. Zalezink, A. (1965). *Zaleznik's Follower Typology.* From Changing Minds: www.changingminds.org/disciplines/leadership/followership/zaleznik_follower.htm
70. Zhang, X., & Bartol, K. (2010). Empowerment, Intrinsic Motivation, and Creative Process Engagement. *Academy of Management Journal , 53* (1), 107-128.
71. Zikmund, W. (2003). *Business Research Methods* (7th Edition ed.). Ohio, United states of America: Thomson South Western.