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The Lived Experience Of Healthcare Leadership Dyads: Perceptions Of Agency

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THE LIVED EXPERIENCE OF HEALTHCARE LEADERSHIP DYADS:
PERCEPTIONS OF AGENCY

By

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ABSTRACT

Healthcare leadership is evolving in response to recommendations from the Institute of Healthcare Improvement (IHI). Physicians and administrators are partnering to form leadership dyads. These leadership dyads are focusing on improving healthcare quality, decreasing costs, and improving access. Existing literature on healthcare dyads explores leadership training needs for physicians, focuses on the differences between physicians and administrators, and emphasizes the need to develop role clarity for dyad leaders. There is a lack of empirical literature exploring how the physician and the administrator develop into a leadership team and extend shared leadership into their organization.

This phenomenological study applies Bandura's (1986) social cognitive theory, triadic reciprocity, and human agency to the lived experience of healthcare dyad leaders. The purpose is to give equal voice to physicians and administrators. This study provides insight into the similarities and differences between the physicians and the administrators in dyad leadership roles. Six participants, three physicians and three administrators, participated in semi-structured interviews. An interpretive phenomenological methodology was used to analyze the experience of each group then compare and contrast the experiences of the two groups.

Results yielded more similarities within each group than between the two groups. Administrators experienced shared leadership with their physician partners whereas the physician group was divided. The full-time physician achieved shared leadership with more than one dyad partner, but the two part-time physician leaders were unable to achieve shared leadership. Part-time physician leaders experienced significant role conflict between their clinical practice and their administrative leadership role. The two roles often overlapped causing internal demotivation and feelings of frustration. All participants experienced internal motivation and professional satisfaction when they were able to meet patient care needs or create programs and infrastructure to serve populations. The key difference in the experience of part-time and full-time physician dyad leaders fills a gap in the literature and creates opportunities for further research into dyad leadership.

Keywords

Keywords: dyad, healthcare leadership, physician leadership, healthcare administration, management, leadership, IHI outcomes

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CHAPTER 1

INTRODUCTION

The Affordable Care Act (ACA) became law on March 23, 2010; since then over 20 million people across the United States have obtained healthcare insurance (Altman, 2016; Bakalar, 2017). While recent threats and ongoing debates have kept the ACA in the forefront for politicians, practitioners and the healthcare industry are evolving to provide patient care in this rapidly changing environment. The National Center for Healthcare Leadership (NCHL) and the Institute for Healthcare Improvement (IHI) agree there is a leadership crisis in healthcare (Swensen & Mohta, 2017). In the 2001 landmark study *Crossing the Quality Chasm*, the Institute of Medicine (2001) published recommendations to create leadership models focused on increasing collaboration. The IHI proposed extending formal leadership roles to physicians to balance the financial and business acumen of healthcare administrators with the clinical and quality expertise of physicians (Institute of Medicine, 2001; Sanford & Moore, 2015; Swensen, Pugh, McMullan, & Kabcenell, 2013). Pairing clinical and business experts into formal leadership roles (dyads) and aligning expectations, rewards, and consequences is the recommended method to support the transformation of healthcare (IHI, 2018). However, there is no general agreement that the leadership dyad, an administrator paired with a physician, is uniquely qualified to navigate the turbulence created by changing legislation (IHI, 2018; Sanford & Moore, 2015). Although the dyad model has been widely adopted throughout the healthcare industry, limited scholarly research explores the lived experience of dyad leadership teams and their perception of agency as they develop into a leadership team (Swensen & Mohta, 2017; Swensen et al., 2013).

Washington State and the ACA

Adoption of the ACA's provision to expand state Medicaid services varies across the United States (Norris, 2018; Patient Protection and Affordable Care Act, 2010). In Washington State, however, more than 500,000 citizens have enrolled in the state's expanded Medicaid program since 2010 (Washington State Health Care Authority, 2018). Growth in the number of insureds has been primarily concentrated in Washington's three largest counties: Pierce, King, and Spokane. According to the Office of Financial Management, the Washington State population is expected to continue to rise from the current populace of seven million to just over nine million by the year 2040 (Office of Financial Management, 2016). The increased number of insured citizens continues to strain the healthcare system as individuals enroll in the state's expanded Medicaid program (Norris, 2018).

The ACA gave Washington citizens unprecedented access to the state Medicaid program (Loomis, 2015). The research location for this study provides healthcare services within each of the aforementioned counties and is one of the largest health systems in Washington State. The health system, a not-for-profit 501(c)3 system of hospitals and ambulatory centers, serves approximately 800,000 unique lives in facilities located in urban, under-served, and rural communities. The health system is composed of nine hospitals: seven acute adult facilities, a children's hospital, and an inpatient psychiatric hospital. Ambulatory services are offered in more than 150 primary care, specialty care, urgent care, and day surgery locations. More than 16,000 employees staff the health system and approximately 900 leaders lead teams through care delivery, business operations, and strategic growth.

The health system adopted the dyad leadership model in 2009 and began forming dyads at many levels within the organization. For example, a clinic supervisor may be paired with the clinic's medical director and tasked with improving quality and patient access. Indeed, a regional manager (overseeing multiple clinics) may be paired with a regional medical director to create the strategic growth plan in their territory. Further, a system executive can be paired with a physician executive to generate a coordinated response to changes in local, state, or federal law. At each level within the organization, the dyad shares authority, responsibility, and accountability to lead their teams and achieve their goals.

In 2017, the health system partnered with a local university and the state hospital association to offer a six-month training program for physicians and their dyad partners. The first cohort completed the program in March 2018; the second cohort begins in the spring of 2019. This formal program included didactic instruction and coursework for the physicians, followed by joint sessions that spanned an additional two months during which the dyad leadership teams completed leadership assessments and projects. The capstone project included a formal presentation to the cohort. The training was based on the NCHL curriculum for healthcare leadership (NCHL, 2005).

Statement of the Problem

The IHI triple aim provided a dynamic, interconnected model to increase access to healthcare, improve overall quality (health outcomes), and decrease the per capita cost of healthcare (IHI, 2018). Dyad leadership teams form the leadership structure that aligns expertise with need. Physicians, as the leader and provider of clinical care, influence healthcare quality. The administrator, with advanced degrees in business or administration, offers expertise in financial acumen. Together, the dyad leadership team can engage to ensure the provision of care

to populations. Creating leadership dyads provides an opportunity for both the administrator and the physician to influence and lead change. An overview of the functions of forming the dyad team and providing the team with leadership training are reviewed in the following sections.

Forming the Dyad

The demand for healthcare leaders has been outpaced by the capacity to staff healthcare systems with capable leaders (Garman & Lemak, 2011). A common approach to address the leadership shortage and address the IHI triple aim model has been to form dyad leadership teams. Creating the dyad leadership team relies on the senior executive's discretion: Senior leaders typically approach and recruit the physicians (Baldwin, Dimunation, & Alexander, 2011; Oostra, 2016; Zismer & Brueggemann, 2010). Administrators, on the other hand, may be subjected to an application and interview process (Oostra, 2016; Sanford & Moore, 2015). The physician and the administrator may not know each other prior to beginning the dyad role (Clausen et al., 2017; Resar et al., 2012). In addition to the responsibilities of co-leadership, the dyad must become acquainted while negotiating their professional relationship.

Leadership Training

Dyads are composed of physicians and administrators (Buell, 2017; Chazal & Montgomery, 2017; Oostra, 2016; Swensen et al., 2013; Swensen & Mohta, 2017; Zismer & Brueggemann, 2010). While many types of dyads are possible (Resar et al., 2012), this research focused exclusively on the physician and administrator dyad. This pairing generates considerations unique to healthcare. Physicians, trained as autonomous professionals, do not typically receive leadership training during medical school or their residency program (Cox, Irby, Cooke, Sullivan, & Ludmerer, 2006; Sadowski, Cantrell, Barelski, O'Malley, & Hartzell, 2018). Administrators, on the other hand, may not have clinical training (Oostra, 2016; Sanford

& Moore, 2015). Administrators employed by the health system in this study typically have a graduate degree in business, healthcare, or organizational leadership. Administrators with graduate degrees in clinical areas may also be placed in dyad leadership roles; this is assessed on a case by case basis. Thus, the physician/administrator dyad unites the clinical expertise of a physician with the business acumen of the administrator.

Considerations arise when either the physician has leadership training or experience, or the administrator has clinical training or licensure. Some authors contend that an administrator/physician dyad, where the administrator is also a registered nurse, experiences an additional layer of relationship difficulty offering that nurses are trained to be collaborative whereas physicians are trained to be independent (Baldwin et al., 2011; Clausen et al., 2017). Regardless of the composition of the dyad, leadership skills vary from no formal training to extensive leadership training. Sanford and Moore (2015) proposed that physicians or administrators with advanced business degrees (e.g., MBA, or MHA) may have obtained tools to understand the business or financial statements of a health system, and contend that while these tools are helpful, they are not substitutes for leadership experience.

This overview of the problem addressed several issues. Healthcare in the United States has a history of poor quality and high cost (Institute of Medicine, 2001). The enactment of the ACA has placed demands on access to healthcare (Altman, 2016; Bakalar, 2017). The industry response to reorganize leadership structures has been widely embraced (Swensen & Mohta, 2017), but there is lack of empirical research to inform the creation of dyad leadership teams. Despite these contradictions, the dyad is expected to develop mutual influence and extend leadership into their organizations to drive transformational change (Sanford & Moore, 2015).

Exploring the lived experience of dyad healthcare leaders is a first step towards understanding how the members of the dyad perceive individual and collective agency as they develop into a leadership team.

Purpose of the Study

The nation's healthcare delivery system needs leaders to assess complex situations, comprehend healthcare policy, create new infrastructure for healthcare delivery, and construct teams capable of providing high quality, cost effective healthcare (Swensen et al., 2013). Leaders in this arena must be able to influence their organization and quickly maneuver to inspire teams to work collaboratively towards a shared vision (Oostra, 2016). The physician and the administrator are central to achieving this vision (Clausen et al., 2017). Understanding dyad leadership from the perspective of healthcare dyad leaders gives voice to their experience and may provide insight on how they develop shared leadership. Exploring the phenomenon of healthcare dyad leadership may also accelerate the pace of transformation and provide insights to strengthen existing dyads. Limited qualitative research exists to describe this phenomenon. The purpose of this study is to explore the lived experience of healthcare leadership dyads within a single health system in the Pacific Northwest.

Research Questions

Because the aim of this research is to explore the lived experience of dyad leadership, the preferred methodology is phenomenology. Phenomenology, as described by Creswell and Poth (2018), is appropriate when it is "important to understand several individuals' common or shared experiences" (p. 79). Creswell and Poth (2018) also noted a distinction between transcendental and hermeneutic phenomenology; the former provides a descriptive account of the "essence of the experience" (p. 78) whereas the later provides for an interpretive approach to each

participant's experience. Interpretive phenomenology (IPA) combines phenomenology and hermeneutics (Creswell & Poth, 2018; Smith, Flowers, & Larkin, 2009). Smith et al. (2009) proposed the following definition of IPA:

It [IPA] is phenomenological in attempting to get as close as possible to the personal experience of the participant but recognizes that this inevitably becomes an interpretative endeavor for both participant and researcher. Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen.
(p. 37)

Interpretation represents a significant part of this study as the experiences of the physicians and the administrators are likely to be unique, not only on an individual level, but on a categorical level as well. Because the physicians and administrators enter the dyad relationship with different skill sets and experiences, exploring the perspective of the individual creates a basis for comparing the groups' lived experiences. This cross-comparative method is unique to IPA (Smith et al., 2009).

All qualitative research is guided by research questions (Merriam, 2009). Creswell's (2015) model proposed a central question followed by sub-questions; the central question serves to focus the study while sub-questions create depth with supporting information. Smith et al. (2009) proposed the central question drives methodology and second order questions leverage additional theoretical analysis. This research relies on the following overarching questions to establish the context for an interpretive phenomenological analysis. The second order questions aim to explore the unique experience of each participant.

1. What is the lived experience of a dyad healthcare leader?

2. What are the perceptions of dyad leaders at a single, large health system in Washington State regarding their development of shared leadership influence in their organization?
 - a. How do physicians experience the phenomenon of dyad leadership?
 - b. How do administrators experience the phenomenon of dyad leadership?
3. How do dyad leaders describe and make sense of their roles?
4. What leadership training and/or interpersonal communication training did the individuals have, if any? Do they feel that was beneficial?

Conceptual Framework

This research design used the agentic perspective of the social cognitive theory (Bandura, 1986). Supporting literature is gathered from communication theory. Leadership and social cognitive theory are briefly introduced in Chapter 1. A detailed examination of the theoretical framework is presented in Chapter 2.

Selected Leadership Theories and the Gap

Leadership has been studied by scholars and practitioners for decades. An abundance of research has described leadership, the attributes and actions of different types of leaders, and the top ten lists of most important traits (Northouse, 2016). In the 20th century, leadership theories focused on personality traits, behaviors, and relationships with direct reports (Northouse, 2016). Leaders were compared to various theories and categorized as charismatic, servant, or situational leaders (Greenleaf, 1977; Northouse, 2016; Spears, 2003). Other leadership theories described the vertical relationship between leaders and their direct reports (Kelley, 1998, 2008). Assessing leadership by studying the individual ignores the relationships that extend leadership into organizations. The dyad model used in healthcare requires an understanding of how leaders, with

equal authority, accountability, and perhaps different leadership styles, negotiate and manage their relationship and extend leadership into the organization. While traits and behaviors are important characteristics, a qualitative approach exploring how individuals with dissimilar professional training and background develop shared leadership influence remains unexplored in the literature. The purpose of this study is to explore the lived experience of dyad healthcare leaders and their perceptions of agency as they develop into a leadership team.

Social Cognitive Theory

Social cognitive theory proposed humans are capable of influencing their social systems (Bandura, 1986). Bandura's (1986) social cognitive theory stated, "human functioning is explained in terms of a model of triadic reciprocity" (p. 18). The interconnected model described a dynamic relationship between "behavior, cognitive agency, and environmental events [which] all operate as interactive determinants of each other" (p. 18). Within the triadic model of reciprocity, Bandura (2001) distinguished three modes of [cognitive] human agency.

Human agency, referred to as the agentic perspective of the social cognitive theory, proposed three interrelated models of human agency: "direct personal agency, proxy agency that relies on others to act on one's behalf to secure desired outcomes, and collective agency exercised through socially coordinative and interdependent effort" (Bandura, 2001, p. 1). Bandura (2001) considered agentic individuals "as thinkers of the thoughts that exert determinative influence on their actions" (p. 4).

This is contrasted with Bandura's (2001) definition of collective agency, which applies to groups such as the dyad, as "shared intentions, knowledge, and skills of its [the group's] members but also of the interactive, coordinated, and synergistic dynamics of their transactions" (p. 14).

Bandura's (2001) agentic perspective of the social cognitive theory and the three modes of human agency form the conceptual framework of this study's design. The modes of human agency allow this research to focus on the two components of the dyad; the individual and the pair. Applying Bandura's (2001) social cognitive theory to dyad leadership provides the framework to explore and interpret the lived experience of dyad leaders and how they construct meaning of their individual and their co-leadership roles. The mode of collective agency provides a theoretical framework to interpret how dyads extend leadership and construct meaning within their organization.

Assumptions and Limitations

Merriam (2009) cited the following limitations in qualitative research: small sample size, researcher bias, and data saturation. Each limitation is discussed in terms of this research. Methods to control limitations are presented here briefly and are thoroughly discussed in Chapter 3. Limitations are considered exogenous, external pressures or confinements on the research whereas assumptions include researcher bias (Creswell & Poth, 2018).

Limitations emanate from the study's design: the topic being researched and the setting within which the research takes place (Creswell & Poth, 2018). This study was conducted in the researcher's place of employment, a choice that can be fraught with political implications (Creswell & Poth, 2018). In addition to being employed within the health system, this researcher enjoys professional relationships with prospective participants.

This may provoke biased self-reporting. To minimize the influence of these limitations, this researcher engaged the strategies of triangulation and memoing.

Triangulation, as defined by Merriam (2009), is a qualitative research technique to reduce subjectivity. Methods of triangulation include using multiple researchers, pursuing multiple

methods of data collection, and gathering multiple types of data. As this study has a solo researcher, memoing (bracketing) techniques were utilized to minimize researcher bias (Creswell, 2015; Creswell & Poth, 2018). Moustakas (1994) advocated for qualitative researchers to bracket their experiences (epoche) to “set aside prejudgments, biases, and preconceived ideas about things” (p. 85). The second type of triangulation, deploying multiple methods of data collection, aligns with the design of this research. Each participant completed an initial semi-structured interview. Selected individuals may participate in a second interview to validate the initial interpretation of the transcript. The third triangulation technique, gathering multiple forms of data, included the collection of participant artifacts and organizational documents. Comparing artifacts with interviews, follow-up interviews, and organizational documents provided multiple points of triangulation and lend credibility to the data (Merriam, 2009).

Purposive sampling to yield a homogenous group of participants is an effective methodology for interpretive phenomenological analysis (IPA); however, this method may also generate limitations (Smith et al., 2009). The voluntary nature of participation allows for either member of the dyad to opt out. Purposive sampling does not prevent both members of the dyad from being willing to enroll in the study. Enrollment was on a first come, first enrolled basis. Enrollment of one half of the dyad automatically excluded the other half of the dyad. Selecting an equal number of physicians and administrators provided a balanced perspective from each half of the dyad model.

The goal of an interpretive phenomenological analysis is to explore the phenomenon in detail. Since the aim of IPA research is to present a “perspective not a population,” IPA sample size can range from three to six participants (Smith et al., 2009, p. 49). The small samples

germane to IPA require follow up interviews to confirm initial interpretations. While the results from a small sample within a single organization do not enable generalizations, the extensive detail from a homogenous group of participants provided rich data to compare and contrast the participant's experiences (Smith et al., 2009).

Significance of the Study

The practical significance of this study is an improved understanding of how members of the dyad team perceive their individual and collective agency as they develop into a leadership team. Giving equal voice to both members of the dyad leadership team may provide common language, mutual insight, and improved communication to the leadership team. Developing a common language may enhance the understanding of the similarities and differences each member brings to the team which may then allow for the greater use of proxy agency (Bandura, 2001). The creation of shared vernacular may strengthen existing dyad leadership teams and inform the selection of future dyad leadership teams.

Additional significance of this study may be the application of the results to evaluate the health system's dyad leadership training program. Each participant completed or is in the process of completing the dyad leadership program. A portion of the program was adapted from the NCHL curriculum (Appendix A). This six-month program was designed by a local university, the state medical association, and the health system. The results of this research may provide a practical assessment of the program.

The outcomes of this research can be shared with the organizational sponsor as well as other health systems within the Pacific Northwest. Developing a dyad leadership training program represents a significant investment for any organization. Adult learning theorists remind

us “learning is the acquisition of knowledge through experiences with the result of a change in behavior” (Papa & Papa, 2011, p. 91). Although the primary purpose of this research was to explore the lived experience of dyad leadership teams, the results may also be applicable to evaluate how the training program supported the development of the individual’s sense of agency.

Definition of Terms

Affordable Care Act (ACA) - United States legislation enacted in 2010 providing access to healthcare through multiple state and federal programs (H.R. 3590, 2010).

Dyad - Any two people engaged in mutually beneficial activity; either joined by purpose or tangible reward. The dyad, in this research, specifically refers to the physician and administrator pair in healthcare. The physician and non-physician leader, “assume accountability for a clinical service, department, strategic initiative, or operating department within a healthcare organization” (Sanford & Moore, 2015, p. 18).

Dyad Leadership - Dyad leadership pairs are composed of a physician and an administrator. Dyad leaders function as equals and share responsibility, accountability, and consequences of their leadership. This is a formal model of “leadership in which two individuals with different skill sets, education, and backgrounds are paired to better fulfill the mission of the organization” (Sanford & Moore, 2009, p. 7).

Personal Agency – From a social cognitive perspective, personal agency describes the ability of individuals to both experience and shape events within their environment. This is also referred to as self-efficacy (Bandura, 2000).

Proxy Agency – A socially mediated mode of agency whereby people try to get those who have access to resources, expertise, influence or power to act on their behalf to secure the

outcomes they desire. Proxy agency relies on self-efficacy to enlist the efforts of others (Bandura, 2001).

Collective Agency – “People’s shared beliefs in their collective power to produce desired results by collective action. Collective efficacy fosters group’s motivational commitment to their missions, resilience to adversity, and performance accomplishment” (Bandura, 2000, p. 75).

Intentionality – Bandura (1987) defined intention “as the [individual’s or group’s] determination to perform certain activities or to bring about a certain future state of affairs” (p. 467). “Intentions center on plans of action...[they] represent a future course of action to be performed” (Bandura, 2001, p. 6). Intentions and actions are separated by time.

Forethought – “Through forethought, people motivate themselves and guide their actions in anticipation of future events” (Bandura, 2001, p. 7). Forethought extends intention into the future which then motivates and regulates behavior. In the context of dyad leadership, forethought creates space for the pair to develop leadership influence.

Self-Reactiveness – The ability to monitor one’s pattern of behavior and the cognitive and environmental conditions within which it occurs (Bandura, 2001).

Self-Reflectiveness – Self-reflectiveness describes the “metacognitive capability to reflect upon oneself and the adequacy of one’s thoughts and actions” (Bandura, 2001, p. 10). This capability allows individuals to evaluate their motivation and action against the outcomes of their motivation and action (Bandura, 2001). Self-reflectiveness is rooted in the belief that people are capable of influencing their environment (Bandura, 2001).

Self-Regulation – Self-regulation moderates the actions of an individual based on that individual’s values and belief system (Bandura, 2001). “Self-regulatory processes link thought to action” (Bandura, 2001, p. 1). It is a dynamic interplay between individuals, their internal

cognitive processes, and their environment. Throughout this interplay, individuals adjust their actions and interactions, and adapt to their environment (Bandura, 1986, 2001).

Conclusion

Changes in healthcare are fueled by uncertainty in the federal government (Altman, 2016; Bakalar, 2017), escalating costs (Congressional Budget Office, 2018; Office of Financial Management, 2016), and misaligned leaders at the operational and senior levels of our nation's healthcare systems (Sanford & Moore, 2015). Caring for patients is a human experience and requires leadership at multiple levels to design and deliver high quality, cost effective, patient centered, compassionate care (Garman & Lemak, 2011; Sanford & Moore, 2015; Swensen et al., 2013; Swensen & Mohta, 2017). Exploring the lived experience of dyad leaders in healthcare is a step towards understanding how dyad leadership teams perceive their individual, proxy, and collective agency. Dyad leadership moves the traditional, hierarchical organizational structure towards a team with equal authority, accountability, and responsibility (Oostra, 2016; Sanford & Moore, 2015). Existing trait-based and behavioral leadership theories explore leadership from the perspective of the leader or from the perspective of the relationship between the leader and the led (Northouse, 2016). The physician/administrator dyad leadership team in healthcare creates a complementary pair with unique skills that acknowledges physicians lack leadership training (Cox et al., 2006; Sadowski et al., 2018) and administrators lack clinical acumen (Sanford & Moore, 2015). The gap explored in this research is how the physicians and administrators in dyad leadership teams experience and perceive their sense of individual, proxy, and collective agency.

Bandura's (2001) social cognitive theory and the concept of triadic reciprocity provided a framework to explore the dynamic relationship between individual cognitive factors, behaviors,

and the environment. The agentic perspective of the social cognitive theory provided an additional framework to support the exploration of human agency as it applies to the individual members of the dyad and as it applies to the collective agency of the leadership pair. The modes of agency: intentionality, forethought, self-regulation, self-reactiveness, and self-reflection are presented in Chapter 2.

CHAPTER 2

LITERATURE REVIEW

Healthcare leadership is evolving in a rapidly changing environment. The Congressional Budget Office (2018) estimated healthcare costs comprise 16% of the United States' gross domestic product (GDP) and expects costs to increase to 40% of the GDP by the year 2040.

While the political arena is focused on the financial viability of healthcare, practitioners and the healthcare industry are focused on more than 20 million U.S. citizens who have obtained health insurance since the ACA became law in 2010 (Altman, 2016; Bakalar, 2017). The NCHL and the IHI agree that the increasing number of insured, the shifting milieu of regulations, and complex legislation are driving rapid change in the healthcare industry; the combination of these factors have amplified the need for dyad leadership (Anderson & Garman, 2014; Garman & Lemak, 2011; Swensen et al., 2013). The IHI proposed that dyad leadership pairs composed of physicians and administrators are ideally suited to lead through healthcare reform (Institute of Medicine, 2001; Swensen et al., 2013).

A review of the literature was undertaken to survey concepts and information related to dyad leadership in healthcare. The major themes of this selected review included the composition of the dyad leadership team, the cultural differences of the dyad team members, descriptions of the leadership influence of the dyad pair, and the essential component of interpersonal skills. In addition to the review of dyad leadership, the literature review included a survey of theoretical concepts that could be applied to the central question of this dissertation - to explore the lived experience of dyad leaders in healthcare and their perceptions of agency. Bandura's (1986) social

cognitive theory was selected as the theoretical framework for this research. The theory is based on the assumption that individuals possess agency over their cognitive factors, behavior, and environment (Bandura, 1986, 2001).

Dyad Composition

The dyad leadership team, as defined by this study, is composed of an administrator and a physician. The review of the literature, however, revealed lack of a definitive definition for dyad composition. Some authors contended the healthcare dyad consists of a physician and an administrator (Clausen et al., 2017; Sanford & Moore, 2009; Zismer & Brueggemann, 2010). An alternative perspective from Garman and Lemak (2011) defined the composition of a dyad leadership pair as a representative fractal of an interdisciplinary leadership team, thus alluding to dyads at all levels of the organization. While Oostra (2016) proposed that in healthcare a physician is always half of the pair. And finally, Resar et al. (2012) proposed that a dyad can be any two members of the healthcare team at any level of the organization; the dyad can emerge organically in any setting and be comprised of any role, including two physicians. The dyad, according to Resar et al. (2012), knows where healthcare is broken and should be empowered to correct problems at the point of origin. While there is limited consensus on the composition of the dyad leadership team in healthcare, there is, however, agreement that the physician/administrator leadership pair represents an effective leadership structure to implement the IHI's triple aim model (Institute of Medicine, 2001; Sanford & Moore, 2009; Swensen et al., 2013).

Culture

The literature provided two perspectives on healthcare leadership dyads and the organization's culture. One perspective views culture as the interaction of the leadership dyad

team with the organization. The other perspective emphasizes the different cultural perspectives each member of dyad leadership team brings to the dyad. Collins, Jacobs, and Perryman (2016) theorized dyad leadership unites two people from different cultures. The individuals hail from diverse backgrounds with little formal education regarding shared leadership (Clausen et al., 2017; Oostra, 2016; Zismer & Brueggemann, 2010). Sanford and Moore (2009) presented the idea of “suits versus coats” which broadly describes an historical view of tension between physicians and administrators (p. 4). This idea of “us versus them” is attributed to siloed professional training which creates isolated thinking and precludes collaboration (Collins et al., 2016; Sanford & Moore, 2009). Further differences comprise those perpetuated by training, wherein administrators learn to value interdependence and collaboration, yet physicians are trained to be autonomous (Sanford & Moore, 2009).

Sadowski et al. (2018) provided additional clarification on physician training, by reporting that even though the Accreditation Council for Graduate Medical Education (ACGME) defines “interpersonal and practice-based communication skills as core competencies” (p. 134); a review of 201 articles revealed no consistent leadership curriculum is offered in U.S. medical schools. Leadership training also represents a concern for healthcare administrators. The NCHL proposed curriculum aimed at undergraduate and graduate students studying healthcare administration, but there is no requirement for universities to adopt this curriculum (Swensen et al., 2013). The NCHL (2018) model included behaviors that focus on others (community and teams), creates transparency, and inspires collaboration. Aside from differences in professional and leadership training, dyads in healthcare continue to be recognized as a means to connect two cultures and “increase the understanding of other team member’s contributions to the organization” (Sanford & Moore, 2009, p. 8).

Collins et al. (2016) reported the cultural backgrounds of the physician and administrator may be quite different, but also emphasized the dyad leadership team, employed by the same company, may share common corporate values. This can create a platform for collaboration. Garman and Lemak (2011) reported a similar perspective on using the common platform of corporate mission, vision, and values to leverage the dyad leadership team's influence within the organization.

Roles and Responsibilities

Dyad leaders share the responsibility to achieve the organization's goals (Zismer & Brueggemann, 2010). For example, the dyad shares decision making, prioritization, goal alignment, and the development of strategic plans. Dyads are unified in their tasks, rewards, and consequences. This differs from traditional leadership organization charts that concentrate decision making power and authority in a single leader. Dyad leadership distributes authority between two individuals (Oostra, 2016).

It is widely accepted that physicians are trained to be autonomous whereas administrators are trained to be collaborative (Chazal & Montgomery, 2017; Collins et al., 2016; Oostra, 2016; Zismer & Brueggemann, 2010). Appointments to dyad leadership teams bypasses the opportunity for the pair to interview and select each other (Baldwin et al., 2011; Collins et al., 2016). This creates a need for the dyad pair to actively negotiate their personal relationship as well as their roles and responsibilities with respect to the organization's expectations.

Division of Duties. Once the dyad leadership team has been established their first task is to negotiate their respective roles. Typically, roles and responsibilities for varying positions are described in job descriptions (Collins et al., 2016; Swensen & Mohta, 2017; Zismer & Brueggemann, 2010). An effective dyad model, however, demands a certain fluidity and overlap;

navigating this ambiguity requires considerable interpersonal and communication skills (Oostra, 2016). High-level interpersonal skills provide the ability to negotiate the ambiguous portion of the relationship. Swensen and Mohta's 2017 study confirmed that, for physicians, "90% say interpersonal skills are the most important attribute" (p. 4).

Shared Decision Making. Members of the dyad leadership team learn from each other and create a cohesive force within the organization (Collins et al., 2016). Some authors contend that leadership dyad teams should be trained to work together by learning skills like shared decision-making and teamwork (Clausen et al., 2017; Zismer & Brueggemann, 2010). Others contend the responsibility for decision making should be deliberately ambiguous to prevent siloes and promote a team-based culture (Oostra, 2016).

Interpersonal Communication

Leadership dyad teams with high levels of interpersonal skills overcome differences when they "intentionally partner" (Clausen et al., 2017, p. 2160). The theory of intentionally partnering aligned with the need for advanced interpersonal skills as defined by Collins et al. (2016), Swensen and Mohta (2017), and Zismer and Brueggemann (2010). Clausen et al. (2017) defined three factors associated with intentional partnering: (a) accepting mutual necessity – when both partners recognize they need each other to achieve shared goals; this requires the ability to change perspective, (b) daring to risk together and, (c) constructing shared responsibility by following through, being flexible, and respecting differences. Intentional partnering requires both members of the leadership dyad team to recognize how professional identities guide or shape their actions and interactions (Clausen et al., 2017). Clausen et al. (2017) encouraged dyad pairs to take deliberate actions to negotiate their relationship and hold

one another accountable for shared goals (Clausen et al., 2017). Effective interpersonal skills, as described by Collins et al. (2016), can enhance organizational trust and improve clinical outcomes.

Literature provided an overview of selected components of dyad leadership teams. The composition of the dyad can be any two people (Resar et al., 2012), although this research focuses on the physician/administrator dyad team. These team members bring different cultural perspectives to dyad leadership (Collins et al., 2016). Negotiating roles and responsibilities in dyad leadership teams can provide clarity, create siloes, or generate ambiguity (Oostra, 2016). Finally, while there is little agreement regarding the aforementioned components of dyad leadership, the concept of interpersonal skills emerged as a key skill for dyad leadership team members.

Review of IHI Outcomes

While the IHI's recommendation to focus healthcare on the triple aim was the catalyst behind the formation of dyad leadership teams, literature provided little empirical evidence that dyad leadership has been effective in achieving the triple aim measures. Whittington, Nolan, Lewis, and Torres (2015) explained the progress made towards implementing the triple aim measures; limited advances in improving the health of populations and modest reductions in the per capita cost of healthcare were found. Improvement has been inconsistent. Organizations have not been able to simultaneously implement all three parts of the triple aim model (Whittington et al., 2015). The primary barrier is the lack of tools to manage population health and the need to create "organizational learning systems" (Whittington et al., 2015, p. 285). The "actual, systemwide, progress on all 3 aims simultaneously has proven elusive," according to Don

Berwick (as cited in Whittington et al., 2015, p. 298). Regardless of lack of published data reporting success of the triple aim measures, the health system in this study established dyad leadership structures at multiple levels within the organization.

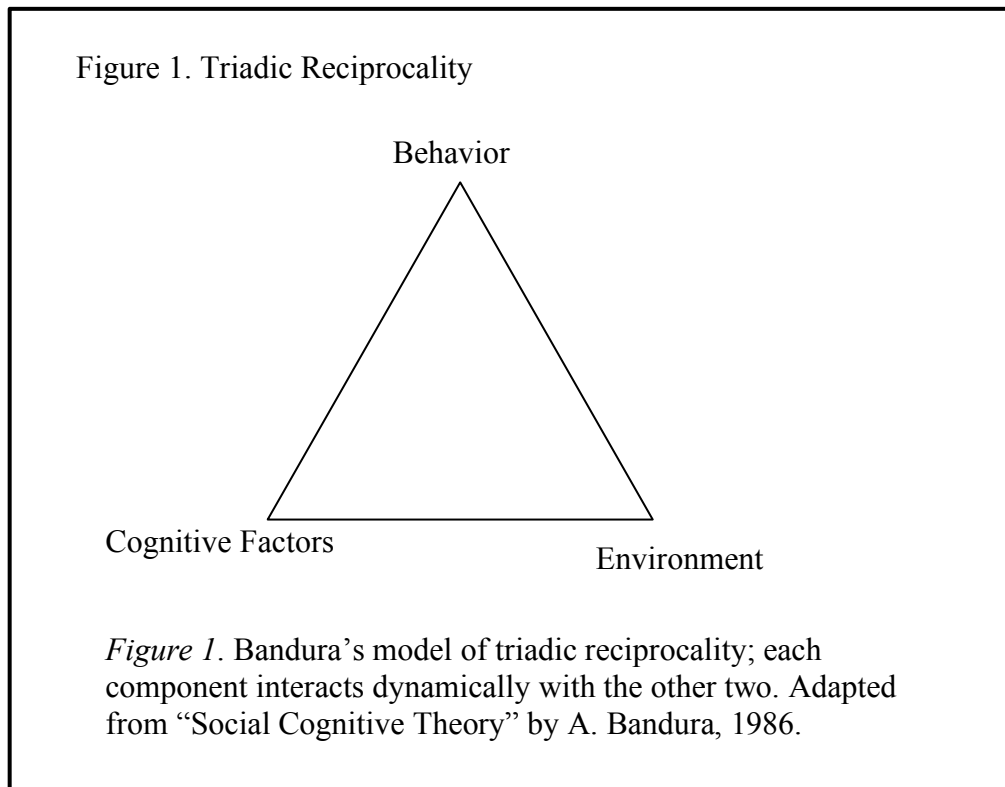
Conceptual Framework

The purpose of this interpretive phenomenological analysis is to explore the lived experience of dyad leaders and their perception of individual, proxy, and collective agency. The previously summarized literature review highlights the differences that administrators and physicians bring to the dyad team. The literature also emphasized the need for each member of the dyad to intentionally partner (Clausen et al., 2017). The theoretical framework provides the opportunity to explore the experience of the individual dyad members (the physician and the administrator) as well as the dyad pair. Bandura's (1986) social cognitive theory, the modes of human agency, provides the theoretical framework for this study. Bandura's (2001) agentic perspective of the social cognitive theory includes three modes of agency; individual, proxy, and collective. These modes of agency are defined in the following section.

Social Cognitive Theory

Bandura's (1986, 2001) social cognitive theory aligns with the purpose of this research to explore the lived experience of dyad leaders in healthcare and their perceptions of individual and collective agency. The theory is summarized and presented with the model of triadic reciprocity (Figure 1) to describe the interdependence between the domains of behavior, cognitive factors, and environmental influences (Bandura, 1986). Social cognitive theory also provides a "framework for analyzing human motivation, thought, and action" by introducing the

concept of human agency (Bandura, 1986, p. xi). Defined as “the capacity to exercise control over the nature and quality of one’s life” personal agency proposed “people are the producers as well as [the] products of social systems” (Bandura, 2001, p. 1).



The cognitive corner of the triangle includes three modes of human agency: personal agency, proxy agency, and collective agency (Bandura, 2001). The components of personal agency include forethought, intentionality, self-regulation, self-reactiveness, and self-reflection. Proxy agency is defined as the actions of one individual who relies upon the actions of another to achieve goals or acquire resources. Collective agency is described by Bandura (2001) as:

The stronger the perceived collective efficacy, the higher the groups’ aspirations and motivational investment in their undertakings, the stronger their staying power in the face

of impediments and setbacks, the higher their morale and resilience to stressors, and the greater their performance accomplishments. (p. 14)

The combination of the three types of agency and the resulting behaviors allow people to react and adapt to their social and organizational situations (Bandura, 1986). Table 1, when read from left to right, depicts how the three elements of agency build on each other; personal agency is required to achieve proxy agency, and personal and proxy agency are required to achieve collective agency.

Table 1

Components of Cognitive Factors

Personal Agency	Proxy Agency	Collective Agency
Forethought Intention Self-Regulation Self-Reflective Self - Reactive	Requires personal agency Achieved through relationship with others	Requires personal and proxy agency Shared belief in collective power Perceived collective efficacy

Note. Adapted from “Social Cognitive Theory: An Agentic Perspective,” by A. Bandura, 2001, *Annual Review of Psychology*, 52, pp. 1 – 26.

Personal Agency. Social cognitive theory proposed individuals are capable of influencing their social systems with deliberate forethought and intention. Bandura (2001) stated, “workers have to cultivate multiple competencies to meet the ever-changing occupational demands and roles” (p. 11). The agentic perspective assumes individuals possess the ability to self-reflect and that self-reflection leads to the ability to shape, change or interact with social systems (Bandura, 2001). Based in constructionism, social cognitive theory reasoned that individuals have the capacity to generate and participate in their surroundings and thereby exercise personal influence. Through this perspective, individuals are not merely acted upon by their environment, they are in an ongoing relationship with their environment. That relationship

influences the environment and affords opportunities for individuals to exercise influence. This is a dynamic relationship between the individual, their behaviors, and the environment (Bandura, 1986). "Personal agency encompasses the endowments, belief systems, self-regulatory capabilities and distributed structures and functions through which personal influence are exercised" (Bandura, 2001, p. 2).

Proxy Agency. Bandura (2000) described proxy agency as a dynamic relationship between individuals and the environment. Furthermore, proxy agency encompasses the potential to create both positive and negative influences between people, and positive and negative influences between individuals and their environment. From the positive perspective proxy agency "allows individuals to seek their well-being and security through socially mediated relationships" (Bandura, 2001, p. 75). This requires both engagement with the environment and with other individuals. The negative perspective of proxy agency describes situations wherein an individual may refuse to "saddle themselves with the arduous work needed to develop requisite competencies and to shoulder the responsibilities and stressors that the exercise of control entails" (Bandura, 2000, p. 75). Proxy agency functions to engage or disengage individuals from their environment (Bandura, 2000).

Collective Agency. Bandura's (2001) social cognitive theory "extends the conception of human agency to collective agency" (p. 14). Collective agency describes the interdependence of individuals, their reactions, and interactions with the environment. The perspectives of individual agency are extended to encompass groups and therefore apply to dyad leadership pairs. Group, team, or dyad success can be attributed to "perceived collective efficacy" (p. 14). In fact, the success of dyad leaders stems from a willingness to engage, share risk, develop common goals and commit to purpose (Sanford & Moore, 2015). Bandura (2000) proposed two approaches to a

group's perceived efficacy to include "individual member's appraisal of their personal capabilities" and secondly each "member's appraisal of their group's capabilities" (p. 76). The three modes of agency are accretive; personal agency provides the resilience to interact with others and the environment, proxy agency allows an individual to engage with others, and collective agency provides the opportunity for individuals to engage with others and their environment to exert influence (Bandura, 2001).

Agentic Perspectives

Agency as defined by Bandura (2001) comprises three distinct modes; personal, proxy, and collective. The mode of personal agency is further explained with five distinct cognitive factors (Bandura, 1986). Each of the five cognitive factors and an interpretation of how these factors apply to the study's purpose are presented in the following section.

Intentionality. The concept of agency, deliberate and thoughtful interactions with our environment, is captured with the term "intentionality" (Bandura, 2001, p. 6). Individuals are capable of devising plans of action within their social contexts and within their relationships with peers. Joint intentionality involves a process of constructing social agreements. This process requires "commitment to a shared intention and coordination of interdependent plans of action. The challenge in collaborative activities is to meld diverse self-interests in the service of common goals and intentions" (Bandura, 2001, p. 7).

Forethought. The ability to think forward is unique to humans. Leaders must be able to plan and prepare for future eventualities. Through the lens of social cognitive theory, the concept of forethought describes the ability of individuals to "motivate themselves and guide their actions in anticipation of future events" (Bandura, 2001, p. 7). Forethought and action are

separated by time. The ability of leaders to plan, with other leaders, the outcomes and goals for their organization within an environment of shifting priorities requires the ability to self-regulate.

Self-Regulation. Self-regulation describes the ability of each member of the dyad as well as the dyad leadership team to constantly monitor their relationship, their influence within the environment, and changes within their environment. The perceptions of timing, influence, and organizational readiness provide continuous feedback. The dyad leadership team responds to this dynamic environment with self, proxy, and collective agency.

Self-Reactiveness. The concept of self-reactiveness describes the process through which individuals move from forethought to motivation and finally to action. The ability to motivate activity and interaction with the environment are essential leadership skills. Designing a course of action based on common goals and vision is also a required leadership skill for dyads. The concept of self-reactiveness "involves not only the deliberative ability to make choices and action plans, but the ability to give shape to appropriate courses of action and to motivate and regulate their execution" (Bandura, 2001, p. 8).

Self-Reflectiveness. Social cognitive theory is grounded in the concept that individuals possess agency and thus the ability to produce change in their surroundings and change within themselves (Bandura, 2001). The belief that change is possible motivates individuals to propose and engage with change. Without this core belief individuals have "little incentive to act or to persevere in the face of difficulties" (Bandura, 2001, p. 10).

These five cognitive factors are constantly acting upon the individual member of the dyad leadership team as well as the dyad pair. Dyads, as co-leaders in their organization, employ intention and forethought as they create and extend leadership into their organizations. Self-reactiveness guide the dyad team's ability to evaluate the timing of their work and the

organizational ability to cope with change. Self-reflectiveness is the individual's ability to assess their interaction with the environment, the needs of the dyad leadership team, and the organization's ability to accept change. The factor of self-regulation, as applied in this research, is the overall ability of the dyad leadership team to work individually and collectively to achieve their organizational goals.

Conclusion

The IHI and the NCHL agree about the leadership challenges in healthcare. In response to the IHI's recommendation, the healthcare industry embraced dyad leadership (Borkowski, Deckard, Weber, Padron, & Luongo, 2011; Chazal & Montgomery, 2017; Clausen et al., 2017; Garman & Lemak, 2011; Oostra, 2016; Resar et al., 2012). The collective industry response represents a step towards ensuring "active collaboration and communication" (Institute of Medicine, 2001, p. 4). However, limited empirical research explores how physicians and administrators experience the healthcare leadership dyad model and their perception of personal and collective agency.

Dyad leadership teams are often placed in their roles by senior leaders within the health system (Sanford & Moore, 2015). The pair's professional training either as clinician or administrator commonly does not prepare the dyad to work together. Hence, dyads must successfully negotiate a personal as well as a professional, collective role. Regardless of their unique professional identities, however, the co-leaders must execute on organizational strategies and learn to accept their mutual necessity (Clausen et al., 2017; Sanford & Moore, 2009).

Successful dyads negotiate a complex, ambiguous relationship and present unified leadership to their organization. Bandura's (1986, 2000, 2001) social cognitive theory and the agentic perspective provide a framework to explore the complex personal and professional

relationship of dyad pairs. Physicians prioritized interpersonal skills (Swensen & Mohta, 2017) to build confidence and trust in the organization (Baldwin et al., 2011; Clausen et al., 2017).

The NCHL (2018) has created a curriculum to support leadership training and made it available on the IHI's website. However, while IHI maintains that the synergy of the dyad pair is a critical element to the transformation of healthcare (IHI, 2018), no standard exists to support the development of new dyad pairs or to strengthen the leadership of existing dyad relationships (Sanford and Moore, 2009). The aim of this research is to explore the lived experience of the dyad and how they create and extend shared leadership influence. The outcomes from this study can be used to fill gaps in empirical knowledge and applied to the research setting to evaluate and potentially improve the shared leadership of the organization's dyad leaders.

CHAPTER 3

METHODOLOGY

The purpose of this qualitative study is to explore the lived experience of dyad healthcare leaders and their perceptions of personal and collective agency. The dyad leadership model has been widely implemented; however, academic studies of the lived experience of dyad leaders sparsely populate the literature. Following Creswell's (2015) recommendation, this interpretive phenomenological study employed central research questions to focus the study and establish boundaries for the extent of the inquiry. Sub-questions follow the central questions and serve to "break down the central question into constituent parts" (Creswell & Poth, 2018, p. 140).

This research is delimited by the following questions.

1. What is the lived experience of a dyad healthcare leader?
2. What are the perceptions of dyad leaders at a single, large health system in Washington State regarding their development of shared leadership influence in their organization?
 - a. How do physicians experience the phenomenon of dyad leadership?
 - b. How do administrators experience the phenomenon of dyad leadership?

The following sub-questions represent areas of interest to this research.

1. How do dyad leaders describe and make sense of their roles?
2. What leadership training and/or interpersonal communication training did the individuals have, if any? Do they feel that was beneficial?

A qualitative phenomenological approach lends itself to the exploration, understanding, and description of the central research questions. In addition, Bandura's (2001) social cognitive theory explores the individual's ability for self-reflective agency. This provides the opportunity to explore a lived experience through phenomenology.

Setting

The health system is a large network of hospitals and ambulatory sites of care in Washington State. The system is divided into geographic regions spanning the eastern and western portion of the state. There are nine hospitals and approximately 200 sites that provide ambulatory services including primary care, specialty care, day surgery, urgent care, and emergency care. The health system employs almost 900 leaders responsible for the delivery of healthcare and services to populations in urban, rural and underserved areas. Using personal knowledge of the health system, this researcher grouped data describing the health system's sites of care into Table 2.

The research site formally implemented the dyad leadership model in 2009. Multiple business units and sites of care have established dyad leaders. Based on this researcher's familiarity with the organization, rapid expansion via strategic growth and acquisitions has created a demand for dyad leaders across the organization. Exploring the lived experience of dyad leaders presents an opportunity for the health system to gain insight into how they have created and extended their leadership influence into the organization.

Site Endorsement. The organizational structure of this large health system includes both employed and community providers. All administrators and employed physicians are members of the medical group. The medical group is led by a president (who is also a physician) whereas

the larger physician enterprise, which includes community providers in addition to the medical group, is led by a senior vice president. Both the president of the medical group and the senior vice president of the medical staff supported this research with a letter of consent.

Table 2

Health System Sites of Care

Hospital or Clinic	Researcher at this site?	Access to this site?
Acute Care Hospital #1	Yes	Yes
Acute Care Hospital #2	No	Yes
Acute Care Hospital #3	Yes	Yes
Psychiatric Hospital #4	No	No
Pediatric Hospital #1	No	Yes
Acute Care Hospital #5	No	Yes
Acute Care Hospital #6	No	Yes
*Primary & specialty clinics	Yes	Yes
Acute Care Hospital #7	No	Limited
Acute Care Hospital #8	No	Limited
**Primary & specialty clinics	No	Limited

Note. *Primary & Specialty clinics is comprised of 114 sites of care.

**Primary & Specialty clinics is a single facility housing 68 sites of care.

This researcher is a member of three dyad teams; serving as the administrator for graduate medical education (GME), primary care, and medical specialties. Dyad partners include the physician executive for GME, the physician executive for primary care, and the medical director of medical specialties. To reduce bias and potential for conflict of interest, this researcher's dyad partners were excluded from participation in this study. Limiting the participation of these leaders did not adversely affect the opportunity to recruit participants. As a health system administrator, this researcher has access to leaders across the system. The limited access to leaders is due to geographical distance.

Participant Rights and Informed Consent

Protecting the privacy and anonymity of research participants is the ethical responsibility of the researcher. Multiple steps were taken to ensure both. All participants were given a pseudonym (e.g., P1, or A2). Their associated hospital, clinic, or interdependent business unit, if necessary, to the overall cogency of the interpretation, was assigned a pseudonym (e.g., IBU1 or IBU2). The taxonomy connecting pseudonyms to the identity of the participants is known only to the researcher.

Prior to enrollment in the study each participant was presented with a printed copy of the informed consent. The participants were given ample time to review the consent form, and time to consider whether to participate in this research. This process respected the autonomy of each participant without causing undue stress. Obtaining informed consent ensures participants understand that (a) their participation is voluntary, (b) the nature of the data collection process, and (c) their ability to opt out at any time for any reason without repercussion.

Prior to conducting each interview, this researcher reviewed the informed consent with each participant and verbally informed them of their right to withdraw from the study at any time. After ensuring all questions were answered and any concerns were addressed, this researcher obtained oral agreement followed by signature on the informed consent. Two copies of the informed consent were available at each interview. The second, fully executed copy of the informed consent was left with the participant. No research activity occurred until signed consent had been obtained.

Overall risk to each participant was minimal; there was no expected harm from participating in this study. All data gathered from the interview was held confidential. The only exception to this ethical code of research, and not unfamiliar to the healthcare environment,

would be if a participant expressed any ideation of self-harm or, abuse or neglect of a vulnerable population. Revelations such as these require immediate reporting to the appropriate authorities.

Participants

Purposive sampling was used to invite dyad leaders within the health system to participate in this research. Participants were recruited from the pool of leaders who completed or are in the process of completing the organization's aforementioned dyad leadership training program. This training represents a substantial investment by the health system in its dyad leaders. It also represents a significant investment by each of the leaders who completed the program. All of the program participants are in formal dyad roles and as such are expected to extend their influence and leadership into their business or clinical units (Sanford & Moore, 2015).

This researcher obtained the list of program participants from the organization's leadership development department. An invitation to participate in the study was sent via email to each person on the list. As noted previously, the researcher's dyad partners were not invited to participate in the study. The letter provided specific instructions to contact the researcher as well as a copy of the informed consent and interview protocol. Participants were enrolled in the order they responded.

Given the voluntary nature of the sampling methodology and the purpose of this research to explore the lived experiences of dyads it was important to ensure a balanced sample of physicians and administrators. This researcher, following the taxonomy described earlier, paid close attention to the pool of participants. When the sample became unbalanced with too many

administrators, a second letter was sent to the physician group. Sampling continued with this method until a final sample of three physicians and three administrators, for a total enrollment of six participants, was achieved.

Interpretive phenomenological analysis, as applied in this research, allows for three types of interpretation: an interpretation of the physicians' experience, an interpretation of the administrators' experiences, and a cross-case comparison of the physicians to the administrators (Smith et al., 2009). Intact dyad leadership teams were not necessary to achieve the purpose of this study. As participants were recruited into the sample, this researcher purposefully avoided enrolling intact dyads. To confirm that no dyad teams were recruited, the researcher asked each participant to identify their dyad partner at the beginning of the interview. This was noted and the researcher confirmed that person was not eligible to participate.

Interviews were scheduled as the participants agreed to enroll in the study. As interviews occurred, analysis began as soon as the transcript was complete. Given the simultaneous nature of recruiting participants, and the manual coding and analysis of transcripts, this researcher continuously monitored for data recurrence. Recurrence, as defined by Smith et al. (2009), describes the distribution of themes across all members of the sample. Superordinate themes were tracked within the physician's and the administrator's datum. A matrix was developed and is shared with the results in Chapter 4 (Smith et al., 2009).

Data

Smith et al. (2009) shared Yardley's four criteria to assess IPA quality: (a) sensitivity to context; (b) commitment to rigor; (c) transparency and coherence; and (d) impact and importance. Sensitivity to context describes the ability of the researcher to conduct a successful interview. Commitment to rigor refers to the "completeness of the analysis" which includes

“sufficient idiographic engagement” (Smith et al., 2009, p. 181). A rigorous IPA study provides “extracts from each participant to illustrate each theme” (Smith et al., 2009, p. 181).

Transparency and coherence describe the essential step of moving beyond simple descriptions of the participants’ account of their lived experience to an interpretation of their experience.

Finally, impact and importance rests with the readers and stakeholders and whether the final report “provides interesting, important or useful information” (Smith et al., 2009, p. 184).

As phenomenology represents the study of the lived experience (Creswell, 2015; Creswell & Poth, 2018; Merriam, 2009; Saldana, 2016), hermeneutic phenomenology further explicates the lived experience is, in fact, a unique interpretation by the individual experiencing the phenomenon (Smith et al., 2009). Furthermore, idiography emphasizes the study of the specific over the generalizable (Smith et al., 2009). Researching a small population creates the opportunity for an in-depth interpretation of each experience allowing similarities and themes to emerge organically from the data (Smith et al., 2009). Smith et al. (2009) explain interpretive phenomenological analysis, by necessity, focuses on small sample sizes to reveal similarities and differences among a homogenous group. The sample size was six (Smith et al., 2009). The final participant group included an equal number of physicians and administrators. This small yet balanced sample of dyad leaders allowed for the in-depth and cross comparative analysis specific to IPA.

Due to the in-depth analysis and cross comparative nature of IPA, this researcher was the sole interviewer of all participants. Interviews required 45 – 60 minutes each. Using a semi-structured interview protocol (Appendix B), participants were asked the same set of open-ended questions. Follow up questions varied based on the individual’s response to prior questions. As each participant retains an “important stake in what is covered” (Smith et al., 2009, p. 4) each

participant was asked the different second order questions. Merriam (2009) proposed follow-up questions could be used to confirm initial interpretations formed during the interview. All follow-up questions focused on each participant's subjective sense-making of dyad leadership. To some extent, the researcher adapted to each participant and adjusted the second order questions to follow the participants as they explored and offered detail related to their lived experiences. The aim was to generate sufficient data to develop "meaningful points of similarity and difference between participants" (Smith et al., 2009, p. 51).

Given the size and culture of the organization, the interview was scheduled like an ordinary business meeting. Five interviews were conducted face-to-face in a private office. One interview was conducted over the phone due to inclement weather. In all cases, the location was of the participant's choosing.

All interviews were recorded using a privately owned, hand-held Olympus digital voice recorder, model WS-853. The device is the property of the researcher. No other persons had access to the recorder, the device is not connected to the Internet, and it was secured in a locked drawer when not in use. Prior to recording, the participant was identified by the aforementioned pseudonym naming convention. Audio recordings were transcribed by Rev.com, a professional online transcription service. Rev.com deleted the audio files after completing transcription. Audio files were maintained on the Olympus digital voice recorder for the duration of the study. At the conclusion of the study, audio files were erased, and the device was reset to factory defaults. Other research materials such as notes, interview transcripts, and documents were secured in a locked file cabinet. Electronic files were stored on a password protected computer. At the conclusion of the study, printed materials were destroyed via a confidential shredding system. Electronic files were permanently deleted from the computer.

During each interview, after establishing rapport and setting the participant at ease, this researcher requested permission to jot down occasional notes during the interview. The goal was to capture the participant's non-verbal cues and body language. This was also an opportunity to formulate follow-up questions without interrupting the participant's dialogue (Merriam, 2009). Notes were taken in the space provided on the semi-structured interview protocol.

Artifacts

Artifacts collected from the participants created additional points of comparison. During the recruiting process, each participant was invited to bring a single artifact that personally symbolized their dyad leadership. Two participants brought artifacts and a third participant drew a diagram of his understanding of the dyad leadership model. During the interview, each participant was asked to describe what the object symbolized and how it characterized their dyad relationship/leadership. A detailed description of the artifacts is included in Chapter 4.

Analysis

Smith et al. (2009) provided a comprehensive outline to conduct an interpretive phenomenological analysis (IPA). While the analytical process was described in chronological order, it is important to recognize that IPA represents a fluid analysis from general to specific and specific to general. Smith et al. (2009) provided the following description of IPA analysis:

At each stage, the analysis does indeed take you [the researcher] further away from the participant and includes more of you. However, 'the you' is closely involved with the lived experiences of the participant – and the resulting analysis will be a product of both of your collaborative efforts. (p. 92)

The steps of interpretative analysis follow the recommendation of Smith et al. (2009) and included the following:

1. Read through the transcripts and listened to the audio recordings multiple times. The goal is to capture an initial impression of the lived experience.
2. Write initial notations. This phase began during the iterative reading. Here the researcher began to create comprehensive notes. Notes were developed in the following sequence from least to most interpretive; descriptive, linguistic (including metaphorical), then conceptual.
3. Develop emerging themes. In this phase the researcher organized or grouped notes to “reduce the volume of detail (the transcript and the initial notes) whilst maintaining complexity” (p. 91).
4. Search for connections across themes. Here the analyst looked for patterns within the lived experience; these can be contradictory or complementary.
5. Subsequent data analysis. Steps 1 – 4 are repeated for the next participant’s data.
6. Across case comparisons. Here the analyst looked for patterns, which can be contradictory or complementary, between participants.

The repetitious nature of the analysis and the iterative cycles of interpretation create a double hermeneutic (Creswell & Poth, 2018; Smith et al., 2009). IPA is essentially the researcher’s interpretation of the participant’s interpretation of their lived experience. In addition to the layered analysis, Creswell (2015) recommended triangulation and member checking to validate qualitative data.

Triangulation is a qualitative research strategy employed to validate the data. This researcher employed several tactics. The aforementioned use of memoing and journaling

techniques bracketed the researcher's experience as a dyad leader. In addition to bracketing or epoche (Moustakas, 1994), this researcher triangulated data as follows: institutional documents were gathered depicting leadership models, artifacts were collected from three participants, and follow up interviews were conducted with selected participants.

This researcher offered to share each transcript and the initial interpretation with the participants. This provided an opportunity for participants to validate the data, provide further explanation, and ensure the interpretation captured the essence of their experience. Finally, Creswell's (2015) recommendation to conduct an external audit was not used in this study as it carried the risk of compromising the participant's anonymity.

Limitations

The small sample size of an IPA study may be viewed as a limitation. In fact, when compared to other qualitative methods, the samples in IPA are very small, often between "three and six participants" (Smith et al., 2009, p. 51). However, Smith et al. (2009) proposed that IPA research is utilized when it is helpful to understand a "perspective, not a population" (p. 49). Theoretical transferability may help the reader or stakeholders "make links between the analysis in an IPA study and their own personal or professional experiences" (Smith et al., 2009, p. 51). These points establish IPA as an effective method in applied research that can bridge the gap between inquiry and practice.

The issue of researcher bias was addressed formally via identity memos and informally with daily journaling. As a dyad leader within the organization where the participants will be recruited, it is possible that this researcher's experience could have elicited unintended bias. Identity memos provide an opportunity to reflect upon experiences that may pertain to the study. Maxwell (2008) proposed that memos allow researcher experiences to be held in abeyance, or

consciously used to provide insight into the interpretation of the participants' data. Saldana (2016) further explained the process of analytic memos, such as daily journal entries, that function as prompts for an internal conversation within the researcher to examine bias as it arises throughout the research. Given the proximity of this researcher to the study site and to the participants, both types of memoing were implemented.

Conclusion

Interpretive phenomenological research, because of its connection to hermeneutics and idiography, can create deep understanding of small groups of people experiencing the same phenomenon. The data from a homogenous sample of dyad leaders within one healthcare system may improve understanding of dyad leadership, what makes a leadership team work, and what gets in their way. Understanding how dyad leaders perceive their roles and applying language to the shared experience may assist in the development of educational materials, leadership development courses, or other tools for the dyad or system to employ in the development of infrastructure to sustain or improve the dyad leadership experience. Common vernacular also promotes a platform for further discussion. Descriptions of successes and barriers provide unique, yet specific information for leaders to reflect on the dyad leadership model.

Interpretive phenomenological research is an exploration and interpretation of the lived experience of individuals with shared phenomena. Applying this methodology to this study permits an exploration of the physician's lived experience and sense of agency, the administrator's lived experience and sense of agency, and the collective agency of the dyad leadership team. Subsequent chapters focus on results of the interpretive analysis, suggestions to apply learning from this study to the organization, and recommendations for further research.

CHAPTER 4

RESULTS

The Institute for Healthcare Improvement (IHI, 2018, 2019; Institute of Medicine, 2001; Sanford & Moore, 2015; Swensen et al., 2013) published the Triple Aim as a framework to focus the transformation of healthcare on three goals: caring for populations, improving healthcare quality, and decreasing the overall cost of healthcare. A new leadership structure partnering physicians and administrators evolved from the IHI framework. This leadership structure, or dyad leadership teams, commonly ascribe the quality goals to the physicians and the cost containment goals to the administrators. This study focuses on the lived experience of dyad leadership team members within a single healthcare system in Washington State.

Method of Analysis

An interpretive phenomenological analysis (IPA) methodology provides the opportunity to explore and analyze the lived experiences of the dyad leadership team members. This study was designed to give equal voice to a purposeful sample of dyad leaders. The study was guided by the research question, “What are the perceptions of dyad leaders at a single large healthcare system in Washington State regarding their development of shared leadership influence in their organizations?” To achieve two homogenous groups, 16 physician and 16 administrative leaders in formally recognized dyad leadership roles were invited to participate. Participants were enrolled in the study in the order they responded to the invitation. A final set of three administrators and three physicians were interviewed for this study. Table 3 displays the characteristics of the sample.

Table 3

Participant Demographics

Pseudonym	Portion of Work Allocated to Leadership	Number of Dyad Partners	Years in the Dyad Leadership Role	WSMA Dyad Program Participant	Previous Experience as a Dyad Leader
A1	100%	1	6	No	Yes
A2	100%	1	3 ½	Yes	Yes
A3	100%	1	3	Yes	Yes
P1	50%	1	2 ½	Yes	No
P2	100%	2	5 ½	Yes	No
P3	40%	3	7	Yes	No

Note. WSMA is an acronym for Washington State Medical Association. The WSMA dyad program is part of the health system's leadership development track to train dyad leaders. Participation is voluntary.

The data was collected in six private, semi-structured interviews which required 45-55 minutes. Each interview was recorded and transcribed verbatim. The analytic coding process was implemented on the administrator group first, as that was the first group to complete interviews. The same analytic process was then applied to the physician group. A final analytical process compared and contrasted the findings of the two groups. Following the recommendations outlined by Smith et al. (2009), the analytic process generated descriptive, linguistic, and interpretive notes. Descriptive notes “take [the participants’ words] at face value” summarizing or restating the content (Smith et al., 2009, p. 84). The second round, or linguistic comments, focused on the paraverbal aspects of language such as tone, speed of speech, and duration of pauses. The third round of analysis is the interpretation of each participant’s and group’s content. Each of these three rounds of coding and analysis were grouped into themes.

Descriptive and linguistic themes were inserted into separate matrices for each group. The combination of descriptive and linguistic codes created a detailed description of the experiences of both groups. As the themes were developed, careful attention was given to the voice of each participant. When sufficient descriptive and linguistic codes were developed, as measured by the inclusion of detail from each participant, the matrices were compared and a final matrix depicting similarities and differences between the physicians and administrators was developed. Interpretive codes were developed for each group and placed into superordinate and minor themes. These were matrixed, compared and contrasted, and inserted into a final thematic grouping of superordinate themes (presented in Table 4).

The repetitive coding of each transcript within each group, followed by a compare and contrast of each group, is referred to as the *double hermeneutic* (Smith et al., 2009). In this study, the IPA methodology provided the researcher understanding of the nuances of experience for each member of the dyad leadership team. Understanding the details of the similarities and differences between the experiences of the physicians and the administrators provided insight into the dyad leadership experience. Figure 2 provides an overview of the analytical process.

The iterative and idiographic nature of IPA requires attention to the details provided by each participant (Smith et al., 2009). Due to the large quantity of data, this chapter presents a high-level overview of the superordinate themes. This is followed by the detailed results from each group; the administrators first, then the physicians. A compare and contrast of their experiences is presented in the last section of this chapter. The aim of presenting the data in this sequence is to document the unique experience of each group, through the perspective of the individual participants and analyze how the groups' experiences were similar and different.

Artifacts included in the research methodology were requested from each participant prior to the interview. Two of the six participants provided artifacts; one physician and one administrator. The interpretation of these artifacts is woven into the analysis. In addition to participants' artifacts, an organizational chart depicting the dyad leadership structure for the medical group was obtained. The interpretation of this object is included in the sections below.

The final analysis uses Bandura's (2001) agentic perspective of the social cognitive theory to interpret and make meaning of the data. Selected superordinate themes and supporting quotes are presented from each group as representative examples for the three components of agency; self, proxy, and collective.

Figure 2. Interpretive Phenomenological Analysis

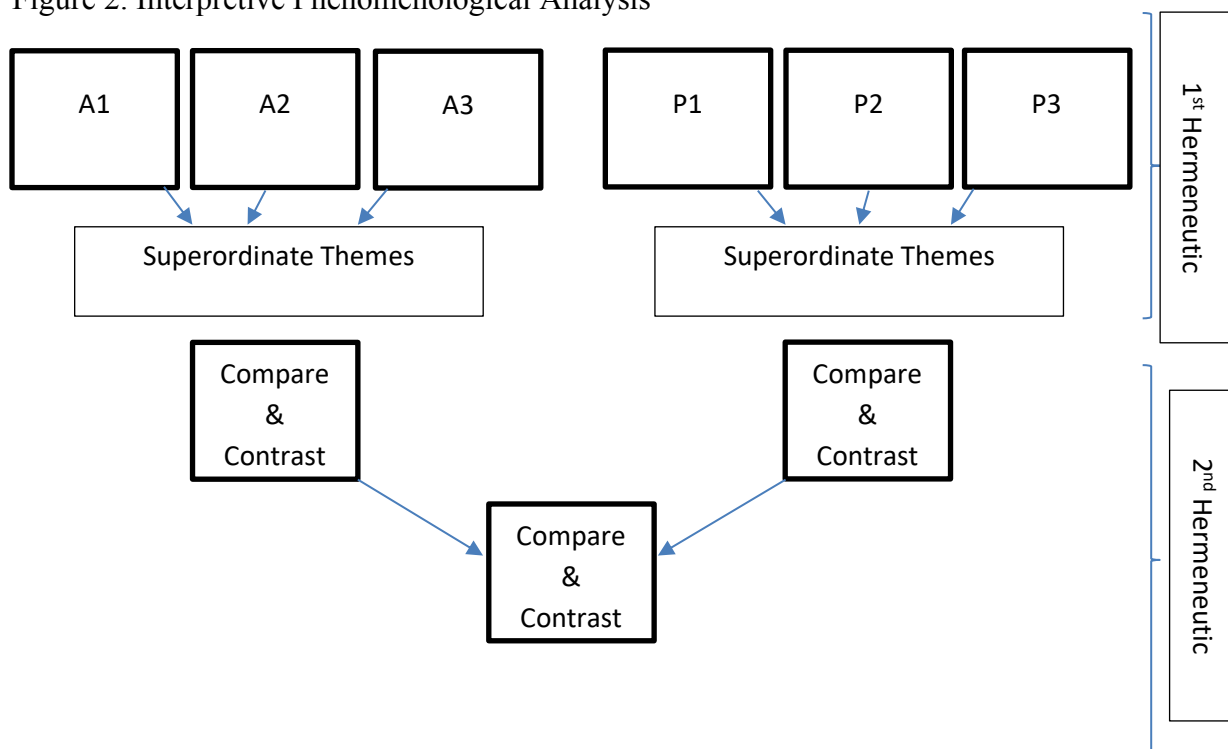


Figure 2. The process to analyze transcripts in IPA follows a double hermeneutic. Analysis for each group was completed before moving to the next group. Matrices summarizing emerging and superordinate themes were developed for each group, then the matrices were compared between the two groups. This process is adapted from J. Smith, P. Flowers, and M. Larkin (2009).

After repetitive reading of each transcript, grouping descriptive, then linguistic, and finally analytic codes, matrices were developed to visualize the superordinate themes. Three superordinate themes emerged from the transcripts and aligned with Bandura's (1986) social cognitive theory, triadic reciprocity, and the three forms of human agency. Each of the three superordinate themes presented specific examples from each group. Table 4 provides a summary of the superordinate themes.

Table 4

Final Superordinate Themes Aligned with Triadic Reciprocity

Triadic Reciprocity & Superordinate Theme	Physician	Administrator
Cognitive & Other Personal Factors		
Internal motivation	Professional Satisfaction	Professional Satisfaction
Internal demotivation	Lonely, Excluded	Fear, Overwhelm
Environment		
Organizational Culture	Respect Turnover Bureaucracy	Respect
Dyad Structure	Role Conflict Polygamous Dyads Type Cast	Role Clarity
Behavior	Leadership Skills	Vulnerability Leadership Skills

Note. Superordinate themes represent the analytic codes derived from the transcripts. Adapted from "Analysis" (Chapter 5) in J. Smith, P. Flowers, and M. Larkin, 2009, *Interpretive Phenomenological Analysis: Theory, Method, and Research*. Los Angeles, CA: Sage.

Administrator's Results

Data from this group aligned with the components of Triadic Reciprocity (Bandura, 1986). The themes, as expressed by the administrators, were grouped into the appropriate

component; cognitive factors, environment, and behavior. Smith et al. (2009) proposed that superordinate themes can be compared across a homogenous group to “represent instances of higher order concepts which the cases share” (p. 101). Table 5 displays the superordinate themes and subthemes from the administrator group. Each theme is supported by direct quotes from the participants. The results are followed by a summary and an overall interpretation of the administrators’ experience.

Table 5

Superordinate Themes Aligned with Triadic Reciprocity – Administrators

	A1	A2	A3
Cognitive & Other			
Personal Factors			
Professional Satisfaction	X	X	X
Humor	X	X	X
Pain	X	X	
Anger	X	X	
Overwhelm	X	X	X
Environment			
Organizational Culture			
Respect	X	X	X
Dyad Structure			
Role Clarity	X	X	X
Behavior			
Vulnerability			
Equal	X	X	X
Personal	X	X	X
Leadership Skills			
Asking for Help	X	X	X
Business Plans	X	X	X

Note. Superordinate themes represent the analytic codes derived from the transcripts. Adapted from “Analysis” (Chapter 5) in J. Smith, P. Flowers, and M. Larkin, 2009, *Interpretive Phenomenological Analysis: Theory, Method, and Research*. Los Angeles, CA: Sage.

Cognitive and Other Personal Factors

The administrator group provided several perspectives on this aspect of their experience. A3 captured the overall sentiment of the group with the following statement, "You have to give space for emotions. We're all human. And we can't be politically correct all of the time. That's the thing, you have to take down your barriers and political correctness." A3 was describing the need for dyads to be "equally vulnerable." A3 went on to add the formation and development of dyad leadership teams is difficult and that a variety of emotions surface during the "get to know you" and negotiating phases.

Internally Motivating. Additional emotions described by this group include professional satisfaction and humor. A2 described professional satisfaction with the following statement. In this statement, the administrator's reference to a physician as an "employee" is colloquial. No administrator in a dyad leadership role has direct line authority over a physician (all physicians and providers formally report to another physician or provider in the medical group). One participant said:

I enjoy connecting with providers and figuring out how to maximize their strengths to build practices that they really love that serve our patients well. The thing about providers is they're so smart, right? These are some of the smartest people you've ever worked with.

This particular administrator found the partnerships with physicians enjoyable and goes on to say, "I think it's a lot of fun to partner with physicians." Throughout this portion of the interview, A2 adopted a thoughtful, deliberate tone of voice. This participant carefully selected words to make the point that while working with physicians presents unique challenges, it is also filled with professional satisfaction.

Humor emerged across all three of the administrators interviews. Administrator A1 provided a detailed description of a secret language of code words used in stressful situations to break the tension. In this dyad, A1 described how to request that her dyad partner have a serious conversation with another physician by asking him to “Go West Point!” His typical response was that he had his “Louisville Slugger.” The administrator recounted this example of shared leadership with laughter, and a smile. Humor, in this dyad, created a framework to deliver difficult information.

Internally Demotivating. Administrators expressed "pain," "anger," and "overwhelm" as their key sources of negative emotions. The administrator group provided examples of negative emotions when they were concerned about the ability to provide care and services to patients. This group expressed a difference between anger with health system policies that prevented care to patients and anger with a system of complex opaque processes. Selected quotes from the administrators provide descriptions of both of these circumstances.

A1 described the pain centered on the inability to provide services to patients. The scenario shared by this administrator required an explanation to hospital leaders of the need to admit patients directly for complex services. The prerequisite justification was often predicated on lack of an available bed or the preferential treatment accorded to patients being admitted through the emergency department. A1 offers this description of being unable to admit a patient for a complex procedure, “to have to constantly explain, because we've had such a turnover in [hospital] leaders, the impact of that [cancelled admission] happening and why they [patients] have to be looked at the same as if they're in [surgery].” A1 goes on to explain, "I end up turning away patients who are in the most need of care for what the team can offer...That's a bad day, it

hurts. It really hurts." Throughout the description of this event, the administrator's facial expression and tone of voice provided additional emphasis on the frustration associated in not being able to provide care in this scenario.

The second type of negative emotion is the frustration that can be experienced with complex systems. A2 spent a thoughtful amount of time describing what it's like to work in a large healthcare system. As a new administrator A2 summarized their experience with this statement, "There was no road map really to say, here's what you *don't* have that you *do* need." Italics represents emphasis made by A2 during the interview. Complex systems and an undefined dyad leadership role were particularly difficult to navigate. This led to feelings of overwhelm. As A2 continued to explain, "Those first few months were really overwhelming...It was like kind of a scary few months. I didn't know who my medical director (dyad) partners were."

Organizational Culture

The administrator group described an organizational culture of respect and failure. While these two concepts may seem opposed, A2 and A3 provided insight into the complexities of a large health care system. These complexities, as described by the participants, are balanced. Respect in the face of failure is complementary not "antithetical" to dyad leadership. A2 provided the following observation about the role of the physician dyad leader:

They are put through medical school to be tough, right? They're supposed to answer all the questions; they are supposed to show how capable they are. No one ever gives them...They never stop and say, 'So, where are you feeling nervous?' And so, the fact that now we expect them to step into these leadership roles where they're going to feel uncomfortable, and we want them to talk about why they feel uncomfortable. I mean, no wonder it's so hard, right?

A3 amplifies this comment in the following statement regarding the willingness to fail:

So, a lot of it just came down to us just being willing to accept that dyads take a lot of work, and we're willing to fail, but we fail fast if we're going to fail. The ambiguity is, we have to allow them [dyad leadership teams] to fail and feel like we've provided a safe space for failure, because if we haven't failed, we haven't reached our potential. We have to be able to fail in order to actually reach potential and we have to fail with enthusiasm rather than fail with – 'I'm not going to try that again.'

Dyad Structure

The administrative group described lack of clarity regarding the structure of the dyad. Only one of the administrators was interviewed by their dyad partner prior to beginning the position. The other two administrators were placed in their positions. One was appointed to the role by the health system's chief executive officer, and the other went through an application and interview process. Both of these administrators have been assigned to additional dyad partnerships during their tenure with the health system. A2 captures the essence of the dyad structure:

Like, I didn't actually understand that dynamic very well when I first started... There was no org structure given to me in the beginning that made it really clear for me. Over time it [the dyad structure] got really clear, both because I figured it out just by working with people, but I think also because we [the health system] have done a better job in formalizing the org structure and how the dyad partners are supposed to work.

In a different scenario, A3 describes the health system's lack of acknowledgement related to the temporal component of forming leadership dyads. While in a consultation with leadership development, A3 explained that dyad relationships can mimic arranged marriages and that "you've got to be okay when some arranged marriages don't work." A3 went on to explain the hallmark for success is allowing the dyad time to "mesh" and "being willing to accept that dyads take a lot of work." A3 was adamant that dyads can take years to form "successful teams."

Vulnerability

The superordinate theme of vulnerability was common to all administrator participants. The three administrators discriminated between equal vulnerability and personal vulnerability. The former applies to both members of the dyad and the latter applies to the individual. A2 describes personal vulnerability in comparison to the assumed perspective a physician would take regarding vulnerability:

It is scary to say, 'I don't feel comfortable here'...just putting those things out is exposing part of yourself, right? I'm naturally fairly willing to be vulnerable... over the years, I think I've developed that, and it doesn't scare me, but not everybody is, and I feel like especially for physicians, they're taught to be the ones who are strong, not the ones to be vulnerable, right?

A2 and A3 provide further detail about vulnerability by examining the learnings from the WSMA leadership course. Here the concept of vulnerability expands to include the dyad partner. The administrators agreed that the leadership assessment in the WSMA course, when approached from the position of equal or shared vulnerability, could provide insights into the dyad team's

dynamic. P3 stated, “It’s a fun way to look at it...we were all kind of able to look at where we fell in that [leadership assessment] and what our strengths and weaknesses were together.”

In this example vulnerability applies to both strengths and weaknesses. As P2 provided further clarification:

Now we can talk about how our strengths and weaknesses complement each other, or where we as a group are vulnerable because no one has a particular strength...I think over the past year [the WSMA course] bolstered our ability to have these kinds of conversations and deepened all of our relationships with each other on the team.

Leadership Skills

The concept of dyad leadership skills was described by two of the administrator participants. All three administrators completed the Washington State Medical Association’s (WSMA) leadership course with their dyad partners. In reference to this course A2 provided the following observation:

It's a fun way to look at it ... we were all kind of able to look at where we fell in that [leadership assessment] and what our strengths and weaknesses were together...so now when we have conversations about things...we meet in the middle.

This statement provides insight into the administrator perspective that learning together creates shared vulnerability. The concept of vulnerability comes up again as one of the major superordinate themes for administrators and will be explained in more detail later in this section.

A second perspective on leadership skills is provided by A3 in reference to the ability of physicians to contribute to financial goals, which is the generally accepted domain of

administrators. The following excerpt provides insight into the difference between theoretical book learning and the tacit knowledge acquired over years of practical experience:

He's always trying to bring out the textbook education of business, because that's what he's trained on, so he's always you know, well I learned this in my class, let's do it this way, and we're just like...the real world you know? We've been experiencing the real world for years, this is how it actually works when you take it out of the context of the business book, and so he still tries to, you know be *that* rather than be vulnerable and accept that somebody else might actually be able to provide that input.

The administrator group generated explicit superordinate themes specific to their group and other superordinate themes partially shared with the physician group. The shared themes included professional satisfaction, leadership skills, organizational structure, and dyad structure. Administrators experienced professional satisfaction while working to build healthcare infrastructure with their physician dyad partners. The administrators also expressed frustration when those processes to care for patients became barriers, preventing access to services. Leadership skills, as perceived by the administrators, involved the ability to collectively problem solve with their teams. Organizational culture supports the administrators with a respectful approach to failure and by acknowledging that creating dyad leadership teams is time consuming and difficult. Dyad structure, although a formal role, was not clearly depicted in the organization's charts. This led to difficulty for the administrators. The final theme, of equal and personal vulnerability, was a common lens for all three administrators. Vulnerability brought insight and awareness into their teams and provided equal opportunity for all members of the team to learn.

Physician's Results

Data from this group aligned with the components of triadic reciprocity (Bandura, 1986). The themes, as expressed by the physicians, were grouped under the appropriate component; cognitive factors, environment, and behavior. Smith et al. (2009) proposed that superordinate themes can be compared across a homogenous group to create instances of shared concepts. Table 6 displays the superordinate themes and subthemes from the physician group. The results are followed by a summary and an overall interpretation of the physicians' experience.

Table 6

Superordinate Themes Aligned with Triadic Reciprocity – Physicians

	P1	P2	P3
Cognitive & Other			
Personal Factors			
Professional Satisfaction	X		X
Lonely	X	X	X
Excluded	X		X
Environment			
Organizational Culture			
Turnover	X	X	X
Bureaucracy	X	X	X
Respect		X	X
Dyad Structure			
Polygamous		X	X
Conflict	X		X
Typecast		X	
Behavior			
Role Conflict			
Clinical vs Admin	X		X
Impact on Patients	X		X
Leadership Skills	X	X	X

Cognitive and Personal Factors

Internally Motivating. The physician group presented two clear examples of professional satisfaction. Satisfaction in the physician group emanated from; (a) achievements with their clinic teams and (b) building trust with their administrative dyad. The first example is from P3 who described the team's response to a collective win against the insurance company and getting a medication approved for their patient. P3 described the scenario when the team literally "did a high five and a happy dance" when they successfully appealed an insurance company's denial and were able to call the patient with a prescription. P2 described the dyad as a positive relationship built on trust, a long-standing relationship of working together, and recognizing the potential of their partnership.

Internally Demotivating. Negative emotions for the physician group related to (a) the dyad leadership role, and (b) lack of access to information. The following examples explore the physician's experiences with the loneliness of leadership. Two examples are provided to capture the perspective of dyad leadership loneliness. All three physicians repeatedly described a sense of frustration with the health system. P2 captured the sense of loneliness associated with dyad leadership in a large health system:

Well, you're not alone as a leader. I think that's the most important thing.

Leadership can be lonely. I think we're meant to be with people. As a leader you get further isolated. You're the 'other,' compared to the people that work with you.

So, having that partnership [dyad] gives, honestly, there's partnerships that probably sustain you when you wanna leave the job, because things aren't going well. Or no matter how much they're paying me, it's not worth it.

P2 admits that while the loneliness of leadership is real, that loneliness can be offset within the partnership of a functioning dyad. In contrast, a different physician participant provided a very concise explanation of feeling excluded from the “black hole” of leadership. For this participant, being on a dyad leadership team does not provide access to information or data. "I get excluded from things that I would like to be included on, because I'm not the clinic manager and I'm not the administrative part of the dyad."

Two of the three physician participants are part-time dyad leaders. The two part-time participants experienced different phenomena than their full-time colleague. The part-time physician dyad leaders expressed both internally motivating and demotivating situations related to both their clinical and leadership roles. The part-time physician leaders described no clear delineation between their work as a clinician and their work as a dyad leader. Their clinical work constantly intermingled with their leadership work.

Organizational Culture

Organizational culture for the physicians is described in terms of bureaucracy, senior leadership turnover, and respect. These three concepts were expressed by all three physicians. Selected quotes portray the collective experience of the physician participants. Each physician made several statements in each of these three areas, for brevity the most salient were selected from each.

The org chart for the medical group was gathered as an artifact for this research. The document is 14 pages long. The administrator and physician dyad are represented on one page. The box depicting the dyad consistently lists the administrator’s name first. There is no supporting detail describing the layers of physician leadership. Each box representing the dyad teams contains the title for each person, there are no names associated with the roles. The

document provides no contact information or detail associated with the scope or span of control of the leadership dyads. Instead of providing clarity, the physicians perceived the organizational chart as bureaucracy in action.

The box depicting the dyad leadership team is connected vertically to one senior leader; the chief operating officer for the medical group who is then vertically connected to the president of the medical group. The organizational chart seems to portray that both the administrative and the physician leader are in equivalent roles and report to the same senior leader. This contradicts the health systems bylaws in which a physician always reports to another physician. P3 summed up the participants' confusion regarding the complex organizational structure displayed on the chart. The comment explicates the inability to decipher who, on the administrator side, is responsible for which job functions. P3 stated, "I think that all I see is a bunch of titles."

The second subtheme, turnover, is captured by P2. This participant has the longest tenure as a physician leader. As such, this person has witnessed the rapid expansion of the health system including the impact and after effect of replacing the health system's CEO. P2 described the impact senior leadership turn over has on trust. "It [trust] is threatened when you have new leadership that don't realize the history you've been through." P2 goes on to explain that lack of shared history slows the pace of change and is a source of frustration to physician leaders.

The third component of organizational culture is respect. P3 describes the perceived lack of respect for physician leaders:

We were being asked to take down all of our personal information from our, our rooms, and, and basically, you know, share office space. Is that a bad thing? Not necessarily, however, you know, you put so much time and energy and effort into

having something that you call your own. My patients, when they would come in, they're like, 'Where are your kids' pictures on your desk?'

Dyad Structure

The physician experience of dyad structure is captured in three words: polygamous, conflict, and typecast. In this participant sample, polygamy is specific to the physicians. Polygamous dyads, in this sample, represent a one-to-many relationship. From the physician perspective, being assigned to more than one dyad partner is common, even for a physician placed in a part-time dyad leadership role. Table 3 displays the distribution of dyad partners in this sample. Figure 3 describes polygamous dyads from the physician's perspective.

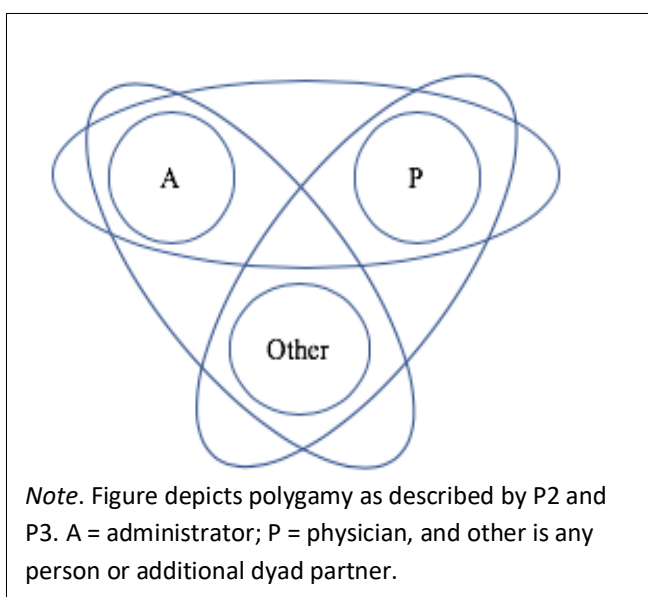


Figure 3. Polygamous Dyads

Conflict is described from several perspectives while typecast is mentioned by only one physician. P2 defines conflict from the perspective of ambiguity. This physician describes the ambiguous nature of this health system's dyad teams by stating, "the dyad relationship - it's not black and white, our relationships were never set, 'you're going to be a dyad' and, yet, we

formed partnerships regardless.” This participant goes on to describe the development of the dyad relationship in the following excerpt:

I don't even remember how that conversation even unfolded; it became clear that we were creating this division. And each of us started to emerge in our unique roles. So, we just started collaborating together, it wasn't said, you two are going to work together closely, so, it just kind of emerged that way.

The same physician leader continues to describe the evolution of the dyad structure by drawing a picture of overlapping circles. This picture was presented as the artifact most closely associated with the dyad model. The Venn diagram (Figure 3) was presented in recent history to a group of physician leaders. Although this diagram is no longer referred to within the organization, it formed early expectations for this participant regarding how to be a dyad leader. P2 goes on to explain the drawbacks from this model:

People get fixed on it [dyad leadership], if it is a black and white solution, or that there are fixed rules. It ignores personalities, it ignores strengths. It can typecast people. I think that's one problem with it. I personally think it's a better conversation on, how do we form the right leadership teams? The key is that it's not about one person, it's about taking advantage of the personalities and strengths on a team.

The other physician participants describe conflict with stronger language and tone of voice. P3 describes conflict related to role ambiguity in the following statement:

Um, where theoretically we're supposed to collaborate on projects, or *whatever*, but I haven't had [dyad partner] come to any of my clinical meetings. Not one for, forever since there was a concept of dyad partners. But my [dyad partner] said I

would be able to handle it, but it's kind of a missing link, I think. [Italics represents emphasis by the participant.]

P1 has a different experience with conflict as reflected in this statement, "We have tension over some things, and other times, other things we agree on, so getting her to agree is tricky."

Role Conflict

Within the physician participants' responses, the data regarding role conflict was inconsistent. This is due primarily to the number of hours each physician has to devote to their dyad leadership role. All of P2's time is devoted to leadership (no clinical practice), while P1 and P3 are in divided roles. P1 has 50% of their time dedicated to leadership while P3 has 40% of their time dedicated to leadership. In other words, both P1 and P3 are actively caring for patients in the same clinics where they are expected to be leaders. Both part-time physicians described role conflict with anecdotes and an emotional, fervent, tone of voice. The experience for the part-time physicians is different than the experience for the full-time physician leader.

The part-time leadership roles of P1 and P3 have a direct impact on their ability to care for their patients. This time in the clinic also limits when they are able to participate in leadership events such as budgeting, strategy, and capital equipment allocations. As formal dyad leaders, P1 and P3 are expected to attend leadership meetings and training sessions. If these meetings are cancelled or rescheduled, patients often feel the impact. As P3 states, "that's *really disruptive* if I have to reschedule patients" to attend a cancelled/rescheduled leadership meeting. [Italics reflects participant's spoken emphasis.]

The other concern with part-time leadership is the assumption that patient care only occurs during business hours. P1 also shares in a demanding call schedule for several hospitals, while P3 provides patient care after hours and on weekends as evidenced by this statement:

I'm out for the day (doing admin) and not typically near a computer in a clinic situation, I still have to - to go into E.H.R. [the electronic health record] and electronically sign prescriptions...I could theoretically push it off to the side and wait 'till Wednesday [regular clinic day] to do all that but I don't like leaving a lot of prescriptions out there or patient questions out there, so I will often go into the E.H.R. and uh, you know work.

The idea of postponing patient care to assume leadership work creates frustration for these two part-time dyad leaders.

Leadership Skills

The physician group described a paradigm of leadership via observations and textbooks. While all three of the physicians completed the WSMA dyad leadership course, none of the physician participants made any explicit comments about the training. Two of the physicians mentioned an intent to learn about leadership and only one provided insight into how they would seek new knowledge about leadership.

P3 described a poignant situation of observing another dyad pair as they presented their shared strategy to the health system's senior executives:

I saw other dyad partners functioning really well, where you know, the doc would speak to some issues on a PowerPoint, and the clinical administrator would also, and they would say these are *our* goals, these are *our* things we were

working on, is that your thing? But I was *never* asked to give any input at all- about anything into those PowerPoint presentations. [Italics indicate where the participant placed emphasis.]

P1 commented about lack of knowledge and the “black hole” of administrative and leadership processes. The physician animatedly pointed to a shelf of leadership books and offered, "I've been reading all these books about how do you lead [through change]?" The frustration was further acknowledged with a wave of the hand and a comment regarding how, "*I didn't expect it to be so much about people management.* That has been a big...although I had all this training, I hadn't done people management. That has been a *big* learning for me." [Italics indicate where the participant placed emphasis.]

P2 added a different perspective related to accessing information and insight into administrative processes. While this indicates disagreement with P1, it also illustrates the varying opinions about dyad structure:

I think physicians presume, naturally, that their voice should be the leadership voice, and the management should be, the operator side should be the management side of that. I just don't think it's been really clear, in distinguishing between those things.

Summary

The physician group generated explicit superordinate themes specific to their group and other superordinate themes partially shared with the administrator group. The shared themes included, leadership skills, organizational culture, and dyad structure. The theme exclusive to the physicians is role conflict. The physicians expressed professional satisfaction when they were able to provide care and treatment to their patients. Expressions of professional fulfillment were

accompanied by words such as “mission,” “making a difference,” and “worth it.” Negative emotions centered on a perceived lack of respect for the leadership role of the physician.

Leadership was further explicated by a sense of frustration after observing other dyads work together or by the unexpected need to “manage people.” Organizational structure and turnover in senior leadership also had a negative impact on the physicians in this study. The physicians experienced ambiguity and lack of clarity regarding their roles as a result of senior leader turnover. Dyad structures were perceived to be either “type cast” as described by P2 or “polygamous” as described by P2 and P3. The polygamous structure for a part-time physician leader presented unique challenges to the perception of role clarity.

The final and unique theme to physicians is the experience of role conflict. The two part-time leaders described the experience of constantly juggling demands to meet patient care needs and attend leadership events or meetings. Although each of these physicians described how their schedules were dedicated to specific roles on specific days, neither physician experienced a clear delineation between their clinical and leadership role. P1 describes a poignant scene when seeing patients in clinic took priority over participation in a strategic planning meeting to allocate capital. With the absence of P1, the capital equipment for that medical specialty was denied. The ability to provide patient care did not assuage the frustration for not being able to advocate for future patient needs. In the words of the physician, "I wish I had been able to advocate [for the equipment] but I was in clinic that day." P3 expressed similar frustration in terms of not being able to participate in strategic planning, "It is feeling like you have a constant source of frustration whether." The short-term needs of seeing patients today interfered with the part-time physician leader's advocacy for the future. The full-time physician leader did not experience role conflict.

The final step in the IPA analysis is to compare the lived experience between the two groups. The following section will compare and contrast the superordinate themes, between the physicians and administrators. For clarity, the themes will be addressed in the same order they were presented in the previous two sections. At the conclusion of the next section, a final overview of the data is provided. This will serve as a summary of Chapter 4 and an introduction to Chapter 5.

Compare and Contrast: Physician and Administrator

The final analysis of the data uses a compare and contrast methodology specific to interpretive phenomenological analysis to examine similarities and differences between the two groups. Although both groups experienced shared superordinate themes, the drivers of those themes varied more between the groups than within the groups. The following section presents additional quotes to support the interpretation of similarity or difference. In the case of the two superordinate themes which were exclusive to each group, an interpretation is made by the researcher regarding the presupposed answer by the missing group.

Cognitive and Personal Factors

Internally Motivating. The administrator group described positive emotions of professional satisfaction from working with their dyad partners. All administrator participants expressed respect for their physician dyad partners. A2 captured the concept in the following statement, “you've gotta’ appreciate the fact that these guys [physicians] are gonna have their own opinions, and they're gonna push back on you and you're gonna have to listen to their opinions, and it's not just about you.” The administrator group appreciated and respected the contributions of their physician dyads while understanding that the ability to be vulnerable varied considerably between the two groups. This is evidenced in the following comment made by A3:

Physicians are looked to as they have all the answers, they're...that is how they're trained, that is how they're supposed to go about life, they're to solve problems and have all of the answers, and so when you take them out of their, 'I have all of the answers,' into this you're responsible for this business, here's your P&L, here's your quality metrics, figure it out...it either makes them or breaks them.

The overall approach by the administrator group is to create a culture of partnership with their physician partner.

The physician group described internal motivation when they were able to secure care, services, or medications for their patients. Additional references to positive emotions were limited. P2 describes the dyad relationship in terms of trust. Trust, from this perspective, is viewed as a positive emotion. P2 said, "[we] trusted each other and so we started collaborating, more going this could really be something special if we build it. And it just started like that, almost without clear structure to it." Reference to the dyad as a unit of trust did not emerge in any other transcript. Unlike the administrator group which openly describes feelings of respect towards their physician partners, two of the three physicians did not express a similar emotion towards their administrative partners. Positive emotions in the physician group were largely isolated to the practice of medicine and caring for their patients.

Internally Demotivating. While both groups expressed demotivators, the specifics varied more between the two groups than within the two groups. Both groups expressed frustration and anger related to the inability to provide care whether the cause was an insurance company or a health system executive's lack of understanding regarding health system policy. Insurance companies had more of a negative impact on the physicians while health system

polices created more difficult situations for the administrators. Both groups, however, expressed considerable frustration with the inability to act out their mission, to care and serve patients.

Leadership Skills

The concept of leadership, although present in both groups, presented itself in very different detail. All six participants completed the WSMA dyad leadership curriculum. Yet where the administrators made multiple references to the WSMA leadership course, the physicians failed to mention it at all. The administrator group explained, in detail, how they used new insights gained from the training and applied those insights to enhance their dyad partnership. This was expressed by all three administrators as a willingness to be vulnerable and to accept the collective wisdom of the team.

A1 provided insight into their experience. The administrator is describing the impact of the dyad partner's skill at running a business meeting with the following statement:

I have to talk to [dyad partner] about how that makes other people feel and how I will take on the role of telling them that you're going to be efficient running this [meeting] and that they *literally* only have 10 minutes...I always have to apologize to everybody in advance ahead of you. [Italics represent participant's emphasis.]

The physician group, on the other hand, expressed frustration with not knowing how to “do” leadership. Two of the three physician participants completed their MBA. One of the physicians summed it up this way:

I also have an MBA. Figuring out what [dyad partner] did versus what I did was tricky. We were feeling each other out. Then what has led to the division of labor ultimately is that I don't have time. I can't go to every meeting. I can't participate in every budget discussion. [Dyad partner] has all these years of experience that I don't have.

Organizational Culture

Both physicians and administrators agreed that turnover in senior executives has a negative impact on the identity of the dyad, organizational understanding of what a dyad is, what dyads are expected to do, and their identity as dyad leaders in the organization. The two groups, however, differ in their perception of organizational respect. The physician group voiced lack of respect for the role of physicians as evidenced by the practice of sharing depersonalized offices. The administrative group gave voice to the concept of respect in two parts; (a) respect for the physician as a dyad leader, and (b) respect for dyad leadership pairs who are not successful.

The concept of failure is addressed by the administrators as a leadership responsibility to promote safety. Acknowledging that not all dyad pairs will be successful and that *failing fast* is a respectful approach simply concedes that not all dyad partnerships are successful. Failing fast allows each dyad team member to return to their previous role while the leadership team searches for replacements.

Dyad Structure

The administrators and physicians shared different experiences and perceptions of the structure of dyads. The administrator perspective focused on the benefits of working through the ambiguity by applying lessons learned from the WSMA training; insight, awareness, and relational dynamics within the dyad. This represented a concerted effort over time. The

physicians, on the other hand, presented an experience of polygamy, conflict, and being typecast in a narrowly defined role. The black and white roles depicted by the overlapping circles seemed to represent additional conflict for P2. The description of this model was accompanied with a tone of regret, or dismissal. The Venn diagram, although no longer used by the health system to describe dyad leadership, created conflict for P2 that persists into the present. The symbol drawn by P2 is depicted in Figure 4.

Figure 4. Venn Diagram for Dyads

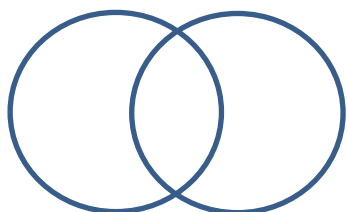


Figure 4. Adapted from the description provided by P2. In this model, the physician and administrator share work only in the overlap of the two circles. Outside the overlap, the physician and the administrator work independently.

Role Conflict

Part-time physician leaders are confronted with the recurring choice of participating in a leadership event or seeing patients. Some part-time physician leaders are compensated based on production (i.e. seeing patients), and if this is the case then seeing patients (generating a pay check) becomes the overriding driver behind the choice. This leaves the physician feeling left out of important opportunities to network, build influence, or increase system knowledge related to strategy. Although P1 and P3 are from different medical specialties, their perspective on the role conflict is very similar. Each physician has a very detailed schedule of when to be in clinic, and both have many patients and a long waiting list to be seen. Rescheduling to accommodate leadership events is detrimental to patients. Having to make the choice creates a conflict between

the two roles of the part-time physician dyad. P1 sums it up with this explanation, “Blurring the lines between admin days and clinical days, is a false choice. One often intrudes on the other - patients need care all the time, not just during business hours.”

In contrast, administrators, as full-time leaders, are able to enjoy the health system’s training and numerous leadership events without worrying about the negative impact of having to reschedule patients or having limited ability to see patients. There is no negative impact to an administrator’s salary for attending a leadership conference. The superordinate theme of role conflict is specific to the part-time physician leaders.

Vulnerability

The final superordinate theme, vulnerability, is exclusive to the administrator group. Each administrator expressed the need to be vulnerable and acknowledge vulnerability in others. A2 describes a perspective about the difference between physician vulnerability and administrator vulnerability, “the contrast for the physician role in terms of being a clinician which is, by necessity, invulnerable and in control, and then stepping into a dyad leadership role where vulnerability is almost essential.” Vulnerability is also addressed by A3 in the description of collective problem solving versus the application of an academic theory in leadership. From this administrator’s perspective the ability to accept another’s recommendation implies that one’s own recommendation may not be superior, which requires a certain amount of vulnerability to admit. The administrator offers this insight:

This business person’s idea, you just have to be okay with the fact that sometimes the physician is going to have to say things, and the physician has to be okay with the fact that sometimes it's going to come better from administration.

This is where administrators would like to have equal vulnerability with their dyad partners.

This section reviewed the similarities and differences between the physicians and administrators in the data. The superordinate themes included: positive emotions, negative emotions, leadership, and organizational culture. These four themes were shared by both groups, although the subthemes within each larger superordinate theme were different for each group. There was more similarity within each group than between the two groups.

The superordinate theme of role conflict presented itself as exclusive to the physician group. Within this group, the two part-time physicians expressed conflict and tension between their part-time leadership roles and the continuous demand from patients seeking their care. The full-time physician leader did not express conflict related to their role. Role conflict also did not apply to the full-time leadership roles of the administrators.

The theme of vulnerability was exclusive to the administrators. This theme was pervasive in all three transcripts. The administrators expressed a common voice of respect for their physician partners along with insight into how their training as physicians may have impacted their ability to be vulnerable. The administrators also acknowledged the need to practice vulnerability with themselves and with their teams.

Conclusions

Following the IPA methodology (Smith et al., 2009) the transcripts were coded in a specific order; descriptive then linguistic themes were developed first, followed by analysis, interpretation and the development of superordinate themes. This process was applied first in the administrator group, then in the physician group. Matrices were created throughout the process to continually compare, add, or merge emerging themes. This process was followed until the final set of seven superordinate themes was created.

The data was presented by group; the administrators first, followed by the physicians. Selected quotes were used to convey the participants' experiences in each of the superordinate themes. Care was taken to ensure that the various sub-themes within each superordinate theme were fairly represented with direct quotes from each participant. For the sake of brevity, not every participant was represented in each theme.

The final section compared and contrasted the experience of the two groups. The aim of the study is to explore the lived experience of healthcare leadership dyads, as such, each groups' perception was presented and compared within each superordinate theme. Further exploration of the superordinate themes with recommendations for further study will be covered in Chapter 5 and aligned with theoretical framework provided by Bandura's (1986) social cognitive theory.

CHAPTER 5

OVERVIEW OF THE STUDY

An interpretive phenomenological methodology (IPA) was applied to the phenomenon of dyad leadership in healthcare. Guided by the research question, “What is the lived experience of a dyad healthcare leader,” this study explored the experience of physicians and administrators in formal dyad leadership roles. Dyad leadership in healthcare emerged as a formal structure after the Institute for Healthcare Improvement (IHI) published the Triple Aim as a framework to focus the transformation of healthcare on improving access, decreasing per capita costs, and improving health outcomes (Institute of Medicine, 2001; Swensen et al., 2013). Physicians commonly assume the responsibility for improving quality while the administrators are often tasked with cost control measures. Together this dyad leadership team assumes responsibility to improve health care quality and decrease cost within their assigned department.

This research took place in a large healthcare system in Washington State. A purposive sample of thirty dyad leaders, in formally recognized roles, were invited to participate. A final sample of six were enrolled in the study; three administrators and three physicians participated in semi-structured interviews. No intact dyad leadership teams were interviewed. As one member of a dyad leadership team enrolled, their counterpart became ineligible to participate.

The interviews were transcribed verbatim and analyzed following the IPA methodology outlined by Smith et al. (2009). Iterative coding of descriptive, linguistic, and analytical themes led to the development of superordinate themes. These themes were grouped into tables and the results of the two groups were compared and contrasted. The physicians and administrators shared five superordinate themes, and one unique theme emerged from each group for a total of seven superordinate themes.

This chapter presents a final interpretation of the findings. The results are presented as answers to each of the research questions. An interpretation of the results from the perspectives of the theoretical framework and literature review are also provided. A final section provides recommendations to the research site to apply these findings to their existing leadership development courses and to the dyad structures within the health system. These interpretations lead to recommendations for further study.

Interpretation of Findings

The data is interpreted from three perspectives. Initially, the data is interpreted through the lens provided by the research questions. Then the data is interpreted with the additional lens of the theoretical framework provided by Bandura's (1986) social cognitive theory, and finally the data will be tied back to the salient points extracted from the literature review. This model of analysis gathers the data from the physicians and administrators into a coherent narrative.

The central question for this study was aimed at exploring the phenomenon of dyad leadership through the lived experience of physicians and administrators in the role. The research questions were:

1. What are the perceptions of dyad leaders at a single, large health system in Washington State regarding their development of shared leadership influence in their organization?
 - a. How do physicians experience the phenomenon of dyad leadership?
 - b. How do administrators experience the phenomenon of dyad leadership?
2. How do dyad leaders describe and make sense of their roles?
3. What leadership training and/or interpersonal communication training did the individuals have, if any? Do they feel that was beneficial?

The lived experience of the physicians and the administrators varies more between the groups than within the groups. This research represents the experiences of three administrators and three physicians, none of whom were in the same dyad leadership team. Similarities and differences persist across all research questions. There are five shared superordinate themes: (a) positive emotions, centered on caring for patients; (b) negative emotions, described barriers to caring for patients; (c) leadership, concentrated on applying leadership theory; (d) organizational culture, focused on decreasing role ambiguity; and (e) dyad structure, centered on polygamous dyads. The primary difference between the two groups are in two exclusive superordinate themes: role conflict for physician leaders and the administrator's perception of lack of vulnerability in their physician partners. All superordinate themes are displayed in Table 4. Highlights from these themes are used to answer the central question.

The inspiration for this study came from the IHI's Triple Aim; a framework to improve health care by placing emphasis on population health, improved healthcare quality, and decreased costs. The IHI placed quality and cost at the base of the triangle, population health is at the peak of the triangle. As previously mentioned, physicians in the dyad leadership role are typically assigned responsibility for improving quality whereas the administrators are often assigned the task of reducing per capita costs. The basis for answering the research questions stem from the assumption that the work on the base of the triangle creates, and then supports patient care. In the IHI Triple Aim model improvement at the base of the triangle assumes improvement in quality and cost improves the health for populations. Improving quality and cost simultaneously is the role of physicians and administrators, respectively.

Research Question #1

Physicians expressed professional satisfaction when caring for their patients and frustration when dealing with the “black hole” (P1) of administration or the complexities of insurance companies (P2). In other words, the physicians in this study have retained their sense of professional satisfaction, or personal agency, in the doctor patient relationship. Not all of the physicians in this study, however, achieved the same level of professional satisfaction, personal, proxy, or collective agency with their dyad leadership partners.

Administrators, on the other hand, expressed professional satisfaction in collaborating with their physician partners to create programs and develop cost effective sites of care to serve patients and communities (A2, A3). They also expressed elements of humor and fun in their dyad leadership roles. A1 brightened with pride as she described a comment made to her dyad partner about the designation of a successor for the physician leadership role, "You smile every time you talk about him...what makes you happy? Is it because you know he's really going to be the new heir apparent?" To emphasize the point, this administrator brought a photograph of her first leadership team which included her first physician partner training her second physician partner. The comment quoted above was made to her second partner as they were discussing the third physician about to step into the role of dyad leader. The concept of legacy and providing care to the community inspired this administrator to continue despite the adversities of dyad leadership. This administrator's experience of dyad leadership exemplified resilience in the face of complexity, or as Bandura (1986) describes - collective agency.

Frustration was expressed by both groups regarding ambiguous organizational structure and senior leadership turnover. Both groups expressed disdain at the lack of clarity provided by the 14-page organizational chart. Where the administrators were able to see progress in the

health system's definition of dyad leadership, the physicians were not able to recognize improvement. Lack of role clarity, as experienced by the participants, created difficulty in developing shared leadership, or proxy and collective agency.

Physician Experience. Physicians described themes of role conflict and bureaucracy. The full-time physician leader did not experience the same role conflict as the two part-time physician leaders. While all three physicians experienced ambiguity, P2 seemed to respond to ambiguity with personal agency. The two physicians with part-time dyad leadership roles, however, experienced a persistent theme that administrative and clinical schedules, although planned for specific days, were not mutually exclusive. Often one function intruded upon the other, which either led to missing important leadership events or rescheduling patients. Either situation caused frustration for the part-time physician dyad leader. P1 provided this explanation, “[It’s] really frustrating. I don't think it's patient-centric... frankly, I get angry, because I'm responsible for those patients' lives.” Whereas P2, who no longer cares for patients, does not give voice to this concern. P3, however, is very concerned regarding the overlap between clinical and administrative duties. As mentioned previously, P3 often reschedules patients when administrative schedules change. The impact of balancing too many demands leads physicians to feelings of anger and frustration.

P2 (full-time physician leader) did, however, experience role conflict. Without clear direction from senior leaders, this individual preferred to maintain relationships stating, "our relationships were never set, you're going to be a dyad, and, yet, we formed partnerships regardless” (P2). This physician goes on to explain, “[we] trusted each other and so we started collaborating, going this could really be something special if we build it.” Acting without direction from senior leaders exemplifies the autonomy captured by Bandura’s (2001) definition

of personal agency to exercise control over one's life and work. Understanding that relationships with administrative partners is crucial to success, P2 noted, "I often don't fit into a clear black and white dyad structure" but, "I know I need these other [administrative] people." This lack of role clarity aligns with Oostra's (2016) recommendation that leadership dyads function situationally not hierarchically. P2 unwittingly stumbled into a distributed model of dyad leadership which encompasses all of Bandura's (2001) components of agency.

The distinguishing difference among the physician participants is the ability of P2, who maintains a sense of personal, proxy, and collective agency in a rapidly changing environment. In the social cognitive perspective, this exemplifies the resilience attributed to teams who have achieved collective agency (Bandura, 1986). Acting without approval from senior executives, P2 continued to build trusting relationships with administrative partners not formally assigned to the dyad leadership role. This is contrasted to the reported experiences of P1 and P3 who appear to have abdicated their personal agency. As the aforementioned quotes in Chapter 4 demonstrate, the two part-time physicians expressed "burnout" as a key concern. Each of these physicians also failed to achieve a high degree of collective agency with their dyad partners. Together P1 and P2 described lack of access to key reports, lack of time to attend business meetings, and lack of understanding and experience to manage people. While these internal demotivators may be fueled by a part-time leadership role, the overall approach of P1 and P2 was to assume they experienced barriers to collective agency. In the words of P1, "I worry that one of my deficiencies is I'm not good at selling [my ideas]."

Administrator Experience. The administrator participants were more uniformly satisfied in their professional roles. They expressed common themes; (a) humor, to develop their teams; (b) respect for the physician colleagues, and (c) an understanding of the amount of time

required to achieve organizational change. All of the administrators had previous experience in healthcare leadership. The administrators as a group also expressed a common understanding of the time required for organizational change as well as the need to collaborate with others to achieve goals.

Research Question #2

Physicians and administrators made sense of their roles by observing other dyads in action or by reflecting on their leadership styles by using tools obtained from the Washington State Medical Association (WSMA) dyad leadership course. Self-reflection, as defined by social cognitive theory (Bandura, 1986), provides insight into thoughts, actions and future actions as individuals gain understanding of their social environment. Administrators used the applied learning from the WSMA forum while the physicians relied on observations skills at health system leadership events. Observation is an important feature of human agency, in that it allows for tacit learning which saves time by avoiding trial and error (Bandura, 1986). Observation alone, however, may underrepresent the tacit knowledge necessary to extract actionable information from the observation (Bandura, 1986).

Research Question #3

Both groups had a variety of advanced training or experience in leadership. While none of the physician leaders had prior experience as dyad partners, all of the administrators had previous experience with shared leadership. Two of the three administrators and two of the three physicians earned advanced business degrees. While A3 voiced concern over the difference between textbook learning and experiential knowledge, all three physicians voiced concern over lack of access to administrative and financial reports. From the physician's perspective, textbook learning provided a foundation to critically assess health system reports, if and when those

reports became available. The limiting factor for the physicians to participate in administrative or leadership training was lack of time.

Theoretical Interpretation

Overall, both groups experienced positive and negative aspects of their dyad leadership roles. Interpreting the participants' experiences through the agentic lens of social cognitive theory provides a unique perspective on the actions and interactions of dyad team members. To gain a better understanding from this perspective, the following section references the components of personal, proxy, and collective agency (Bandura, 1986, 2001). Salient examples are provided for each type of human agency.

Personal Agency. All of the participants demonstrated personal agency. Data from the participants is grouped into four of Bandura's (1986) core features of personal agency. Personal agency is prerequisite to achieving proxy or collective agency. The examples from each group add clarity to the definitions of the social cognitive terms provided in Chapter 1. Table 5.1 provides details of the different types of personal agency described by each group.

Table 7

Results Compared to Bandura's (2001) Core Features of Personal Agency

	Forethought	Intention	Self Reflective	Self Regulative
Physician	Forming dyads regardless of senior leader direction	Seeking new knowledge by reading business books or earning an MBA	Observing other dyads in action	Monitoring the ability to find joy in caring for patients
Administrator	Forming dyads knowing that over time many will fail, yet continuing to search for the right partners	Applying tacit & experiential knowledge not just book learning	WSMA leadership assessments & insight into team dynamics	Considering physician training when thinking about how to work with dyad partners

Note. Adapted from "Social cognitive theory: An agentic perspective," by A. Bandura, 2001, *Annual Review of Psychology*, 52: 1-26.

Proxy Agency. Proxy agency, however, seemed to be limited to specific examples when their roles were more clearly delineated. A2 described a salient moment when her dyad partner shifted a disciplinary conversation into a career coaching session for a physician team member struggling with another member of the team. The dyad leader was able to connect professionally with the physician in a way an administrator would never be able to do; as a result, the physician experiencing difficulty was able to self-regulate, self-reflect, and take action to improve the relationship with the other member of the team. This example illustrates movement from personal, to proxy, and finally into collective agency.

The development of proxy agency rests within the individual. Personal agency is a prerequisite. The cognitive factors of personal agency form beliefs about an individual's ability

to impact the environment, and relationships with others. P1 and P3 provided multiple examples of the bidirectional influence of triadic reciprocity. As Bandura (1986) noted, lack of personal agency is a barrier to achieving proxy and collective agency.

Collective Agency. Bandura (1986) presented three conditions that interrelate to form collective agency: (a) collective agency is more than the sum of the individual's personal agency, (b) collective agency increases as the will of the team increases, and (c) collective agency is more difficult to achieve when environmental conditions are rapidly changing. All of these conditions are predicated along the continuum of time. Triadic reciprocity and the interactions between an individual's behavior, the environment, and an individual's cognitive processes, are not symmetrical. Several examples of collective agency from the administrators and physicians provide a glimpse into collective agency in the health system.

A1 described the ability of the physician team to gather, despite different clinical opinions, to provide clinical care. In this circumstance, A1 described collective agency as "The fact that we still come together around care." P2 offered a different perspective on collective agency. This physician, who previously acknowledged a need for his administrative partner, went on to state "Texting is a symbol of connectedness. A good dyad relationship, in my mind, is texting back and forth because you're constantly checking bases with each other." The intent of constant communication, in this example, is to extend unified leadership into the organization. Oostra (2016) added that a strong dyad can be recognized when the artificial lines between administrator and clinician are blurred and speaking to one yields the same information as speaking to another.

P1 demonstrates the temporal component of collective agency. This physician explained the relationship with her dyad partner, "It's a very, really intense relationship. We spend a lot of

time together, all day, three days a week." Building collective agency requires time and opportunity to observe each other to acquire the tacit knowledge of how to work together (Bandura, 1986). P3 offered a different perspective on the time component of collective agency. As the composition of a community board of directors changed, P3 noted "after a point, I realized why am I really here on this board now that I can't even offer a vote to make a difference?" As roles change over time, the ability to self-regulate and reflect on individual contributions is an important component of collective agency. These examples from the data demonstrate the fluid nature of collective agency, and the multiple components that enhance or detract from collective agency.

Literature Review and Findings

The review of the literature presented in Chapter 2 revealed lack of consensus regarding the composition of the dyad team. This study, however, revealed a consistent pattern of partnering physicians, within their medical specialty, with administrators who actively pursued a dyad leadership role in the same specialty. The physician and administrator dyad pairs in this health system were supported by an organizational chart, that according to A2 continues to improve in accuracy and clarity. The data also revealed conflict for the physicians holding part-time dyad leadership roles. The concern about part-time leadership was largely ignored in the literature.

Dyad Structure

A second concern presented by the participants in this study, is the situation when a dyad leader (physician or administrator) has more than one dyad partner. P2 referred to this situation as a polygamous dyad. Two of the six participants in this study were paired with more than one dyad partner (Table 3). Participants in polygamous dyads described increased ambiguity and less

role clarity than their colleagues in one-to-one dyad pairs. As P2 explains, the ability to rely on trust and relationships has been a key feature of successful dyad partnerships providing the resilience to survive senior leadership turnover. Without trust the dyad is easily “infiltrated” by others, undermining their ability to form a cohesive team (P2). This finding aligns with the sociology of Georg Simmel (n.d.) who postulated an argument that when a third person is added to any dyad the original pair are fundamentally changed. The participants’ description of their lived polygamous experience aligns with Simmel’s (n.d.) explanation. Figure 4 captures the phenomenon of polygamous dyads as perceived by the participants.

Cultural Differences

The review of the literature described training for physicians that perpetuates and magnifies an autonomous, independent professional role (Sadowski et al., 2018; Sanford & Moore, 2009). Indeed, Collins et al. (2016) proposed dyad leadership unites two cultures: the autonomous physician and the collaborative administrator. The health system, in a deliberate effort to support dyad leadership teams, offered a unique training opportunity to all physicians and administrators in formally recognized dyad roles. The training provided insight into leadership styles, and as A2 stated, “it was a great training [WSMA]. What I liked about it was the focus on how administrators and medical directors function together, and understanding our different styles and preferences.”

Interpersonal Skills

A grounded theory by Clausen et al. (2017) emerged in the literature review that described a model of intentional partnering for dyad leaders. The theory is comprised of three parts: (a) mutual need, (b) joint risk taking, and (c) shared responsibility. These three parts viewed through the lens of Bandura’s (2000) perspectives of agency align with the description of

collective efficacy. The ability of a dyad to achieve collective efficacy begins with the four dimensions of personal agency, followed by the exercise of proxy agency, and finally the deliberate intention to form a team (dyad) around shared goals. Mutual need, as described by Clausen et al. (2017), aligns with Bandura's (2001) concept of proxy agency wherein individuals accept mutual need and rely on the skill or expertise of others to achieve goals.

Intentional partnering and the development of collective goals relies on the dyad's ability to accept mutual necessity and negotiate their relationship (Clausen et al., 2017). While the health system bears the responsibility to support proxy agency by generating clarity around structure, the work of negotiating the relationship belongs to the members of the dyad. Negotiations in dyad leadership is somewhat akin to "marriage" according to A3. Not all dyads are successfully matched, allowing time for the pair to appreciate each other's expertise, supports the development of proxy agency which in turn builds the capability of collective agency. Given the temporal component of developing proxy and collective agency (Bandura, 1986), rapidly forming and reforming dyads is not recommended. In the words of P2, "switching dyads every 2 years would be a disaster!"

Institute for Healthcare Improvement Results

Whittington et al. (2015) reviewed the nation's progress towards achieving the IHI Triple Aim. The literature review revealed less than exemplary results. Lack of infrastructure has been attributed as the root cause of failure to make simultaneous progress on all three aims (Whittington et al., 2015). The magnitude of organizational change required to take physicians out of clinical roles and place them into leadership roles has proven to be costly and time intensive. The dyad leadership team, represented at the base of the triangular model depicting the Triple Aim, likely needs time to evolve at the national and local level.

Recommendations for Action

Recommendations to apply the findings from this research are sorted into four categories. The findings can also be applied within the health system to improve or strengthen existing dyad leaders. The phenomenological, idiographic approach provides a deep look into the experience of dyad leadership. As such the outcome from this study builds upon the empirical body of research on health care transformation and leadership.

Results and the Individual

Individual members of each dyad are encouraged to engage in leadership assessments and reflection. Participation in joint training or leadership events with their dyad partners allows for relationship building and joint observation of other dyads in action. Real time observations allow for real time debrief and learning together. Individual growth as a leader, through the lens of social cognitive theory (Bandura, 1986) requires self-reflection and self-regulation in an environment where leaders can adapt to each other and to their changing circumstances.

Health System and Dyads

The health system is encouraged to consider the following recommendations. Leadership assessments could be administered prior to assigning dyads. A variety of assessments could provide different perspectives on an individual's leadership tendencies and preferences. The Harrison Assessment® and LEAD® assessment provide tools for the health system and the individual (Harrison Assessments, 2019; Merrill & Reid, 1999). The Harrison Assessment offers insight into individual preferences and is capable of comparing those preferences to the preferences of other individuals. In this way, the Harrison Assessment® can provide a preview of dyad leadership team dynamics and potential collective agency. The LEAD® assessment

provides an easy to use tool that allows individual team members to reflect on their leadership styles. Self-reflection is a component of the personal and cognitive factors of Bandura's (1986, 2001) theory of triadic reciprocity and social cognitive theory.

Alternatively, the relationship could be enhanced by allowing prospective dyads to interview each other. P1 was interviewed by their dyad partner, which in the words of this physician created mutual acceptance and early enjoyment of their relationship. If the aforementioned assessment tools were implemented, the Harrison Assessment® provides interview questions based on the individual's preferences. The interview team would be composed of the potential dyad partner, and physician and administrative leaders on the team.

Results and the Organization

Attending leadership training and events is difficult for part-time physician dyad leaders. The development of an on-line open course with access to the WSMA content and curriculum could facilitate participation for part-time leaders, leaders unable to travel, or leaders in remote locations. Assessments and assignments could be completed electronically and presented via an electronic classroom. Leveraging an online solution could increase access for health system leaders in geographically distant counties.

For those leaders able to complete the initial WSMA training, advanced training could focus on the attributes of leadership and the development of collective agency. Continuing with the investment in the WSMA leadership development program supports the dyad leadership team and a culture of learning. However, since the reactions from the three physicians in this study revealed at best a neutral response to the training, health system may consider a follow up survey of the physician participants to glean feedback before extending the training to more dyad leadership teams. An anonymous survey focused on the physicians' experience with the content,

their ability to apply learnings to their leadership practice, and any changes in their relationship with the dyad partner may evoke practical information to improve the course.

Within the physician group professional satisfaction from patient care is limited to the two part-time physicians. The full-time physician dyad leader no longer practices clinical medicine. While the need for part-time physician leaders within specialties is necessary, as is the case for P1 and P3, the ability to remove physicians from clinical practice to serve as full time dyad leaders may not be feasible. Lack of feasibility could be attributed to cost or limited number of physicians able to provide specialty care.

Results and Institutions

The NCHL (2019) recently revised the curriculum to include more interpersonal skills. The IHI has also updated the Triple Aim to the Quadruple Aim by creating a fourth component on creating joy in the work place (Feeley, 2017). These two nationally recognized organizations continue to assess and reassess the needs of the health care leadership and provide up-to-date research to support the creation of a path towards transformative healthcare.

Recommendations for Further Study

This study revealed a distinction between job satisfaction and the experience of joy at work. The physician and the administrator groups expressed glimpses of both; the physicians narrowed professional satisfaction to providing patient centered care while the administrators viewed the creation of processes as a satisfying, foundational element to the provision of patient care. Joy in relationships with colleagues was cited by P2 as the reason for continuing with work even when “it wasn’t worth the money.” P1 and P3 confirmed that fulfilling the mission of caring for others, “making a difference ” and “having a patient say, 'I'm so much better!'" brings

them happiness. The joy of caring for others, and fulfilling a collective mission to care for communities, has the power to carry physicians through turbulent change.

Recognizing the need to sustain physicians through tumultuous change, the IHI published a response and added an additional element to the Triple Aim (Feeley, 2017). This fourth element, regarded as the antidote to slow transformation, focused on how to bring and sustain joy at work (Feeley, 2017). Exploring the experience of joy for dyad healthcare leaders could provide insight into the development of training curricula and cultures that create and sustain joy.

A final recommendation for further inquiry is for a longitudinal exploration of dyad leadership in healthcare. As Bandura (1986, 2000, 2001) iterated the temporal and interactive components of social cognitive theory, triadic reciprocity, and human agency are important elements of the human experience. Combined with the participants in this study who proclaimed the improvement of relationships over time as a key indicator of successful dyads, a longitudinal study would create space to examine the impact of time on dyads. Finally, the IHI has yet to achieve its goals of population health. Again, the element of time and the dynamic interplay between the components of the Triple Aim cannot be forced.

Conclusion

Healthcare is a rapidly changing industry. Fueled by political discourse (Altman, 2016; Bakalar, 2017), rising national expenditure (Congressional Budget Office, 2018), and an epidemic of physician burnout (Feeley, 2017), the IHI recommended the Triple Aim as a framework to refocus healthcare delivery and services (Swensen et al., 2013). The Triple Aim first appeared in 2010. Since then progress within the three components of population health, improved quality, and decreased cost has proven elusive (Whittington et al., 2015). The Institute for Healthcare Improvement's Triple Aim is represented by a triangle; each leg of the triangle

interacts dynamically and simultaneously with the other two (IHI, 2019). This IHI model approximates Bandura's (1986) model of triadic reciprocity, the foundation of the social cognitive theory.

Social cognitive theory (1986) is predicated on the dynamic interplay of the environment, the individual's behavior, and the individual's cognitive processes. The interplay of these three components rests in the social cognitive belief in human agency: Humans have the capacity to produce desired effects with their actions (Bandura, 2000). Collectively, humans have the ability to share beliefs, mission, vision, and values to create collective agency that benefits all. However, the results of this study revealed the difficulty for two individuals, joined by mission in a dyad leadership role, to achieve collective agency. The barriers included siloed professional training, lack of time dedicated to the professional relationship, and inconsistent, non-hierarchical infrastructure to support the development of healthcare dyad leadership teams.

The people who can fix healthcare, work in healthcare (Resar et al., 2012). Coordinated teams delivering patient-centered care are capable of transforming their local healthcare delivery systems. Beginning with the successes revealed by this research; dyad training for both members of the team, full-time physician leaders, processes that allow dyads to interview each other, and the application of leadership assessments, the health system in this study enjoys fertile ground to continue their journey towards the Triple Aim.

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Appendix A

NCHL Health Leadership Competency Model

The National Center for Healthcare Leadership curriculum was utilized, in combination with a local university, the research site, the organization's leadership development team, and the state's medical association, to create a unique curriculum for the organization's dyad leaders.

Table A1

NCHL List of Competencies

Transformation	Execution	People
Achievement Orientation	Accountability	Human Resources Mgmt.
Analytical Thinking	Change Leadership	Interpersonal Understanding
Community Orientation	Collaboration	Professionalism
Financial Skills	Communication	Relationship Building
Information Seeking	Impact & Influence	Self Confidence
Innovative Thinking	Information Tech	Self Development
Strategic Orientation	Initiative	Talent Development
	Org Awareness	Team Leadership
	Perf. Measurement	
	Process Mgmt.	
	Org Design	
	Project Mgmt.	

Note. Adapted from the NCHL competency model version 2.1 Retrieved November 17, 2018 from http://www.nchl.org/documents/navlink/nchl_competency_model-full_uid892012226572.pdf

Appendix B

Semi-Structured Interview Protocol

The Lived Experience of Healthcare Leadership Dyads: Perceptions of Agency

Date of Interview: TBD

Interviewee: Insert pseudonym

Thank you for taking the time to participate in this research. The purpose of this interview is to explore the lived experience of dyad leaders in healthcare.

This will take about an hour. With your permission, I will record this interview. The recording will be transcribed by Rev.com. This professional, on-line company will delete the audio file after 7 days. Please refrain from using proper names for places or people. If you forget, I will redact these from the written transcript. I will delete the audio file from the recording device at the end of the study.

I will provide a copy of your signed consent, and if you would like, I will provide a copy of the transcript to you as well.

If at any time during this interview you would like to stop, please inform me and we will cease immediately. If at any time you would like to skip a question, for any reason, please let me know and we will immediately move on to the next question.

What questions do you have before we get started?

Demographics

1. How long have you been in your dyad leadership role?
 2. How much of your FTE is dedicated to leadership?
 3. Do you hold a clinical degree or board certification?
 4. Who is your dyad partner? (The partner will be excluded from the study)
-

Background

1. How did you come to be in this position as a dyad leader in this healthcare system?
2. Please describe the first time you met your dyad partner.

The Lived Experience of Dyad Leadership (Personal & Proxy Agency)

1. What did you expect when you began this leadership role?

2. Describe a typical day as a dyad leader.
 - What do you enjoy the most about being a dyad leader?

 - What is the most challenging aspect of being a dyad leader?

Experiencing Shared Leadership (Collective Agency)

- Please describe methods of communication used in your dyad.

 - Describe your most recent meeting with your dyad partner.

 - Please describe how this artifact represents dyad leadership for you.
-

Is there anything we did not discuss that you would like to add?

Appendix C

University of New England

Consent for Participation in Research

Project Title: The Lived Experience of Healthcare Leadership Dyads: Perceptions of Agency

Principal Investigator: Susan Campanelli, University of New England, doctoral candidate

Introduction:

- Please read this form, you may also request that the form is read to you. The purpose of this form is to provide you with information about this research study, and if you choose to participate, document your decision.
- You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. You can take as much time as you need to decide whether or not you want to participate. Your participation is voluntary.

Why is this study being done?

- The purpose of this research is to explore the phenomenon of dyad leadership in healthcare.

Who will be in this study?

- You have been identified as a potential participant because of your formal role as a dyad leader in a healthcare organization. You must be at least 18 years old to participate; there will be six to ten participants. There are two exclusion criteria:
 1. The principal investigator's dyad partners will be excluded from this research.
 2. Only half of each dyad team will be eligible to participate.

What will I be asked to do?

- You will be invited to participate in an oral interview that will last approximately one hour. A follow up interview may be requested. The purpose of the interview(s) is to gather information about your experiences as a dyad leader. You have been intentionally selected to participate. There is no financial reimbursement for your time.

What are the possible risks of taking part in this study?

- There are no foreseeable risks associated with participation in this study.

What are the possible benefits of taking part in this study?

- There are no direct benefits to you for participating in this study.

What will it cost me?

- There is no cost to participate in this study.

How will my privacy be protected?

The following steps will be taken to protect, not guarantee, your privacy.

1. Participants will be contacted by the principal investigator in two ways: (1) via health system email, and (2) via direct invitation.
2. All interviews will be conducted on a date/time and location of the participant's choosing.
3. Interviews scheduled during the work day will be scheduled by the principal investigator and marked as 'confidential.'
4. Any correspondence related to the interview or follow up interview will be generated from the principal investigator's University of New England email address.

How will my data be kept confidential?

The following steps will be taken to ensure your private data will be kept secure.

1. All participants will be assigned a pseudonym known only to the principal investigator and the participant.
2. Audio recordings will be prefaced with the pseudonym.
3. Verbatim interview transcripts will be completed by a reputable company that has no connection with the health system. The name of the health system and the proper names of locations will be transcribed as initials.
4. The recording device, transcripts, and the informed consent will remain in the direct possession of the principal investigator or locked in a safety deposit box. At the conclusion of the study, the recording device will be wiped and returned to default settings.

What are my rights as a research participant?

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University.
- Your decision to participate will not affect your relationship with the health system.
- You may skip or refuse to answer any question for any reason.
- If you choose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You are free to withdraw from this research study at any time, for any reason.
- If you choose to withdraw from the research, there will be no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You will be informed of any significant findings developed during the course of the research that may affect your willingness to participate in the research.
- If you sustain an injury while participating in this study, your participation may be ended.

What other options do I have?

- You may choose not to participate.

Who may I contact with questions?

- The researcher conducting this study is Susan Campanelli, M.A., R.N.

- For more information regarding this study, please contact Susan Campanelli, M.A., R.N. at scampanelli@une.edu or via cell phone at (360) 731-8369
- If you choose to participate in this research study and believe you may have suffered a research related injury, please contact Carey Clark, Ph.D., R.N. at cclark14@une.edu or via cell phone at (707) 239-6738
 - If you have any questions or concerns about your rights as a research subject, you may call Mary Bachman DeSilva, Sc.D., Chair of the UNE Institutional Review Board at (207) 221-4567 or irb@une.edu.

Will I receive a copy of this consent form?

- You will be given a copy of this consent form.

Participant's Statement

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily.

Participant's signature or
Legally authorized representative

Date

Printed name

Researcher's Statement

The participant named above had sufficient time to consider the information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

Researcher's signature

Date

Printed name